

Medical Insurance

Plans Available

- ◆ [Health Net HMO Health Plan](#)
- ◆ [Health Net PPO Health Plan](#)
- ◆ [Kaiser Foundation Health Plan](#)
- ◆ [PacifiCare Health Plan](#)

Eligibility

Those eligible to participate in the district medical plans include:

- A. Regular full-time and regular part-time employees who are members of the Los Rios Management Association (LRMA).
- B. Dependents, as defined by medical insurance plans, include:
 1. The employee's spouse.
 2. A dependent child of the employee or employee's spouse who is both unmarried and under age 19.
 3. An unmarried dependent child of the employee or employee's spouse who is between the ages of 19 and 24 and a full-time student.
 4. Either you or your spouse's dependent children over your group's age limit who are incapable of self-sustaining employment because of total disability (as defined by the carrier), which occurred prior to the limiting age and who are chiefly dependent upon you or your spouse for support and maintenance.
- C. Employee's domestic partner and children of domestic partner.

Enrollment

New employees must file an application for enrollment within 31 calendar days of their date of hire. Coverage will begin on the first day of the month following their date of hire. **It is the employee's responsibility to enroll newborn children, adopted children, new spouses and other dependent children within 31 calendar days of birth, adoption or marriage.** If not enrolled within 31 calendar days, the employee must wait until the next District open enrollment.

The District's annual open enrollment for Health Net, Kaiser or PacifiCare medical plans is typically scheduled from September 1 through September 30 of each year. Coverage for new enrollees and any changes would become effective on November 1. During this open enrollment period, eligible employees will be able to:

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1. Enroll in Health Net, Kaiser or PacifiCare medical plans.
2. Change from one medical plan to another.
3. Add dependents to medical plans.

Domestic Partners

Employees may enroll domestic partners and eligible children of domestic partners in a medical plan within 31 calendar days of submitting a notarized [Affidavit of Domestic Partnership](#), within 31 calendar days of adoption or birth, or during the District's annual September open enrollment period.

Under applicable federal and state income tax law, payments for medical coverage for a domestic partner are not eligible for pre-tax treatment. In addition, coverage of the domestic partner will result in additional imputed taxable income to the employee. If domestic partners and/or their dependents meet the definition of a dependent under section 152 of the IRS code, the value of their medical/dental insurance is exempt from imputed income. You may want to contact your tax advisor for guidance if you believe you might be exempt from imputed income.

Effective January 1, 2002, California law exempts you from paying State income tax on *imputed income* if you have filed a Declaration of Domestic Partnership with the California Secretary of State, and either of the two following conditions are met: (1) you and your partner are of the same sex or 2) either you or your partner is over 62 and meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) or Section 1381.

If you have already filed a declaration with the Secretary of State, please forward a copy to the Employee Benefits Department and we will adjust your State taxable income accordingly. If you have not filed a declaration, but are eligible and wish to do so, you can download the form from the Secretary of State's website, www.ss.ca.gov, (under "Special Programs Information") and follow the directions printed on the form.

Please refer to the [domestic partner](#) section of this site for detailed information regarding the District's domestic partner policies and procedures.

Important Eligibility and Coverage Information

Normally you cannot change medical plan elections in which you participate during a calendar year, except during open enrollment, which is typically scheduled during the month of September each year.

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An exception to waiting for open enrollment would be by reason of a Qualifying Family Status Change event. Acceptable Family Status Changes are listed below. You have 31 calendar days from the date of your qualifying event to notify the Employee Benefits Department and submit the required forms.

Qualifying Family Status Changes
Marriage, divorce, legal separation, or death of your spouse or domestic partner
Birth, adoption or death of your dependent child or domestic partner's child
Change in your dependent child's status or the child of your domestic partner (student eligibility; marriage; etc.)
Termination or commencement of your spouse's employment
A significant change in health coverage provided by your spouse's employer that affects you or your spouse
You enter or end a domestic partnership
Your dependents have moved into, or out of, the service area
You change from part-time to full-time status, or vice versa

If you have a Qualifying Family Status Change, you can revise your benefits only in ways that are consistent with that change. For instance, if one of your covered children is no longer a full-time student, you would delete her/him from your coverage, but you would not be eligible to change any other dependent's coverage or your own coverage. **Your written request to make plan changes must be received by Employee Benefits within 31 calendar days of the qualifying event.**

Premiums

**Current Monthly Cost for Regular Employees
Premiums Listed Below Are Effective From 7/1/2008-6/30/2009
(This cost includes coverage for enrolled dependents)**

MEDICAL PLANS	2008-2009 PREMIUMS	2008-2009 DISTRICT CONTRIBUTION	2008-2009 EMPLOYEE CONTRIBUTION
Kaiser	\$746.66	\$746.66	\$ -0-
Health Net HMO	1,105.81	746.66	359.15
Health Net PPO	1,455.07	746.66	708.41
PacifiCare	1,083.56	746.66	336.90

Out-of-pocket premium costs are deducted from gross wages **before** taxes are calculated.

Termination of Coverage

Coverage will end on the last day of the month in which employment is terminated, paid status ceases or cancellation is requested.

COBRA

COBRA continuation benefits may be available if you and/or your dependents lose coverage due to termination of employment, divorce, legal separation or dependent ineligibility. The Los Rios Employee Benefits Department must be notified in writing within sixty (60) days of the date of the later of the qualifying event or the date on which coverage would end under the plan because of the qualifying event.

In the event of an employee's termination of employment or death, the Los Rios Employee Benefits Department will inform the employee or qualified beneficiary of their right to continue coverage. Qualified beneficiaries will have sixty (60) days from the date they lose coverage because of a qualifying event to inform the Los Rios Employee Benefits Department in writing that they want COBRA continuation coverage.

Note: Refer to the [COBRA](#) section of this site for a detailed description of COBRA continuation benefits.

MEDICAL PLANS

**Kaiser
Health Net HMO
Health Net PPO
PacifiCare**

**Kaiser (Group #233)
Member Services – (800) 464-4000**

Kaiser is a health maintenance organization (HMO) providing comprehensive health care. You must reside within an eligible service area zip code to qualify for enrollment. For a list of qualifying zip codes you may visit the Kaiser Permanente's website at <https://prospectivemembers.kaiserpermanente.org/kpweb/entryPage.do?cfe=052>, or you may contact Member Services or the Employee Benefits Department for a list of eligible zip codes. Members must utilize Kaiser Facilities and Kaiser Physicians unless it is an emergency (as defined by Kaiser). Standard co-payments are \$15 for office visits and \$10 for each prescription. Please refer to the [schedule of prepayment fees](#) for additional co-payment/coverage information.

Selecting a Primary Care Physician

As a member of Kaiser, you are encouraged to choose a personal physician(s) for yourself and covered dependents. You may select personal plan physicians from the following specialties: internal medicine, obstetrics/gynecology, family practice and pediatrics. To select or change a personal physician, contact Kaiser Member Services at the number listed above. If you do not select a physician beforehand, Kaiser will assign a physician the first time you call to schedule an appointment.

Terms & Conditions

Your participation and the benefits to which you are entitled under the Kaiser Health Plan are subject to the terms and provisions of the plan as defined by Kaiser and/or [District policies](#). This description of the Kaiser Health Plan is general in nature and does not fully describe all of the terms and conditions of this plan. To obtain a more detailed description of the plan, contact Kaiser or the Employee Benefits Department. You may also visit Kaiser's web site at <http://www.kaiserpermanente.org/>.

**Kaiser Schedule of Prepayment Fees
Group #233**

BENEFIT	DESCRIPTION	CO-PAYMENT
In The Hospital	All physician and surgeon services	No Charge
	Intensive care/Cardiac Care	No Charge
	Room and board	No Charge
	Laboratory and X-ray	No Charge
	Physical therapy (short term)	No Charge
	Other necessary services and supplies (including special nursing and administered medications)	No Charge
In The Doctor's Office	Allergy test and injection visits	\$3 Per Visit
	Physical therapy visits (short term)	\$15 per visit
	Laboratory and X-ray	No Charge
	Office visits (includes routine physical exams, OB/GYN appointments, hearing and vision exams)	\$15 Per Visit
Ambulance	Ambulance Services	No Charge
Emergency Room	Emergency Department Visits	\$35 Per Visit (does not apply if admitted)
Maternity Care	Prenatal and well baby exams (up to 23 months old)	\$5 Per Visit
	Hospital services	No Charge
	Complications of pregnancy	No Charge
Prescription Drugs	Obtained at Plan pharmacies (up to 100-day supply for generic and prescribed, medically necessary brand name drugs)	\$10
Durable Medical Equipment	Covered DME according to Kaiser formulary	No Charge
Extended Care	Up to 100 days per calendar year of prescribed care in a skilled nursing facility	No Charge
Mental Health Care	Office Visits (up to 20 days per calendar year) Individual/Group visit	\$15/\$7 Per Visit
	Hospitalization (up to 45 days per calendar year)	No Charge
Alcohol or Drug Dependency Care	Office Visits Individual/Group	\$15/\$5 Per Visit
	Inpatient detoxification	No Charge
	Transitional residential recovery services	\$100 Per Admission

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Health Net HMO (Group #F5910A) Member Services – (800) 522-0088

Health Net is a health maintenance organization providing comprehensive health care. You must live within an eligible service area zip code to qualify for enrollment. You may contact Health Net Member Services or the Employee Benefits Department for a list of eligible zip codes.

Selecting a Primary Care Physician

As a member of Health Net Health Plan, you are required to select a primary care physician from the participating provider directory. A copy of the directory may be obtained from Health Net, from the District Office Employee Benefits Department or you may visit the Health Net web site at <http://www.healthnet.com/> for up-to-date directory information. If you do not select a physician when you enroll, Health Net will select one for you. Each family member may choose his/her own primary care physician. Your primary care physician, when necessary, will refer you to a Health Net specialist by issuing a referral form called an Authorization for Consultant's Services. This form lists the type of care or services that you need and the number of visits that you can schedule. Self-referrals are allowed for Obstetrician and Gynecological services.

You may switch doctors within the same physician group at any time. You may also transfer to another physician group monthly. Contact Health Net by the 15th of the month to have your transfer effective by the 1st of the following month. If you call after the 15th, your transfer will be effective the 1st of the next month, or an additional 30 days later.

Co-payment/Prepayment Fees

Standard co-payments are \$15 for office visits, \$10 for generic prescription drugs and \$20 for brand name prescription drugs included in Health Net's Formulary. Health Net's new Pharmacy Benefit Plan now offers a \$35 non-Formulary benefit under which members pay a \$35 co-payment when the drug is not on the Health Net Drug Formulary. If a brand name drug is requested by a member when a generic equivalent is commercially available, the co-payment is \$35 plus the difference in cost between the brand name drug and the generic equivalent. However, if the Prescription Drug Order states "do not substitute" or "dispense as written," in the physician's handwriting, only the non-formulary brand name drug co-payment will apply. Please refer to the [schedule of prepayment fees](#) for additional co-payment/coverage information.

Terms & Conditions

Your participation and the benefits to which you are entitled under the Health Net Health Plan is subject to the terms and provisions of the plan as defined by Health Net and/or [District policies](#). This description of the Health Net Health Plan is general in nature and does not fully describe all of the terms and conditions of this plan. To obtain a more detailed description of the plan, contact Health Net or the Employee Benefits Department.

**Health Net HMO Schedule of Prepayment Fees
Group #F5910A**

BENEFIT	DESCRIPTION	CO-PAYMENT
In The Hospital	All physician and surgeon services	No Charge
	Intensive care/Cardiac Care	No Charge
	Room and board	No Charge
	Laboratory and X-ray	No Charge
	Physical therapy (short term)	No Charge
	Other necessary services and supplies (including special nursing and administered medications)	No Charge
In The Doctor's Office	Allergy test and injection visits	No Charge
	Physical therapy visits (short term)	No Charge
	Laboratory and X-ray	No Charge
	Office visits (includes routine physical exams, OB/GYN appointments, hearing and vision exams)	\$15 Per Visit
Ambulance	Air or Ground Ambulance Services	No Charge
Emergency Room	Emergency Department Visits	\$35 Per Visit
Maternity Care	Prenatal exams	\$15 Per Visit
	Hospital services	No Charge
	Complications of pregnancy	No Charge
Prescription Drugs	Obtained at Plan pharmacies (up to 30-day supply for generic and prescribed, medically necessary brand name drugs)	\$10, \$20 or \$35
Durable Medical Equipment	Durable Medical Equipment	No Charge
Extended Care	Up to 100 days per calendar year of prescribed care in a skilled nursing facility	No Charge
Mental Health Care	Office Visits (up to 20 days per calendar year) Individual/Group visit	\$30/\$15 Per Visit
	Hospitalization (up to 30 days per calendar year)	No Charge
Alcohol or Drug Dependency Care	Office Visits Individual/Group	\$30/\$15 Per Visit
	Inpatient (30 day max per calendar year)	No Charge

**Health Net PPO (Group # 29196A)
Member Services – (800) 522-0088**

A Preferred Provider Organization (PPO) is a form of managed care, but it is similar to a traditional “fee-for-service” plan. PPO’s contract with doctors, hospitals and other providers of health care to provide services for an agreed upon charge. Unlike an HMO, where a primary care physician directs all of your care, a PPO allows you to select a provider, and a specialist, without referral. You have freedom of choice to select the physician or hospital of your choice, as long as you are in the group plan.

Level of Coverage

Basically, Health Net’s PPO provides two levels of coverage, “In-Network” and “Out-of-Network.” If you select a physician or hospital from within Health Net’s network, your out-of-pocket costs will be lower because these providers have agreed in advance to provide services for a specific fee. If you are utilizing providers outside the network, you will be responsible for the applicable co-payments or coinsurance, plus payments of any charges that Health Net considers excessive. Certain services require “certification,” or prior approval, to ensure that you receive full benefits under the plan. These services are listed in Health Net’s *Summary of Benefits* brochure, available from the Employee Benefits Department.

Pre-Existing Conditions

Unlike our HMO contracts, Health Net’s PPO plan imposes a pre-existing conditions exclusion on medical conditions for which the employee, or any dependent, has been treated during the six-month period prior to enrollment. A pre-existing condition is a medical condition, illness or injury for which a member received care or advice within six months prior to enrolling in the plan. The pre-existing conditions clause would be waived if the employee or dependent were covered by a medical plan for the immediate prior six months preceding enrollment. If there were a lapse in coverage for even one month during the prior six months, the pre-existing conditions clause would apply.

Participating Physicians

A copy of the PPO directory of physicians may be obtained from Health Net, from the District Office Employee Benefits Department, or you may visit the Health Net web site at www.healthnet.com for up-to-date-directory information. Please refer to the [schedule of prepayment](#) fees for additional co-payment/coverage information.

Terms & Conditions

Your participation and the benefits to which you are entitled under the Health Net Health Plan is subject to the terms and provisions of the plan as defined by Health Net and/or [District policies](#). This description of the Health Net Health Plan is general in nature and does not fully describe all of the terms and conditions of this plan. To obtain a more detailed description of the plan, contact Health Net or the Employee Benefits Department.

**Health Net PPO Schedule of Prepayment Fees
Group #29196A**

Plan Benefits	Health Net Plan 2U	
	In-Network	Out-of-Network
Lifetime Maximum	\$5,000,000	
Annual Deductibles	\$250 individual/\$750 family	
Out-of-Pocket Maximum	\$3,000	\$5,000
Doctor Visit	\$15	70%
Inpatient Hospitalization/Supplies	90% after \$250 copay	70% up to \$600/day After \$250 copay
Outpatient Surgery	90% after \$250 copay	70% up to 50% of billed charges after \$250 copay
Outpatient Services	90%	70% up to 50% of billed charges
Maternity Care	90% after \$250 copay	70% up to \$600/day After \$250 copay
Substance Abuse – Inpatient (up to 30 days/calendar yr.)	90% up to \$175/day	70% up to \$175/day
Substance Abuse – Outpatient	90%	70%
Mental Health – Inpatient (up to 30 days/calendar yr.)	90% up to \$175/day	70% up to \$175/day
Mental Health – Outpatient	90%	70%
Skilled Nursing Facility	90% after \$250 copay	70% after \$250 copay
Short-Term Therapy (12 visits/calendar yr) <i>Physical, Speech, Occupational</i>	90%	70% up to \$25/per visit
X-Ray, Lab Diagnostic Services	90%	70%
Durable Medical Equipment (up to \$2,000/calendar year)	90%	70%
Emergency Room	90%	70% (+ \$100 copay if not admitted)
Rx Drugs Walk-In Generic Brand Name Non-formulary	\$5 (30 day supply) \$10 (30 day supply) 50%	
Rx Drugs Mail Order Generic	\$10 (90 day supply)	Not Available
Brand Name	\$20 (90 day supply)	

**PacifiCare (Group #100807)
Member Services (800) 624-8822**

PacifiCare is a Health Maintenance Organization (HMO) providing comprehensive health care. You must live within an eligible service area zip code to qualify for enrollment. You may contact PacifiCare Member Services or the Employee Benefits Department for a list of eligible zip codes.

Selecting a Primary Care Physician

As a member of PacifiCare Health Plan, you are required to select a primary care physician from the participating provider directory. A copy of the directory may be obtained from PacifiCare, the Employee Benefits Department, or you may visit the PacifiCare web site at www.pacificare.com for up-to-date directory information. Each family member must choose his/her own primary care physician. Your primary care physician, when necessary, will refer you to a PacifiCare specialist. If you do not select a physician when you enroll, PacifiCare will select one for you.

If your request is received on or before the 15th of the month, PacifiCare will change your participating medical group or primary care physician effective the first day of the following month. If PacifiCare receives your change request after the 15th of the month, the change will be effective the first day of the second month.

Co-payments & Prepayment Fees

Standard co-payments are \$15 for office visits, \$10 for generic prescription drugs and \$20 for brand name formulary prescription drugs. Non-Formulary prescription drugs are only available if they have been pre-authorized by PacifiCare. Please refer to the [schedule of prepayment fees](#) for additional co-payment/coverage information.

Terms & Conditions

Your participation and the benefits to which you are entitled under the PacifiCare Health Plan are subject to the terms and provisions of the plan as defined by PacifiCare and/or [District policies](#). This description of the PacifiCare Health Plan is general in nature and does not fully describe all of the terms and conditions of this plan. To obtain a more detailed description of the plan, contact PacifiCare or the Employee Benefits Department.

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**PacifiCare Health Plan Schedule of Prepayment Fees
Group #100807**

BENEFIT	DESCRIPTION	CO-PAYMENT
In The Hospital	All physician and surgeon services	No Charge
	Intensive care/Cardiac Care	No Charge
	Room and board	No Charge
	Laboratory and X-ray	No Charge
	Physical therapy (short term)	No Charge
	Other necessary services and supplies (including special nursing and administered medications)	No Charge
In The Doctor's Office	Allergy test and injection visits	\$15 Per Visit
	Physical therapy visits (short term)	No Charge
	Laboratory and X-ray	No Charge
	Office visits (includes routine physical exams, OB/GYN appointments, hearing and vision exams)	\$15 Per Visit
Ambulance	Ambulance Services	No Charge
Emergency Room	Emergency Department Visits	\$50 Per Visit (waived if admitted)
Maternity Care	Prenatal exams	\$15 Per Visit
	Hospital services	No Charge
	Complications of pregnancy	No Charge
Prescription Drugs	Obtained at Plan pharmacies (up to 30-day supply) Generic/Brand	\$10/\$20
	Mail order (up to 90-day supply) Generic/Brand	\$20/\$40
Durable Medical Equipment	Durable Medical Equipment	No Charge
Extended Care	Up to 100 days per calendar year of prescribed care in a skilled nursing facility	No Charge
Mental Health Care	Office Visits	\$15 Per Visit
	Hospitalization	No Charge
Alcohol or Drug Dependency Care	Office Visits	\$15 Per Visit
	Inpatient	No Charge