2014 Benefits Enrollment

Jump In!

pathways

Executive Management and Elected Officials

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Phone numbers, addresses and web site addresses mentioned in this guide can be found in the Helpful Information section at the end of this guide.

Pathways to Your Benefits

Each day we confront challenges, make decisions, and choose particular pathways to follow. Those pathways may be familiar or they could offer exciting new opportunities. To help you create a successful future for you and your family, the County is proud to provide you with a benefits program — Pathways to Your Benefits.

We know that your benefits are important to you and your whole family. We also know that you need tools and resources to help you take advantage of all your coverage has to offer. This Enrollment Guide is designed to help you take the first steps down the pathways to your benefits — understanding and choosing your benefits for the coming year. Inside you'll find details about your eligibility, enrollment instructions, and an outline of your medical and other benefits, as well as tips on where you can find additional information. Take some time to read through this guide carefully and share it with your family. Then you'll be ready to make the decisions that are right for you and your family. This guide is only meant to be used as a resource. For complete information, review the plan documents and plan guidelines on the Benefits Center Web Site at **www.benefitsweb.com/countyoforange.html.**

Time to Enroll

You may be eligible to enroll or change your benefits if:

- It is the Annual Open Enrollment Period.
- You are a new employee.
- You experience a Qualified Life Event such as marriage, divorce, or addition of a new dependent through birth or adoption. If adding a newly eligible dependent, you must provide the appropriate documentation (i.e., birth certificate, marriage certificate, and/or tax documents).
- You are a current employee and you experience an eligible change in employment status (e.g., promotion, full time to part time, transfer).
- You have moved out of your health plan's coverage area (HMO plans).
- You begin or end a Leave of Absence.

If You've Got Questions, We've Got Answers

If you have questions about enrollment, you can visit the Benefits Center Web Site at www.benefitsweb.com/countyoforange.html or call the Benefits Resource Line toll-free at 1- 866- 325- 2345, enter your Social Security Number, and wait to speak with a Benefits Specialist. Benefits Specialists are available Monday through Friday, 7:30 a.m. to 5:30 p.m. PT, except for holidays. If you need assistance in another language or are hearing impaired, Benefits Specialists can connect you with a translation service or TDD at no cost to you. You will need your Social Security Number and PIN to avoid delays speaking with a Benefits Specialist.

What to Do Now

It is your responsibility to understand and enroll in a health plan that is right for you and to make changes to your benefits when you experience a Qualified Life Event (QLE). Follow these steps as you prepare to enroll:

- Review your Benefits Enrollment Summary for all your options and costs.
- Review all sections of the Pathways to Your Benefits Enrollment Guide carefully and discuss your options and plan requirements with your entire family to ensure you make an enrollment choice that works for everyone you cover.
- Know what your plans do and do not cover, as well as how to access services or file claims. All plans have limitations and exclusions and some plans have prior approval requirements. You should be aware of all of these factors before you enroll. Summaries of Benefits and Coverage are available for each health plan on the Benefits Center Web Site.
- Make your elections and be sure to receive and review a confirmation statement of your elections for accuracy.
- Act within the deadline whether that is during Open Enrollment or the 30 days you have to notify the Benefits Center – online or over the telephone – that you've had a Qualifying Life Event. You will not be allowed to make changes until the next Open Enrollment unless you have another QLE.
- If enrolling a new dependent, complete and sign a Dependent Verification Form and submit the form with the documentation of eligibility to the County of Orange Benefits Center. You will have 60 days from the date of the event that made you or your dependent eligible for coverage (e.g., hire date, marriage, birth, etc.) to submit the form and documentation. If you fail to submit the required documentation within the 60 day deadline, coverage for your dependent will be cancelled at the end of the month in which the 60-day period ends. See "What Documents Must I Provide?".
- Once you've enrolled in the plans that meet your needs, learn as much as you can about how to maximize your experience as a participant. The Benefits Center Web Site and many of the insurance carriers offer tools and resources to help you manage your health, use the plans effectively and reduce your out-of-pocket expenses.

Annual Open Enrollment

The Annual Open Enrollment period generally takes place during the month of November. This is your only opportunity to make changes to your benefits unless you have a Qualified Life Event during the calendar year. Even if you do not want to change health plans, you should still review your annual Benefits Enrollment Summary as it reflects your updated costs and options for the coming year. You will be enrolled in the automatic benefits coverage shown on your Benefits Enrollment Summary if you do not make any election changes before the annual enrollment deadline.

Summary of Benefits and Coverage: Your Open Enrollment package includes a Summary of Benefits and Coverage (SBC) for your current health plan. This provides you with a summary of the health plan coverage you are currently enrolled in and allows you to easily compare your current health plan benefits to those of other County offered health plans.

SBCs for the County's other offered health plans are available to download or view at the Benefits Center Web Site at www.benefitsweb.com/countyoforange.html or the County Employee Benefits Web Site at www.ocgov.com/hr/employeebenefits or you can call the Benefits Resource Line at 1-866- 325-2345 and request to have the document(s) mailed to you.

We encourage you to utilize the various decision support and planning tools on the Benefits Center Web Site when considering your Open Enrollment options and to enroll well before the Open Enrollment deadline so that you're not left "waiting in line" to speak to a Benefits Specialist at the last minute. The benefits you elect during Open Enrollment will be effective January 1st of the following year. A series of Open Enrollment meetings will take place at various County locations to review your benefit options and answer your Open Enrollment questions. Remember, all you have to do to enroll is click or call – log onto the Benefits Center Web Site: www.benefitsweb.com/countyoforange.html or call the Benefits Resources Line 1-866-325-2345 to speak with a Benefits Specialist.

If you experience a Qualified Life Event (QLE) after the end of Open Enrollment but before the start of the new year and want to make a change to your benefits, you must call the Benefits Resource Line within 30 calendar days of your Qualified Life Event. You may need to confirm or change your recent open enrollment elections to ensure benefits coverage during the current and upcoming plan years. If you have any questions, please call the Benefits Resource Line and speak with a Benefits Specialist.

If You're a New Employee

If you are a new hire, you are invited to attend a New Hire Orientation. New Hire Orientations are held on the first Monday of each month unless the first Monday is a holiday and then the orientation will be the first Tuesday of the month. The orientations are at 9:00 a.m. You may visit the Employee Benefits Web Site at www.ocgov.com/hr/employeebenefits for location and more information.

Summary of Benefits and Coverage: To assist you selecting a health plan, a Summary of Benefits and Coverage (SBC) for each of the County offered health plans is available for you to review. This document allows you to easily compare the benefits of each of the County offered health plans. SBCs are available to download or view on the Benefits Center Web Site at www.benefitsweb.com/countyoforange.html or the County Employee Benefits Web Site at www.ocgov.com/hr/employeebenefits or you can call the Benefits Resource Line at 1-866-325-2345 and request to have the document(s) mailed to you.

You have 30 calendar days from the event date on your cover letter in your enrollment package to enroll in your benefits for the first time. After this period, you won't be allowed to make changes to your benefit elections until the next Open Enrollment unless you have a Qualified Life Event. See "Making Changes to Your Benefits if You Have a Qualified Life Event" later in this guide for more information.

Important: If you don't enroll in a County health plan within the 30-calendar-day enrollment period, a full- time employee will be enrolled in Premier Wellwise health plan with employee-only coverage. If you are a part- time employee you will be automatically enrolled in the Premier Sharewell health plan with employee-only coverage. Your employee health insurance coverage becomes effective on the first day of the month following 30 days from your hire date. The effective dates on your supplemental benefits coverage varies based upon the benefit. For more information refer to the "Supplemental Employee Benefits" section in this guide.

If You're a Current Employee with a Change in Employment Status

Status changes such as promotions, full time to part time, etc. may change your benefits options and costs. You will be sent a package from the Benefits Center outlining your options and the timing to make those decisions. If your health plan enrollment change results in an increase or decrease to your biweekly premium, it will be processed on the next available payroll cycle. Due to the timing of the file transmission and payroll deadline, you may receive your current deduction on one additional paycheck before the new premium amount is reflected.

You will be enrolled in the automatic coverage shown in your Benefits Enrollment Summary if you do not make any changes before the enrollment deadline. Review the summary, including the dependent coverage section, within the enrollment period as no changes can be made after the deadline.

Summary of Benefits and Coverage: If your status change event allows you to select a new health plan, you may review a Summary of Benefits and Coverage (SBC) for each of the County offered health plans. This document allows you to easily compare the benefits of each of the County offered health plans. SBCs are available to download or view on the Benefits Center Web Site at www.benefitsweb.com/countyoforange.html or the County Employee Benefits Web Site at www.ocgov.com/hr/employeebenefits or you can call the Benefits Resource Line at 1-866-325-2345 and request to have the document(s) mailed to you.

When you receive your Benefits Confirmation Statement, review it promptly for accuracy and remaining enrollment requirements and deadlines— you must report any errors to the elections you made within 10 business days from the date on your statement.

Keep in mind that after the Enrollment period you can't change your benefit elections during the year unless you have a Qualified Life Event. See "Making Changes to Your Benefits if You Have a Qualified Life Event" later in this guide for more information.

If You Change Your Mailing Address

If you change your mailing address, you must contact your human resource services and/or payroll department. It's important that the Benefits Center and health plan have your correct mailing address so that they can send your ID cards and important information about your benefits. You should follow up with the Benefits Center, and/or Human Resource Services, and/or payroll department to ensure your address change is processed. This will ensure that the Benefits Center has your correct address to send you important benefits information.

If You Move Out of Area

If you're enrolled in an HMO plan and move outside your plan's network, you must enroll in either another HMO, if one is available in your area, or in one of the PPO plans. If you do not make another election, you'll be automatically enrolled in the Premier Wellwise health plan, if you are a full-time employee or Premier Sharewell if you are a part-time employee.

Begin or End a Leave of Absence

When you go off payroll, you must pay a portion or the full cost of your health insurance if you want to continue coverage. The full cost includes both the County and the employee portions of the premium. The amount you pay is based upon the nature of the leave and/or the length of the leave. You will be sent a leave of absence package detailing your options and costs. All billings for employees on leave of absence are done on a monthly basis. You can also log onto the Benefits Center Web Site to review monthly billing and payment history.

If you do not want to continue coverage while on leave, please notify the Benefits Center. You will receive an updated package and an opportunity to re-enroll in the eligible health plan of your choice when you return to work. Your health insurance will be effective on the first day of the month following 30 calendar days from the date you return to work. For the PPO plans, new deductibles will apply. If you cancel your coverage and subsequently retire before returning to work, you will not be eligible to enroll in a County retiree health plan. This lapse in coverage also makes you ineligible for COBRA coverage.

You may choose to retain your coverage but terminate coverage for your dependents while you are off payroll. Upon return to work you may enroll dependents by responding to the return from leave package you will receive prior to the deadline given.

Leave Programs

Employees may request to take a leave of absence while employed at the County. The County offers many different leave types, such as Family Medical Leave and Pregnancy Disability Leave. The leave type you have been approved for will dictate how you continue to pay for your health insurance premiums.

Contact a Human Resource Services Specialist in your agency for specific requirements and more information on the leave programs for which you are eligible.

Making Changes to Your Benefits if You Have a Qualified Life Event

You may change your benefits during the year if you experience certain Qualified Life Events. Listed below are some of the situations in which a change may be permitted:

- You marry, divorce, become legally separated, or your marriage is annulled.
- You file a declaration of domestic partnership.
- You gain a dependent through birth, marriage, adoption, placement for adoption, or domestic partnership.
- Your dependent or legal spouse/domestic partner dies.
- Your dependent no longer meets the eligibility requirements.
- You, your legal spouse/domestic partner has a change in employment status that results in gaining or losing eligibility for coverage.
- You, your dependent, or your legal spouse/domestic partner moves to a location where your current coverage is not available.

Please note: when you experience a Qualified Life Event you will not be allowed to change your health plan unless you move to a location where your coverage is not available. You can change health plans during Open Enrollment.

Any change in your coverage must be made within 30 calendar days of the Qualified Life Event and must be consistent with that event. If your Qualified Life Event allows you to add or remove dependents, log onto the Benefits Center Web Site or call the Benefits Resource Line and speak to a Benefits Specialist to make any necessary changes. You will have 60 days from the date of the event that made you or your new dependent eligible for coverage to submit the Dependent Verification Form and any other required documentation to the Benefits Center. Forms or written documentation may include birth certificate, marriage certificate, and tax return documentation (verification of ongoing marriage status). Keep in mind that health plan contracts do not allow you to add newly eligible dependents after the 30-day period.

If your health plan enrollment change results in an increase or decrease to your biweekly premium, it will be processed on the next available payroll cycle. Due to the timing of the file transmission and payroll deadline, you may receive your current deduction on one additional paycheck before the new premium amount is reflected.

You must notify the Benefits Center within 30 calendar days of the date on which your covered dependent no longer meets eligibility requirements. Some examples of loss of eligibility may include divorce or a dependent child no longer meets eligibility requirements. If an ineligible dependent is enrolled, or you fail to report loss of eligibility, you may be responsible for repayment of the County's portion of your premiums paid retroactive to the date of ineligibility as well as the cost of services provided to ineligible dependents. There will be no refund of the dependent rates you paid during the period of ineligibility. In addition, failing to report a loss of eligibility within 30 days may result in loss of eligibility for continuation of coverage through COBRA.

The Last Step on Your Pathways to Benefits

After you enroll (or at the end of your enrollment period if you did not make any enrollment elections), you'll receive a Benefits Confirmation Statement in the mail. You can also print out a statement if you enroll online. Your online Confirmation Statement should have a number assigned to it. This will show you that you have properly saved your elections. Review the statement to make sure it correctly reflects your benefit elections. If during your election period you added a newly eligible dependent, you must submit the required documentation of your dependent's eligibility to the Benefits Center within the time frame noted on your Benefits Confirmation Statement. If you fail to submit the required documentation in a timely manner, your dependent's coverage will be cancelled. You will be responsible for the cost of medical expenses incurred after the cancellation of your dependent's coverage. If any of the information on your statement is incomplete or incorrect, call the Benefits Resource Line right away to speak with a Benefits Specialist. You have 10 business days from the date of your Benefits Confirmation Statement to report errors in elections you've made. After the enrollment period, if you don't receive a Benefits Confirmation Statement shortly after making your elections, call the Benefits Resource Line right away to notify a Benefits Specialist. You are solely responsible for informing the Benefits Center of any errors in your benefits selection.

Employee Married to Employee (EME) Program

Employee Married to Employee (EME) Program

The Employee Married to Employee (EME) Program can save you money if you and your legally married spouse/domestic partner are enrolled in the same health plan. Under the program, both employees must work full-time, one spouse/domestic partner must enroll as the subscriber, and the other spouse/domestic partner and any eligible children enroll as dependents in the same health plan. If you're enrolled in the EME Program, the County pays 100% of your and your dependents' health care premiums.

EME Participants Must Enroll on the Benefits Resource Line

If you're a County Employee Married to an Employee (EME), you both must call the Benefits Resource Line and speak to a Benefits Specialist to enroll in a health plan.

If you're participating in the EME Program for the first time, you'll also need to fill out the EME enrollment form, available on the Benefits Center Web Site or by calling the Benefits Resource Line. You both must call the Benefits Resource Line to make your election prior to sending in your EME enrollment form by the Enrollment deadline or, if you're a new employee, within the 30-day enrollment period.

If You Have a Qualified Life Event That Changes Your EME Status

If at any time you and your spouse or DP are no longer legally married, or have another change in family or employment status that affects your eligibility for enrollment in the EME program, you must contact the County of Orange Benefits Center immediately. **Notification to the Benefits Center must be provided within 30 days of status change. Failure to report legal separation or divorce from a covered dependent shall require repayment of all rates paid by the County under this program during the period in which the employees were ineligible due to legal separation or divorce.**

If you and your spouse or DP are active employees and one of you goes on an unpaid leave of absence (no longer on County payroll), your EME status will automatically be terminated and the person on unpaid leave will be enrolled as a dependent on the active employee's coverage. Once the employee on the unpaid leave of absence returns to work full-time, **you must contact the Benefits Center and re- enroll in the EME program** if you wish to resume EME status.

Re-establishing the EME Relationship

It is the responsibility of both full-time employees to re-establish your EME status within 30 calendar days of the event date that makes you eligible once again for the EME program. The EME status will become effective the 1st of the month following notification and receipt of the properly completed EME form to the Benefits Center. Failure to notify the Benefits Center within 30 calendar days of the event will result in not being eligible to establish an EME relationship until you experience another eligible Qualified Life Event or the next Annual Open Enrollment.

Pathways to Enrollment: Enrolling Step-by-Step

You Can Click or Call to Enroll

The Benefits Center makes it easy to enroll and get information about your benefits. You can enroll or find information about your benefits on the Benefits Center Web Site or through the Benefits Resource Line. If you need help finding information, you may speak to a Benefits Specialist.

Here's a summary of the types of information available and the kinds of changes you can make, either online or by phone:

	Log on to the Benefits Center Web Site to…	Speak to a Benefits Specialist to…
Review your automatic benefit coverage	✔	✔
Find out the cost of your benefit elections	✔	✔
Confirm who is covered under your benefit plans	✔	✔
Enroll for coverage during enrollment period	✔	✔
Use tools such as Compare/Evaluate Health Plans to help you make decisions about your benefits	✔	
View plan documents, SBCs and health plan Provider Directories	✔	
Report most Qualified Life Event changes	✔	✔
Change dependent information	✔	✔
Review status of dependent eligibility verification documentation	✔	✔
Request forms	✔	✔
Find answers to your questions about benefits	✔	✔
Direct Billing payment history	✔	✔
COBRA election and payments	✔	✔
Health Care & Dependent Care Reimbursement account information	✔	✔

- **On the Web** — You can get instant access to your benefits information at the Benefits Center Web Site 24 hours a day, 7 days a week. You can also use the Benefits Center Web Site to enroll when you're ready. You will need your Social Security Number and PIN to enroll. Once you log-in you can register for "Forgot Your Pin?" so you can access the Web Site anytime, even if you've forgotten your PIN.
- **By phone** — You can call the toll-free Benefits Resource Line and speak to a Benefits Specialist. Benefits Specialists are available to answer your questions and take your elections Monday through Friday, from 7:30 a.m. to 5:30 p.m., PT, except for holidays. If you need assistance in another language or are hearing impaired, Benefits Specialists can connect you with a translation service or TDD at no cost to you. You will need your Social Security Number and PIN to avoid delays in speaking with a Benefits Specialist.

Online enrollment and related Web tools are available to most employees and retirees eligible for County health plan coverage. Some situations, such as employees married to employees and retirees with Medicare, require speaking with a Benefits Specialist by calling the Benefits Resource Line.

What to Have with You When You Enroll

When you enroll, you should have the following handy:

- Your Social Security number.
- Your Benefits Enrollment Summary.
- Your Personal Identification Number (PIN).

If you're electing a health plan that requires you to select a Primary Care Physician when you enroll, you can find a list of Primary Care Physician identification numbers on the Benefits Center Web Site by clicking on "Helpful Links" and following the links to the health plan provider sites.

Benefits Enrollment Summary

Your personalized Benefits Enrollment Summary is a valuable tool to help you make your choices. You'll find your Benefits Enrollment Summary in your enrollment package.

This summary shows:

- Your automatic benefit coverage.
- The benefits you're eligible to enroll in.
- The share of cost for each benefit.

You will automatically be enrolled in the Automatic Benefits Coverage shown in your Benefits Enrollment Summary if you do not make any elections/changes during the enrollment period. Carefully review the benefits for which you're eligible before you enroll. You can even highlight your benefit selections on your summary so that you can quickly and easily reference them as you enroll.

You can also access your Benefits Enrollment Summary on the Benefits Center Web Site. If you can't find your PIN, either use the Benefits Center Web Site's "Forgot Your PIN?" feature (requires pre-registration) or call the Benefits Resource Line and enter your SSN and wait to speak with a Benefits Specialist.

The first time you log in with your PIN, you should also register for the "Forgot Your PIN?" feature. This will help you access the Web Site should you forget your PIN.

How to Change Your PIN

When you log on to the Benefits Center Web Site or call the Benefits Resource Line for the first time, you'll be prompted to change your PIN. You can also change your PIN any time you want. You have two ways to change your PIN:

- Online — Log on to the Benefits Center Web Site and follow the instructions to change your PIN.
- By phone — Call the Benefits Resource Line and follow the instructions to change your PIN.

Because your PIN provides access to your personal information, and the ability to make changes to your benefits, please keep it confidential at all times.

How to Enroll Through the Benefits Center Web Site

At the Benefits Center Web Site, you have information right at your fingertips. You can access the site from any computer with Internet access, at home, or locations that provide Internet access. To begin online enrollment:

1. Go to www.benefitsweb.com/countyoforange.html.
2. When prompted, enter your Social Security number and Personal Identification Number (PIN).
3. The first time you log on to the Web Site, change your PIN (you'll automatically be prompted). At this time you should also register for "Forgot Your PIN?".
4. Follow the instructions for enrollment.

From the enrollment section of the Benefits Center Web Site, you can do the following:

- Get an overview of the benefits available to you.
- Compare health plans that are important to you. You can also use the "Compare/Evaluate Health Plans" feature (available to most employees who are eligible for County health plan coverage) which estimates your out of pocket healthcare expenses for each health plan.
- Review the Summary of Benefits and Coverage for each health plan to easily compare the benefits offered.
- Read PPO plan documents and HMO Group Service Agreements, which provide detailed information about your County of Orange benefit plans.
- Elect or make changes to your benefit elections and/or dependent information.
- Review your elections, including a list of all the benefits you are eligible for through the County of Orange. The benefits you see are the benefits you will receive in the upcoming calendar year unless you make changes during enrollment period.
- Use the "Report & Manage an Event" tool to help you plan for the future. Enter different scenarios and find out how each would affect you financially. You can preview certain life events, for example, and determine what your health plan cost would be if you added a dependent.

After you have made and saved your benefit elections, you will see a Benefits Confirmation Statement. Your Confirmation Statement from the Web Site should have a number assigned to it. This will show you that you have properly saved your elections. Print a copy of this statement for your records. You'll also receive a Benefits Confirmation Statement in the mail shortly after making your elections.

Web Tools[1]

Here are some of the great tools that you'll have at your fingertips, anytime of the day or night, on the County Benefits Center Web Site.

- Compare/Evaluate Health Plans

  This tool estimates your out of pocket healthcare expenses for each health plan. There are many factors that affect your out-of-pocket healthcare expenses. The Health Plan Evaluator tool estimates your claims based on your health status and national benchmarks. This tool allows you to add or delete dependents and edit your estimated claims as needed in order to create the best estimates possible. Your estimated expenses are then calculated based on these estimated claims.

- Research Medical Conditions & Find a Hospital

  You can use the Research Medical Conditions & Find a Hospital tool on the Benefits Center Web Site to research medical conditions. Use this tool when you become aware of a health issue to learn about treatment options, risks, the recovery process, and to find suggestions for questions you should ask your doctor or health plan. The tool even lists those hospitals rated the best in treating a given condition.

The Research Medical Conditions & Find a Hospital tool also has a medical encyclopedia with additional information on various medical terms including diseases, symptoms, tests, surgical procedures, and more.

How to Use the Benefits Resource Line

To use the Benefits Resource Line:

1. Dial the toll-free phone number, 1-866-325-2345.
2. Enter your Social Security number and PIN when prompted. If this is your first time calling the Benefits Resource Line, you'll be prompted to change your PIN. Now is a great time to go to the Benefits Center Web Site and register for "Forgot Your Pin" to avoid delays in accessing the Web Site in the future and if you forget or lose your PIN.
3. Listen to the list of available options and select the one you need.

Your Benefits Confirmation Statement

You'll receive a Benefits Confirmation Statement in the mail shortly after you enroll (or at the end of your enrollment period if you did not make any enrollment elections). Review this statement carefully to make sure it's accurate. If you find an error in the elections you made, or if you make an election and don't receive a statement within 10 business days, call the Benefits Resource Line right away and speak to a Benefits Specialist. You'll have 10 business days from the date on your statement to report errors in elections you've made. You are solely responsible for informing the Benefits Center of any errors in your benefits selection.

Complete Final Enrollment Requirements

Be sure to follow any instructions in your Benefits Confirmation Statement and, if applicable, complete and return the Dependent Verification Form and documentation to ensure your elections are complete. If you fail to complete the required steps and return the completed forms, your coverage will be significantly impacted.

[1]*Compare/Evaluate Health Plans Web Tool not available to EMEs.*

How the Pathways to Benefits Program Works

The County provides benefits to help you take care of and protect yourself and your family. The benefits you're eligible to enroll in depend on your job classification. Many employees also receive supplemental benefits through their Employee Associations.

Who Is Eligible?

You're eligible for health care coverage if you're a:

- Full-time employee working 40 hours a week, or
- Part-time employee working at least 20 hours a week.

Your eligible dependents for health care coverage include your:

- Spouse or domestic partner; Same sex spouses who are legally married in a state that recognizes same sex marriage may be enrolled as a legal spouse. (Employer contributions to health premiums for a domestic partner may be treated as taxable {imputed} income.)
- Children under age 26, including step children, foster children, children placed for adoption, legally adopted children, and children of domestic partners. (Employer contributions to health premiums for children of an employee's domestic partner may be treated as taxable {imputed} income if you cannot claim the children as your dependent.)
  - The term "children" shall not include any legally married spouse or domestic partner or children of your dependent child (i.e., you may not enroll your dependent's children or spouse).
- Incapacitated children age 26 and over who are dependent upon the participant for support and were incapacitated prior to their 26th birthday. The child did not have to be covered by the County of Orange at the point they became incapacitated if the event was prior to their 26th birthday.

What Documents Must I Provide?

When you enroll a new dependent, you will be required to complete a Dependent Verification Form and submit the form along with the required documentation. A list of dependent eligibility definitions and acceptable documentation required to confirm eligibility of a dependent is available on the Benefits Center Web Site at www.benefitsweb.com/countyoforange.html, but includes documentation of adoption, birth, marriage, domestic partnership, or legal guardianship (including but not limited to; marriage certificates, birth certificates, and/or tax return documents). By enrolling your dependent in the County benefit plans you are certifying that the information supplied by you is true and correct and that your dependent meets these definitions and you are able to provide the required documentation.

IMPORTANT DEPENDENT ELIGIBLITY CHANGE FOR COUNTY HEALTH PLANS:

Effective January 1, 2014, dependent children ages 19 through 25 may be covered under a County health plan even if they are eligible for other employer health plan coverage (i.e., through their or their spouse's employer). Previous restrictions on coverage have been eliminated. You are still required to provide dependent verification documents.

You will have 60 days from the date of the event that made you or your new dependent eligible for coverage (hire date, marriage, birth, etc.) to submit the Dependent Verification Form and a copy of the required documentation for each new dependent(s) to the County of Orange Benefits Center. You will receive your health plan identification cards directly from the health plan once your dependent is enrolled; however, if you fail to submit the required documentation within 60 days from the date of the event, coverage for the dependent will be cancelled even if you have already received your card.

If you fail to respond with the form and required documentation within the 60 days, coverage for your dependent will be cancelled at the end of the month in which the 60 day period ends. You will be responsible for any medical expenses incurred after your coverage has been cancelled. If your dependent's coverage is cancelled for failure to provide the required documentation, you will not be permitted to enroll your dependent(s) again until the next Open Enrollment period unless you have a new qualified life event as defined by IRS regulations.

Once your documents are received and reviewed, you will receive an acceptance or denial letter followed by a Benefits Confirmation Statement. At any time you may verify the receipt and review status of your dependent documentation by visiting the Benefits Center Web Site at www.benefitsweb.com/countyoforange.html and selecting **My Benefits > Verify My Dependents.**

You must notify the Benefits Center within 30 calendar days of the event if your covered dependent no longer meets eligibility requirements. If an ineligible dependent has been enrolled, or you fail to report a loss of eligibility event, such as a divorce, within 30 days, you may be responsible for repayment of the County's portion of your premiums retroactive to the date of ineligibility as well as the cost of medical services provided to ineligible dependents. There will be no refund of the dependent rates you paid during the period of ineligibility. In addition, failing to report the loss of eligibility within 30 days may result in loss of eligibility for continuation of coverage through COBRA.

Domestic Partner Coverage

The County of Orange offers many of the benefits described in this guide to the registered domestic partners of eligible employees. Benefits available to a spouse and eligible dependent children may also be available to a domestic partner and his or her eligible dependent children. Coverage may include health care (including prescription drugs), dental, dependent life insurance, and voluntary AD&D coverage. Employer contributions to health premiums for a domestic partner or children of an employee's domestic partner may be treated as imputed income. Please consult your tax advisor for guidance.

What Is a Domestic Partnership?

In California, a domestic partnership is established when two people file a "Declaration Of Domestic Partnership" with the Secretary of State and meet a number of legal requirements. The partners must, among other things, have a common residence, be at least 18 years of age, not be blood-related in a way that would prevent them from being married to each other in California, and be of the same sex (unless one of them is over age 62 and at least one of them is eligible for Social Security retirement benefits).

The County also recognizes domestic partnerships that are valid in other states, so long as they are substantially the same as California domestic partnerships.

Enrolling a Domestic Partner

If you want coverage for a domestic partner and his or her eligible children, you may elect it when you first enroll for benefits, during any Open Enrollment period, Qualified Life Event, or within 30 calendar days of establishing your domestic partnership.

To enroll, you must call the Benefits Resource Line and affirm that you have a valid California "Declaration Of Domestic Partnership" or similar document from another state. You will be asked to provide a copy of the document to verify eligibility. If you and your domestic partner are both benefit-eligible County employees or retirees, you must follow the same rules for dual coverage that apply to Employee Married to Employee (EME) or Retiree Married to an Employee (RME) Program that pertain to you and your partner.

Effect on Taxes when Enrolling a Domestic Partner

If you do not claim your covered domestic partner and his or her children as dependents on your federal income tax return, you will have to pay federal tax on both the County's contributions and any before-tax contributions you make toward the cost of their health care coverage. The value of these contributions will be reported to the IRS as "imputed income." If you prefer, you may elect to make your own contributions on an after-tax basis. After-tax contributions are not taxable as imputed income. However, County contributions will still be subject to imputed income. County contributions towards domestic partner coverage are not taxable for California State income tax purposes. You will see imputed income for any before-tax contributions you make towards the cost of your domestic partner's health coverage. Please be aware that tax laws may vary from state to state. You should consult with your tax advisor in connection with the tax implications of domestic partner benefits offered by the County. The County cannot provide you with any tax advice.

For More Information

If you need more information about domestic partner coverage, call the toll-free Benefits Resource Line at 1- 866- 325- 2345 to speak to a Benefits Specialist. Benefits Specialists are available Monday through Friday, 7:30 a.m. to 5:30 p.m. PT, except holidays.

Health Plan Options

To give you choice and flexibility, the County provides a variety of health plan options. You can elect coverage from a:

- Health Maintenance Organization (HMO):
  - Cigna HMO, or
  - Kaiser HMO.
- Preferred Provider Organization (PPO):
  - Premier Wellwise PPO, or
  - Premier Sharewell PPO.

Summary of Benefits and Coverage: To compare the benefits offered by each of the County's health plans, visit the Benefits Center Web Site at www.benefitsweb.com/countyoforange.html or the County Employee Benefits Web Site at www.ocgov.com/hr/employeebenefits. There you can download or view the Summary of Benefits and Coverage (SBC) for each plan or you can call the Benefits Resource Line at 1-866-325-2345 and request to have the document(s) mailed to you.

Cost of Coverage

The County pays 95% of full-time employee-only health plan premiums and a large percentage of dependent health plan premiums. For part-time employees, the County pays a portion of employee-only health plan premiums and a portion of dependent health plan premiums.

Information on the cost of the various health plan options is available in your Benefits Enrollment Summary and through the Benefits Center Web Site.

How the HMO Plans Work

HMO plans provide a comprehensive array of services, including preventive care, at a minimal cost, but you must use providers in the HMO network. An HMO network includes doctors, hospitals, and other health care providers and facilities that have contracted with the HMO to provide care at lower rates. HMOs do not generally pay benefits for care received outside the HMO network, except in emergency situations.

Important features of HMO plans include:

- Minimal co-payments for most services (e.g., doctor's office visits).
- No claim forms.
- Coverage for preventive services such as annual physicals, Well-Baby and Well-Woman care, and Immunizations.
- No lifetime maximums.
- No pre-existing condition exclusions.

Provider changes within a plan network occur as a normal course of business and are not considered a QLE that permits a mid-year change in health plan.

Your HMO Options

The County offers two HMO plans:

- Cigna Health Plan HMO.
- Kaiser Health Plan HMO.

Summary of Benefits and Coverage for each HMO plan offered can be found under Documents and Forms on the Benefits Center Web Site.

Cigna Health Plan HMO

A few highlights of the Cigna Health Plan HMO:

- You select a Primary Care Physician from the Cigna network to coordinate all of your health care. With the exception of emergency treatment, Well Woman exams, and mental health services, your Primary Care Physician must authorize, provide, and/or arrange all of your care in order for you to receive benefits.
- You contact your Primary Care Physician's office when you need care. At the time of your appointment, you present your ID card and pay a small co-payment.
- Schedule an appointment with an OB/GYN in the same medical group as your Primary Care Physician without referral.
- When medication is prescribed, you must fill the prescription at a Cigna-contracted retail pharmacy. You pay a small co-payment for up to a 30-day supply of either a generic, brand-formulary, or Non-formulary prescription drug. A list of Cigna pharmacies is available on the Cigna Web Site and through Cigna Member Services.
- You may order up to a 90-day supply of maintenance drugs through Cigna's mail order program. To place an order, log onto myCigna.com, and go to the Cigna Home Delivery Pharmacy page or call 1-800-835-3784.
- In an emergency, seek care at the nearest hospital. Call or have the doctor or a family member call your Primary Care Physician or Cigna Member Services within 48 hours to receive benefits.
- If you need vision care, call Vision Service Plan.
- Chiropractic care is covered. See details later in this section.

How to Locate a Cigna Primary Care Physician

The provider directory for Cigna contains a list of Primary Care Physicians. It is available through the Benefits Center Web Site. A PCP listing is also available on the Cigna Web Site, and you can get assistance locating a Primary Care Physician through Cigna Member Services. When you elect the Cigna Health Plan HMO for the first time or add a dependent, you must select a Primary Care Physician before you enroll.

Kaiser Health Plan HMO

Highlights of the Kaiser Health Plan HMO:

- Health services must be provided by Kaiser providers, but it is not necessary to select a Primary Care Physician upon enrollment.
- When you need care, either contact your Kaiser primary care physician or the Kaiser appointment center in your area. At the time of your appointment, present your ID card and pay a small co-payment. You can access any Kaiser office for care.
- You can self-refer to a number of specialists, including OB/GYN, internal medicine, optometry, and mental health (varies by location).
- You have access to Kaiser's Web Site (www.kp.org/ca/oc), which offers both health and member information. You can schedule appointments, get health education information, and receive other valuable services. Health information is also available through Kaiser's toll-free number, at 1-800-464-4000.
- You must fill prescriptions at any Kaiser pharmacy, located at most medical offices. You pay a small co-payment for up to a 100-day supply of a prescription drug. Dental prescriptions are included in your coverage.
- In an emergency, seek care at the nearest hospital. Call or have the doctor or a family member call Kaiser as soon as possible to receive benefits.
- Kaiser covers chiropractic care.

Chiropractic Care

With the Cigna and Kaiser HMOs, you have direct access to the American Specialty Health Plans (ASHP) network of more than 2,400 chiropractors throughout California. If you wish to see an ASHP chiropractor, you just make an appointment and pay your co-payment at the time of your visit. A directory of ASHP chiropractors is available on both the Benefits Center and ASHP Web Sites. You can also call ASHP Customer Service for help locating a chiropractor near you.

How the PPO Plans Work

Preferred provider organizations (PPOs) give you the freedom to choose any doctor, whether or not he or she is a member of the PPO network, but you receive a higher level of benefits from in-network providers. You do not need to select a Primary Care Physician to coordinate your care and you can see a specialist any time you wish.

When You See a Network Provider, You…	When You See a Non-Network Provider, You…
Pay an annual deductible before the plan pays benefits	Pay a higher annual deductible before the plan pays benefits
Receive a higher level of benefits	Receive a lower level of benefits
Pay a percentage of a negotiated fee *	Must pay a percentage of Usual, Reasonable, and Customary (URC)** charges plus any amounts above URC charges
Have less paperwork (provider processes the paperwork and submits claims)	Pay up front, file a claim form, and wait for reimbursement (if any)

**When providers join the PPO network, they agree to accept the negotiated fee as payment in full for covered services.*
***Usual, Reasonable, and Customary charges are the usual charges to provide a health service in your geographic area as determined by the plan.*

Your PPO Options

You have two PPO plans to choose from:

- Premier Wellwise PPO, or
- Premier Sharewell PPO.

Summary of Benefits and Coverage for each PPO plan offered can be found under Documents and Forms on the Benefits Center Web Site.

A few highlights of the PPO plans:

- Blue Shield of California is the claims administrator for both PPO plans.
- When you need care, you can go to a Blue Shield of California Network provider or Non-Network provider. Although the PPO plans have the same provider network, they have different deductibles and coinsurance amounts. See the Summaries of Benefits and Coverage for details.
- When you see a Network provider, present your ID card at the time of your appointment. Your provider files the paperwork for your claim and you receive a bill in the mail for your deductible and/or coinsurance amount — 10% of the discounted rate for most covered services.
- For Premier Wellwise, when you see a Non-Network provider, you generally pay 30% of the Usual, Reasonable, and Customary (URC) charge for most covered services you have a higher deductible and, in some instances, you may have to pay up front. You are responsible for all expenses above URC.
- For Premier Sharewell, when you see a Non-Network provider, you generally pay 20% of the Usual, Reasonable, and Customary (URC) charge for most covered services and, in some instances, you may have to pay up front. You are responsible for all expenses above URC.

- Premier Wellwise pays 100% of eligible Network health care expenses that exceed $10,000 per calendar year per participant and 100% of eligible Non-Network health care expenses that exceed $15,000 per calendar year per participant. You may also be responsible for any additional expenses above URC. Premier Sharewell pays 100% of eligible health care expenses that exceed $10,000 per calendar year per participant. You are responsible for any additional expenses above URC.
- You are responsible for 100% of expenses that are not eligible under the plan.
- If you're scheduled for hospital admission or surgery, you must contact the claim administrator to obtain precertification for the hospital stay before admittance to receive the higher level of benefits.

In an emergency, seek care at the nearest hospital and call or have the doctor or a family member call Blue Shield of California's Customer Service Center within 2 business days of admission to a hospital.

Blue Shield of California Network

Each of the County plans uses the Blue Shield of California Network as its preferred provider organization network. Blue Shield of California includes more than 5,500 hospitals and 680,000 physicians across the country. You can use the provider directory on Blue Shield of California's Web Site to find out which hospitals and doctors are in the network, or you can call Blue Shield of California's Customer Service Center for assistance.

Prescription Drug Benefits — Premier Wellwise PPO

If you enroll in the Premier Wellwise PPO, Catamaran Rx will administer your prescription drug coverage. Catamaran offers discount prices on name brand and generic drugs with no annual deductible and no claim forms. Catamaran also has a large network of more than 62,000 pharmacies throughout the country, including most major pharmacies like Rite-Aid, Sav-on, CVS, and Costco, and offers state-of-the-art mail order facilities.

You must fill your prescriptions through Catamaran's participating retail pharmacies or through their mail service program. Claims for prescriptions obtained out of the network as a result of an emergency must be paid in full then filed with Blue Shield of California, the PPO claims administrator, for reimbursement. When you purchase prescription drugs from a Catamaran participating retail pharmacy, you will always present your health plan ID card to the pharmacist. The Retail90 Program is a convenient way to get a 90-day supply of your medications at select retail locations. (Your doctor must authorize a 90-day supply of medication(s). Some medications may not be available in 90-day supplies under applicable law.) This is a great way to save time and money. For more information please visit Catamaran's web site at www.mycatamaranrx.com or call toll free 1-800-573-3583 with any questions you might have. For mail service prescription drugs, or if you have a new "maintenance" medication prescription, you may use the Catamaran Mail Order program.

Here's an overview of Catamaran's prescription drug coverage:

Premier Wellwise Prescription Drug Benefits			
Type of Medication	30-Day Retail Coinsurance	90-Day (Advantage90) Retail Coinsurance	90-Day Mail Service Coinsurance
Generic	20%	20%	20%
Brand Formulary	25%	25%	25%
Non-formulary	30%	30%	30%

The Premier Wellwise Plan has a prescription formulary through Catamaran which is a list of prescription drugs that includes all Generic Drugs and certain Brand-Name Drugs. The Non-Formulary includes those Brand- Name Drugs that do not have a generic equivalent or may be a less-expensive but equally effective alternative to other Brand-Name Drugs. Catamaran determines which Brand-Name drugs are included on the Formulary.

Prescription Drug Benefits — Premier Sharewell PPO

If you enroll in the Premier Sharewell PPO plan, Blue Shield of California administers your prescription drug coverage and you can fill your prescriptions at any retail pharmacy. You pay the cost of the prescription upfront, then send a claim form with attached receipts to Blue Shield of California for reimbursement. You must satisfy the annual deductible before the plan pays 80% of the cost of covered prescription drugs.

Things to Consider If Selecting a PPO Plan

Although the County's PPO plans are very similar, there are some differences in benefits, such as different deductibles, coinsurance, and prescription drug coverage. Here are two examples:

- The Premier Wellwise PPO offers wellness incentives — up to a $200, $400, or $500 taxable incentive, depending on the level of coverage you elect — if you or your enrolled dependents don't file any claims (except for claims paid under the Preventive Care Benefit set forth in the plan document) or fill prescriptions using your PPO ID card during the year, as well as a $50 year-end taxable cash incentive for non-smoking subscribers.
- The Premier Sharewell PPO has a $5,000 annual deductible per family and is designed for employees who have other health insurance coverage but want to supplement their family's coverage. You should be aware that if you elect Premier Sharewell, and you lose your other coverage, you will not be allowed to change health plans until Open Enrollment.

Because of these differences, it's important to review each health plan's Summary of Benefits and Coverage if you're thinking about electing a PPO plan.

Health Plan Decision Guidelines

Here are some things to think about as you decide which health plan is right for you:

- Are the doctors and specialists your family prefers in the network? If they're not, are you willing to change doctors?
- Are network facilities close to your home?
- How much do you and your family typically spend on health care each year? How much are you willing to pay out-of-pocket in health care expenses? Remember that the PPO plan pays a higher percentage of expenses when you use network providers. HMOs require flat co-payments for most services, with no deductible, but you must use HMO providers.
- What do you value more — having the lowest possible out-of-pocket costs (HMO options) or the flexibility to see any provider (PPO options)?
- Are you or your children eligible for coverage under your spouse's employer's plan? If yes, you may want to enroll in the Premier Sharewell plan.

Health Plan Identification Cards and Claim Forms

If you are a new employee, or you are changing health plans during Open Enrollment, you will receive an ID card for the health plan you selected.

If you're required to submit a claim to receive plan benefits, claim forms are available directly from the Benefits Center Web Site or by calling the Benefits Resource Line.

Health Care and Dependent Care Reimbursement Accounts

The Health Care Reimbursement Account (HCRA) and Dependent Care Reimbursement Account (DCRA) allow you to set aside before-tax dollars from each paycheck to help pay eligible health care and dependent care expenses for you and your family. Effective January 1, 2014, the County of Orange Benefits Center will administer these programs.

On the Benefits Center Web Site you will be able to: access your account balance, track your claim status, see payment details, view images of the documents you have submitted, submit claims online, and more.

How the Reimbursement Accounts Work[2]

- When you enroll in a reimbursement account, you elect how much money you want to put into the account from each paycheck over the course of the year. Your before-tax contributions are automatically deducted each pay period. As a result, you have a lower net income and may pay less in income tax.

[2] Court employees not eligible for the HCRA

- When you have an eligible expense, you pay the expense and then submit a claim form to the County's HCRA/DCRA administrator.
- You may file claims for reimbursement account expenses incurred at any time during the calendar year, and claims must be filed before March 31st of the following year. If you leave County employment, including if you retire, you may only submit claims for expenses incurred up through your last day of employment.
- HCRA expenses can be reimbursed up to your full annual election immediately. For example, if you decide to contribute $1,200 to your HCRA over the course of the year and you have $1,200 of eligible expenses in February, you may request reimbursement for $1,200 at that time even though you have yet to have payroll contributions equal to the full amount.
- DCRA expenses can only be reimbursed up to the amount you have contributed via payroll. If your claim is for more than you have in your account, you will be reimbursed for the amount available to you, and the remaining approved amount will remain in the system and automatically be paid to as additional payroll contributions are made into the account.
- For both HCRA and DCRA, expenses must have been fully incurred (meaning that services have been rendered) prior to being eligible for reimbursement.
- An HCRA and a DCRA are separate accounts. Although you may enroll in both accounts, you can't use money from one account to reimburse yourself for expenses that are eligible under the other account.
- The maximum contribution amounts noted below may be lower for employees who are classified as "highly compensated employees" according to IRS rules. You will be notified of the limit on either your HCRA or your DCRA contributions, if any apply.
- Over-the-counter medications such as pain relievers and allergy medicines are not covered unless they are prescribed by a physician (with the exception of insulin). Medical supplies, such as bandages, contact lens solution and diabetic supplies are still covered and do not require a prescription.

Health Care Reimbursement Account

You may contribute up to the allowable annual limit to your HCRA. Please refer to your Benefits Enrollment Summary for the current maximum amount. The tax-free funds in your account can be used to reimburse you for eligible out-of-pocket health care expenses incurred by you and your family. Beginning 2014 you may access your HCRA funds in the following ways:

- Upload claim information and supporting documentation online at the Benefits Center Web Site;
- Submit paper claims and supporting documentation to the Benefits Center – either by mail or fax.

Eligible HCRA Expenses

Eligible health care expenses include:

- Deductibles, co-payments, and other amounts you pay out of your own pocket to cover eligible health care expenses.
- Medical, dental, vision, and prescription drug expenses that are not covered or are only partially covered by your health plans.
- No Over-the-Counter medications will be covered unless prescribed by a physician with the exception of insulin. The prescription must be provided along with the documentation for reimbursement, and must have been written by the physician in advance of the purchase.

For a list of eligible and ineligible expenses, log onto the Benefits Center Web Site, select the Reimbursement Accounts tab, and access the information under the Library and Links section.

Dependent Care Reimbursement Account

You can use a DCRA to set aside tax-free money to pay eligible dependent care expenses, such as day care for your child who is 12 years of age or younger, or care for an elderly family member. Once your child reaches age 13 their expenses are no longer eligible for reimbursement. So, plan your election amount carefully.

You're eligible to participate in a DCRA if you pay an eligible day care provider to take care of your dependent so you can work. If you're married, your spouse must also be working, looking for work, a full-time student, or physically or mentally disabled.

Each year, you may contribute up to $5,000 to your DCRA. If you're married, the amount you may put in your account is limited by a number of IRS rules:

- If you and your spouse/domestic partner file separate tax returns, the most you may set aside every year is $2,500 each.
- If your spouse/domestic partner also participates in an employer-sponsored DCRA, the total amount you and your spouse/domestic partner may set aside in both of your DCRAs can't be more than $5,000.
- The total amount you and your spouse/domestic partner set aside can't be more than either your annual income or your spouse's/domestic partner's annual income. If your spouse/domestic partner is incapable of self-care or is a full-time student for at least five months during the year, the IRS assumes that your spouse's/domestic partner's monthly income is no less than $250 if you have one eligible dependent and $500 if you have two or more eligible dependents.
- You may have to pay taxes for any expenses paid for the child of a domestic partner who you cannot claim as your own dependent.

Eligible Dependents

You can use your DCRA to pay for day care for:

- Your dependent children under age 12 and under.
- Your spouse, domestic partner, parent, or other dependent age 13 or older who is incapable of self-care. If care is provided outside the home, the dependent must spend at least eight hours each day in your home.

Eligible DCRA Expenses

Eligible dependent care expenses include:

- The cost of care at a qualified day care center that complies with local laws, gives care for more than six people, and receives payment for its services.
- Nursery school expenses.
- Payment to a private school or other provider for before- or after- school care.
- The cost of care at a day camp, or the portion of overnight-camp expenses that is for day care.
- Amounts paid providers who care for your dependent while you work if they are not your spouse/domestic partner, your child under 19, or someone else you claim as a dependent.
- Social Security and unemployment taxes you pay an eligible provider.

For a list of eligible and ineligible expenses, log onto the Benefits Center Web Site, select the Reimbursement Accounts tab, and access the information under the Library and Links section.

Important IRS Information about HCRAs and DCRAs

The "Use It or Lose It" Rule

Due to the special tax advantages of reimbursement accounts, the IRS requires that you forfeit any money left in an account after the claims-filing deadline. So, be sure to estimate your reimbursement account expenses carefully before you decide how much you want to contribute for the year.

DCRA vs. the Dependent Care Tax Credit

A DCRA allows you save on dependent care expenses by paying them with before-tax dollars. Another way to save on dependent care expenses is to take advantage of the dependent care tax credit on your federal income tax return. The amount of the federal tax credit depends on your income and the number of children you have. Keep in mind that you can't use both a DCRA and the dependent care tax credit, so you may want to consult a tax advisor to determine which one gives you greater tax savings.

How to File HCRA and DCRA Reimbursement Claims

You can obtain reimbursement claim forms:

- From the Benefits Center Web Site, you can print a claim form or request that one be mailed to you.
- By calling the Benefits Resource Line at 1-866-325-2345 and requesting a claim form.

You'll need to complete and sign your claim form, attach receipts and documentation of payment (including any Explanation of Benefits statements for HCRA claims), and mail them to the HCRA/DCRA Administrator at the address on the form.

Things to Consider before Enrolling in an HCRA or a DCRA

Before participating in an HCRA or a DCRA, you need to carefully estimate the expenses you're likely to incur and consider whether those expenses are eligible for reimbursement.

To help you plan, consider these questions:

- What were your out-of-pocket costs for health care and dependent care this year?
- What do you expect your out-of-pocket health care and dependent care expenses to be next year?
- Are you expecting a baby? If so, estimate your day care expenses and consider whether DCRA or the dependent care tax credit makes the most sense for you.
- Are you expecting any health-care expenses that are not totally covered by your benefits (e.g., orthodontia)?
- Does your spouse have a HCRA or DCRA available through his or her employer? If so, how do you want to coordinate your accounts?
- Do you have other eligible dependents for whom you want to use the HCRA or DCRA?
- Are you planning to retire in the next year? Remember, you can only file claims for expenses incurred up to your last day of employment, so plan accordingly.

Determining Your HCRA and DCRA Contributions

You can use the forms below to help estimate your and your dependents' expenses for the coming year. You may want to review your bills and checkbook register from the previous 12 months as you estimate your upcoming expenses. Remember to estimate conservatively – the IRS requires that you forfeit any amounts left in your accounts after the claim-filing deadline. In addition, you cannot change the amount you elect unless you experience a Qualified Life Event. For more information, obtain a copy of the County's Section 125 Plan Document which is available on the Benefits Center Web Site. For information about eligible expenses, you can log on to the Web Site, select the Reimbursement Accounts tab, and access the information under the Library and Links section or you can call the Benefits Resources Line and speak with a Benefits Specialist. For additional information, you may also call the IRS at **1-800-828-3676** or visit **www.irs.gov**.

HCRA Expense Estimates for the Coming Year				
	Your	Your Spouse	Other Dependents	Total
Medical and dental insurance deductibles				
Medical, dental, vision and prescription drug co-payments *				
Health care expenses not covered by health plans				
Other eligible expenses				
Your total estimated expenses				

*Remember, over-the-counter medications are not covered unless they are prescribed by a physician.

Based on your total estimated expenses, choose the amount (up to the allowable annual limit) you want deducted from your paycheck and deposited in your HCRA.

DCRA Expense Estimates			
	Your Children Age 12 and under	Other Dependents	Total
Preschool			
After-school care			
Day care for eligible children or disabled adults			
Other eligible expenses			
Your total estimated expenses			

Based on your total estimated expenses, choose the amount (up to $5,000 a year) you want deducted from your paycheck and deposited in your DCRA.

Supplemental Employee Benefits

The County of Orange offers supplemental benefits to protect you and your family in addition to your health coverage. These benefits include:

- Dental Plan.
- Basic Life and Basic Accidental Death and Dismemberment (AD&D) insurance.
- Voluntary Life and AD&D insurance.
- Short-Term and Long-Term Disability plans (Salary Continuance).
- Employee Assistance Program.
- Optional Benefit Plan.
- 401(a) Defined Contribution Program.
- 457 Defined Contribution Program.
- Retirement Benefits.
- Annual Physical.

Eligible Dependents

Some supplemental benefits cover your dependents. You may have to pay taxes on deductions or benefits used by your domestic partner. Please consult your tax advisor for guidance.

For the Dental Plan, your eligible dependents include your:

- Spouse or domestic partner.
- Unmarried children — including step children, foster children, children placed for adoption, children of a legal spouse/domestic partner, or legally adopted children — under age 19 (or under age 25 if full-time students at an accredited school, high school, college, or university) who are dependent on you for financial support.
  - Note: you are required to provide documentation of full-time student status each year for your dependent child age 19-24 to remain on your dental coverage.
- Unmarried incapacitated children over age 19 who are dependent upon the participant for support and were incapacitated prior to their 19th birthday. The child did not have to be covered by the County of Orange at the point they became incapacitated if the event was prior to their 19th birthday.

For Dependent Life insurance, your eligible dependents include your:

- Spouse or domestic partner.
- Unmarried children — including step children, foster children, children placed for adoption, children of a legal spouse/domestic partner, or legally adopted children — under age 19 (or under age 25 if full-time students at an accredited school, high school, college, or university) who are dependent on you for financial support.
- Unmarried incapacitated children of any age who are dependent upon the participant for support and were incapacitated prior to their 21st birthday. The child did not have to be covered by the County of Orange at the point they became incapacitated if the event was prior to their 21st birthday.

For Voluntary AD&D insurance, your eligible dependents include your:

- Spouse or domestic partner.
- Unmarried children — including stepchildren, legally adopted children, and children of a domestic partner — under age 20 (or under age 24 if full-time students at an accredited school, college, or university) who are dependent on you for financial support.
- Unmarried incapacitated children of any age who are dependent upon the participant for support and were incapacitated prior to their 20th birthday. The child did not have to be covered by the County of Orange at the point they became incapacitated if the event was prior to their 20th birthday.

Coverage Costs

Your personalized Benefits Enrollment Summary lists the benefit options available to you and your cost for each option (if applicable).

Dental Plan

The County Dental Plan offers comprehensive dental benefits for you and your family. The coverage is provided at no cost to you.

When Dental Coverage Begins

If you're a full-time employee, you are automatically covered under the Dental Plan effective the first day of the month following 30 calendar days from your date of hire/appointment date to an Executive Management or Elected Official position or the first day of the month after you're promoted to an Executive Management or Elected Official position.

If you wish to enroll your eligible dependents, documentation of adoption, birth, marriage, domestic partnership, or legal guardianship (such as a marriage certificate, birth certificate and/or tax return document) will be required when adding a new dependent to your coverage. For dependent children age 19 through 24, you must provide documentation that they are full-time students at initial enrollment and each year they are eligible. You must elect the appropriate family coverage within 30 calendar days after your coverage begins. If you don't enroll your dependents, you receive automatic dental coverage for yourself only, and you will be unable to add your dependents until Open Enrollment or at such time as you experience a Qualified Life Event.

How the Dental Plan Works

The Dental Plan is a "freedom of choice" plan administered by Blue Shield of California Dental. You may see any licensed dentist for your care, though you will maximize your benefit and pay lower out-of-pocket costs if you see a dentist who is part of the Blue Shield dental network. After you pay a lifetime deductible (for basic services) and an annual deductible (for major services), the plan pays a percentage of eligible expenses, based on Usual, Reasonable, and Customary (URC) charges — the usual charges for dental services

in your geographic area as determined by the plan. If your dentist charges more than URC charges, you are responsible for paying the amounts above URC limits.

The percentage of eligible expenses that the plan pays for basic dental services increases each consecutive year that you receive a dental service and file a claim. The first year, the plan pays 80%; the second year, the plan pays 90%; and the third year and after, the plan pays 100%. If you do not have a dental service in any year or do not file a claim, you revert back to the 80% reimbursement level.

The benefit rate for major dental services is always 50%.

Your Dental Plan At-A-Glance

Dental Plan Benefits			
Basic Services (including prophylaxis twice a year, X-rays, teeth scaling and polishing, fillings, extractions, oral surgery, root canals, space maintainers, periodontal procedures, pain treatment, and fluoride treatment)			
Lifetime Deductible	$25 / person		
	1st Calendar Year	2nd Calendar Year	3rd Calendar Year
Plan Pays	80% of URC	90% of URC	100% of URC
Major Services (including inlays, onlays, bridges, crowns, crown and bridge repairs, and partial and full dentures)			
Annual Deductible	$25 / person		
Plan Pays	50% of URC*		
Calendar-year Maximum (basic and major services combined)	$1,500 / person		

*The benefit rate for major dental services remains the same each year.

Predetermination of Benefits

If a proposed dental treatment is expected to cost more than $1,200, the dentist should submit a treatment plan to the Dental Plan Administrator, Blue Shield of California for review before providing services. You and your dentist will be advised what's covered and how much you'll have to pay.

How to File Claims

When you see your dentist, you may have to pay upfront for services then complete a claim form and send it to Blue Shield of California for reimbursement. You can get a claim form from the Benefits Center Web Site or by calling Blue Shield of California Dental.

For More Information

More information on the Dental Plan is available on the Benefits Center Web Site or by contacting Blue Shield of California.

Basic Life and Accidental Death and Dismemberment Insurance

The County provides you with $125,000 of Basic Life Insurance as well as $125,000 Basic Accidental Death and Dismemberment (AD&D) coverage if you die or suffer a dismembering injury due to an accident. These benefits are provided at no cost to you.

When Basic Life and AD&D Coverage Begins

Your Basic Life and Basic AD&D insurance becomes effective on the first day of the month following 30 consecutive days from your hire date or the first day of the month following your promotion date

IRS Rules on Life Insurance over $50,000

The Internal Revenue Service (IRS) considers the cost of life insurance coverage over $50,000 paid by an employer as employee income, subject to Federal and State income taxes. Coverage amounts above $50,000 are assigned a value based on an IRS table. That value is reported as "other compensation" on your W-2 form and treated as taxable income.

Voluntary Life Insurance

You may purchase voluntary coverage — Additional Life, Extra Additional Life, Dependent Life — in addition to your County-paid Basic Life insurance.

Evidence of Insurability (EOI)

For voluntary life insurance, evidence of insurability (EOI), means that you or your dependents will need to complete a medical history statement and be approved in writing by The Standard Insurance Company prior to any voluntary life coverage becoming effective. You (or your dependents) need EOI to be approved for certain types of coverage, including:

- Additional Life, 1x and 2x Extra Additional Life, or Dependent Life of any amount if elected more than 30 calendar days after the latest of your hire date, promotion date, or the date on your enrollment package
- Additional Life of 3x Basic Life (always required)
- Extra Additional Life of $150,000, $200,000, or $250,000 (always required)

If a Medical History Statement is required, it will be included with your Benefits Confirmation Statement. You'll need to complete and sign the Medical History Statement and return it directly to Standard. The Benefits Center and Standard will notify you if your coverage has been approved and you'll receive a confirmation statement showing the new coverage level and cost. Standard will notify you if your additional coverage has been denied.

When an election is pending EOI approval, you are given the highest level of coverage permitted that does not require EOI approval.

When Coverage Begins

You may elect voluntary life insurance at any time, subject to EOI. You may end coverage at any time.

If EOI is not required, your effective date for any voluntary life insurance plan is the first of the month following your election date. If EOI is required, then your effective date is the first of the month following approval by The Standard Insurance Company.

Additional Life Insurance Benefits

You may buy Additional Life insurance for yourself in these amounts:

- One times (1x) Basic Life
- Two times (2x) Basic Life
- Three times (3x) Basic Life

Extra Additional Life Insurance Benefits

You may buy Extra Additional Life insurance for yourself in these amounts:

- $50,000
- $100,000
- $150,000
- $200,000
- $250,000

Dependent Life Insurance Benefits

You may buy Dependent Life insurance in these amounts:

- Spouse/domestic partner: $20,000
- Dependent child: $5,000

Life Insurance Portability Feature

Your life insurance is portable. This means that if your employment with the County ends, you may continue your Basic Life, Additional Life, Extra Additional Life, and Dependent Life insurance if:

- You're under 65 years old,
- You've been continuously insured for at least 12 months for the amount of insurance that you wish to continue, and
- You're able to perform the duties of at least one gainful occupation for which you're reasonably suited by education, training, and experience.

The minimum amount of life insurance that you may continue is $25,000. The maximum total life insurance coverage that you may continue for any individual is the amount in effect on your employment end date or $300,000, whichever is less.

After you leave employment with the County, you pay group rates for portable coverage. Group rates are not the same as the County's rates, but are generally lower than the cost of an individual term or whole life policy. To select portable coverage, you must contact The Standard Insurance Company within 31 days of the date your employment ends. If you are not eligible for the Portability provision, you may elect the Conversion option. Conversion must also be elected within 31 days of your date of termination. Portability and Conversion forms are available on the Benefits Center Web Site.

Voluntary AD&D

You may buy Voluntary AD&D insurance for yourself only or for yourself and your family at any time with coverage levels:

- $20,000
- $40,000
- $60,000
- $80,000
- $100,000
- $150,000
- $200,000
- $250,000

Beneficiary Designations

The beneficiary(ies) you designate for Basic Life and Basic AD&D are used for any voluntary coverage you elect.

If you're a new employee, you may make your beneficiary designations online at the Benefits Center Web Site or you can complete the Beneficiary Designation form (included with your Confirmation Statement) and return it to the Benefits Center.

It's important to keep your beneficiary designations up to date so that your family will not encounter delays or legal problems before receiving benefits. Any time you wish to change your beneficiary designation, log onto the Benefits Center Web Site and make your change or call the Benefits Resource Line and speak to a Benefits Specialist.

Short-Term Disability Coverage*

The County provides a Disability Salary Continuance Plan, also known as a short-term disability (STD) benefit, to help protect your income if an injury or illness keeps you from working for an extended period of time. There is no cost to you for STD benefits.

You'll receive a taxable STD benefit of 60% of your covered earnings. Your STD benefits are reduced by any income that you receive from other sources during your disability (e.g., workers' compensation, Social Security, catastrophic leave, etc).

STD coverage is effective on the 31st consecutive day after your hire, appointment, or promotion date, as long as you meet the active work requirement.

When STD Benefits Begin and End

You begin receiving STD benefits after you exhaust 192 hours of annual leave and a disability keeps you from working an additional seven days. If your disability is caused by an accident or you're hospitalized, the seven-day waiting period is waived and your benefits begin immediately.

You stop receiving benefits when you are again able to work or when you receive STD benefits for 12 months, whichever comes first.

*Does not apply to Elected Officials

How to Apply for STD Benefits

You may receive STD benefits if:

- A licensed medical professional determines that you're totally disabled,
- You're unable to perform your normal job duties,
- Your disability is expected to last longer than seven working days after you exhaust your 192 hours of annual leave, and
- You're not on a catastrophic leave. You're considered to be on catastrophic leave when you're on an extended unpaid medical leave due to a catastrophic medical condition and you receive donated vacation and/or compensatory time from other employees.

You can apply for STD benefits using forms downloaded from the Benefits Center Web Site. You must fill out and submit a disability package, Salary Continuance form, and W-4 form.

Once the County of Orange Employee Benefits Office receives your completed STD package it will complete the employer portion of the form and send it to Standard for processing. You will be notified by Standard if your STD benefits are approved.

Long-Term Disability Coverage*

The Long-Term Disability (LTD) Plan provides you with income protection if you have a disability that prevents you from performing your regular job duties and you exhaust your Short-Term Disability benefits.

If your STD benefits end and you still cannot perform your regular job duties, you may receive benefits under the LTD Plan. The Standard Insurance Company will automatically consider your eligibility for LTD benefits when it's determined that your disability will continue longer than 12 months.

If you are approved for LTD benefits, you receive a taxable benefit of 60% of your covered earnings (up to a maximum benefit of $12,000 per month). You receive this benefit for up to 24 months if you cannot perform your regular job duties. After 24 months, you continue to receive a benefit if you cannot perform any job duties in any employment or occupation for which you are or become reasonably fitted by education, training, or experience. LTD benefits are reduced by any income you receive from other sources (e.g., workers' compensation, Social Security, catastrophic leave, etc.).

LTD benefits end automatically on the earliest of date: you are no longer disabled, the date your maximum benefit period ends, the date you die, the date benefits become payable under any other LTD plan under which you become insured through employment during a period of temporary recovery or the date you fail to provide documentation of continued disability and entitlement to benefits.

*Does not apply to Elected Officials

Continuing Your Benefits and Payments While on Disability Leave		
Here's the cost breakdown to continue your other benefits while on disability leave.		
If You're on STD Leave...	**The County Pays...**	**You Pay...**
Health Coverage	Its share of health premiums.	Your share of the health premium for your dependents, if any, or 5% for employee only coverage.
Dental Coverage	The full premium for you and your enrolled dependents.	$0
Basic Life and Basic AD&D	The full premiums up to maximum of 90 days.	$0 up to maximum of 90 days.
Additional Life, Dependent Life and voluntary AD&D	$0	The full premiums.
If You're on LTD Leave...	**The County Pays...**	**You Pay...**
Health, Basic Life*, Basic AD&D and Voluntary Life*	$0	The full premiums.

*When you apply for LTD benefits, The Standard Insurance Company will automatically consider waiving your premium for Basic Life and Voluntary Life. If the Standard approves your waiver, you'll no longer be responsible for paying premiums to continue these coverages.

Employee Assistance Program

The Employee Assistance Program (EAP) is a confidential counseling and referral phone service that addresses personal problems you or your family members may have. EAP counselors can help you identify and discuss personal problems and develop a plan of action to resolve them. The EAP's role is to provide an initial assessment, referrals, and short-term therapy. For longer-term care, the EAP can direct you to an appropriate provider. To contact the EAP, call **1-800-221-0945.**

Optional Benefit Plan

The Optional Benefit Plan (OBP) is an additional benefit provided by the County to help eligible employees meet personal needs and goals.

Who's Eligible?

You're eligible for the OBP benefit if you're a regular, limited term, or probationary employee who works full-time 40 hours a week. If you work part-time 20 hours or more a week, you're eligible to receive 50% of the full-time OBP benefit.

If you're newly hired or promoted, you must make an OBP election within 28 days of your hire or promotion. If you do not, you

When Benefits Begin

If you're a new employee, your OBP benefits begin on the first day of the month following 28 days from your hire or promotion date. Employees hired or promoted after the start of a plan year are eligible for a prorated benefit that starts on the first day of the month after 28 days from being hired or promoted.

Your OBP Options

You may use your OBP benefit amount in a number of ways.

Taxable Cash Lump Sum

If you elect this option, you receive your OBP dollars as a single taxable payment in the first pay period following 28 days after your hire or promotion (if you're hired or promoted) or on the first pay period of the calendar year (for current employees).

Voluntary AD&D Payroll Credit

You may allocate a portion of your OBP dollars to pay all or part of the cost of your Voluntary AD&D insurance. You must be enrolled in Voluntary AD&D to elect this option and your allocation cannot exceed the actual cost of Voluntary AD&D insurance. If you elect this option, you receive your allocation as a biweekly credit. You may allocate any amount up to the maximum annual payroll credit listed below for each coverage level.

Health Care Reimbursement Account (HCRA)

You may allocate OBP dollars to fund your HCRA. Once you allocate OBP dollars to your HCRA, you can use your HCRA to reimburse yourself for eligible medical, dental, or vision expenses. Refer to the "Health Care and Dependent Care Reimbursement Accounts" section for more details.

Important Limitations

- You cannot change your OBP HCRA amount during the year.
- The total OBP benefit amount you allocate plus any regular HCRA contributions cannot exceed the HCRA allowable annual limit
- Any OBP amount in your HCRA that is not used for eligible health care expenses during the year is forfeited.

457 Defined Contribution Plan Lump Sum

If you elect this option, your OBP dollars are paid as a lump sum amount into the 457 Defined Contribution Plan, a voluntary retirement plan administered by Great West Retirement Services.

Keep in mind that both your OBP and employee contributions to the 457 Defined Contribution Plan apply to the annual IRS limit.

You can't change your OBP 457 Defined Contribution Plan allocation after Open Enrollment, or after the election period for any reason. Because choosing this option is an irrevocable election and it affects your total annual plan contributions, you may want to speak with a Great West Retirement Services representative and your tax adviser before allocating OBP dollars.

OBP Claim Filing Deadlines

The OBP reimburses you for eligible expenses incurred during a calendar year. Claims for OBP reimbursements must be filed by March 31st of the following year.

401(a) Defined Contribution Program

The County contributes a percentage of your biweekly salary to the 401(a) Defined Contribution Program. This is an automatic contribution.

457 Defined Contribution Program

The 457 Defined Contribution Program is a voluntary retirement program that allows you to defer some of your salary through before-tax payroll deductions. You can defer up to the annual IRS limit or 100% of your taxable compensation, whichever is less. Deferred funds become available when you separate or retire from the County and you do not pay taxes on the money or the interest it earns until that time.

You can enroll in the program at any time by calling the plan administrator, Great West Retirement Services, at 1-866-457-2254 and pressing "2." For more information, see the "Pathways to Your Financial Future" Planning Guide.

1.62 Defined Contribution Plan

The County offers employees in the "1.62 at 65" retirement benefit (OCERS) formula the ability to enroll in the 1.62 Defined Contribution Plan through TIAA-CREF.

The 1.62 Plan combines a traditional defined benefit plan pension with a defined contribution component to work together to help you achieve an adequate and secure retirement. The 1.62 Defined Contribution Plan is a voluntary retirement savings program that allows you to contribute a portion of your bi-weekly salary on a pre-tax basis and receive employer matching contributions.

Employee contributions are made on a pre-tax basis and go into a 457 account for you to manage. Employee contributions vest immediately on behalf of the employee. The employer matching contributions go into a 401(a) account for you to manage. Employer contributions vest on behalf of the employee after five (5) years of continuous employment with the County.

You may enroll in the program at any time by calling the plan administrator, TIAA-CREF, at 1-800- 842-2252 Monday through Friday from 5 a.m. to 7:00 p.m. PT and Saturdays from 6:00 a.m. to 3:00 p.m. PT.

Retirement Benefits

The Orange County Employees Retirement System (OCERS) provides retirement benefits for employees of the County. While you're a member, both you and the County make contributions to OCERS. When you retire, you receive a monthly allowance that is based on your tier (determined by your date of membership in OCERS), your age at retirement, your average monthly earnings, and your years of service. For more information about OCERS, call 1-888-570-6277 or visit www.ocers.org.

Annual Physical

You're eligible for one County-paid physical examination every 12 months. For more information or to schedule your exam, call Employee Health Services at 1-714-565-3780, press 0, Monday through Friday from 7:30 a.m. to 11:00 a.m.

For More Information

If you have questions about your supplemental benefits, visit the Benefits Center Web Site or call the Benefits Resource Line. Plan documents are available on the Benefits Center Web Site, and you can contact plan administrators for additional information —their contact information can be found in the Helpful Information chart at the end of this guide.

Planning on Retiring Soon?

New Retiree Checklist

One important part of the retirement process is enrolling in a retiree health plan. If you are planning on retiring in the near future, below is a checklist to ensure a smooth transition and that you have completed all the necessary steps to enroll in a retiree health plan. Some of those steps may include submitting documents that verify dependent eligibility and/or Medicare enrollment. When you are ready to retire, take the following steps:

- Notify the Orange County Employees Retirement System (OCERS) of your intent to retire. It is strongly recommended that you do this at least 60 days before your desired retirement date. OCERS will notify the County of Orange Benefits Center and this will initiate a series of communications to let you know what you need to do—and by when—to enroll in a retiree health plan.
- Carefully review the Intent to Retire package that will be sent to your home. You will receive it within 30 days after you declare your intent to retire. Among other things, the package includes a copy of your retiree Benefits Enrollment Guide and a personalized Benefits Enrollment Summary that explains your retiree health plan options, rates, requirements, and instructions.
- Enroll in Medicare if you are 65 or older. Ideally, you should enroll in Medicare 90 days before your intended retirement date to ensure that your Medicare coverage is in place by the time you retire. To learn more about Medicare or to enroll in Medicare, call the Social Security Administration at 1-800-772-1213 or visit www.Medicare.gov.
  - If you elect a Medicare Advantage Plan which requires Centers for Medicare and Medicaid Services (CMS) approval, failure to have Medicare enrollment in place at retirement (if age 65) may result in you paying a higher cost and being enrolled into the Wellwise Retiree PPO health plan while your Medicare is being finalized (all Medicare Advantage plans require CMS approval and Medicare assignment prior to enrollment).
  - If you are eligible for Medicare Part B only, you can only enroll in certain plans. If you are eligible for Medicare Part B only, you should immediately call the Benefits Resource Line toll-free at 1-866-325-2345 and advise the Benefits Center. They will require you to provide verification of your Medicare Part B only. You can find the Medicare Part B only health plans in the Your Retiree Health Plan Options section of the retiree Benefits Enrollment Guide.
- Attend pre-retirement meetings. These meetings explain what you need to know and do about your Retiree Medical Plan.
  - Attend an OCERS pre-retirement meeting.
  - Attend a New Retiree Benefits Orientation. Meetings are held on the first Monday of each month at 1 p.m. If the first Monday is a holiday, the meeting will be the first Tuesday of the month. Visit the Employee Benefits Web Site at www.ocgov.com/hr/employeebenefits for the location and more information.

- Contact the health plans you are considering. If you have questions about a specific health plan's benefits, coverage areas or procedures, you may contact that plan directly. Contact the County of Orange Benefits Center to obtain health plan telephone numbers and web site addresses.
- Make your retiree health plan election as soon as possible to avoid delays in approval. You have 30 calendar days from the date on your Intent to Retire package to accept the Automatic Benefits Coverage shown on your Benefits Enrollment Summary or elect a new retiree health plan with the County.
  - If you are enrolled in the Cigna HMO health plan as an employee, you must make a new health plan election as Cigna is not offered as a retiree health plan.
  - Complete and submit Medicare Advantage enrollment forms promptly (Kaiser Senior Advantage Plan only); Medicare Advantage Plans require approval from CMS and you will not receive the coverage and rates associated with these plans until approved.
  - Submit documents that verify Medicare enrollment; and/or
  - Submit documents that verify dependent eligibility.
- Log on or call to enroll.
  - The Benefits Center Web Site. Visit the Web Site 24 hours a day, 7 days a week to enroll. Log on at www.benefitsweb.com/countyoforange.html.
  - The Benefits Resource Line. Call the Benefits Resource Line toll-free at 1-866-325-2345. Benefits Specialists are available to take your enrollment elections Monday through Friday, from 7:30 a.m. to 5:30 p.m. PT, except holidays. TDD and translation services are available.
- Review your Benefits Confirmation Statement for accuracy and special instructions immediately upon receipt. You will have 10 business days from the date of your Benefits Confirmation Statement to report any errors to the elections you made. If you fail to notify the Benefits Center within the 10-business day correction period, you will be unable to change your elections until the next Open Enrollment or until you experience a Qualified Life Event. You are solely responsible for informing the Benefits Center of any errors in your benefits election.
- Pay your health plan rates. You will be billed automatically on a monthly basis for your share of health plan rates. You will receive a monthly invoice for your health plan rate until your pension deductions begin. This may take up to 90 days. If you do not pay the invoice for your monthly rates, your coverage will be terminated. **After the initial transition period, your health plan rate will automatically be deducted from your monthly OCERS pension, however you must still pay the remaining balance due on your final monthly invoice or your coverage will be cancelled.**

Retiree Medical Information

The County currently offers you these benefits to assist you in retirement.

Retiree Medical Plan

When you retire, you may be eligible to receive a Retiree Medical Plan Grant (Grant) provided by the County of Orange to use toward the cost of your County health plan and/or your Medicare premiums (if applicable). The Grant is not a vested or guaranteed benefit.

To be eligible for the Grant, you must:

- Have a minimum of 10 years of continuous eligible County service, if you have a normal retirement. However, if you've been granted a non-service-connected disability retirement, you must have a minimum of five years of continuous service. If you've been granted a service-connected disability retirement, there is no minimum- service requirement.
- Be at least 50 years old on your date of separation of service,
- Receive a monthly retirement allowance from the Orange County Employees Retirement System (OCERS), and
- Be enrolled in a County health plan when you separate.

The amount of the Retiree Medical Plan Grant you receive is based on your age of separation and years of eligible County service hours to a maximum of 25 years of service multiplied by a base dollar amount. The base dollar amount is adjusted up or down annually up to a maximum of 3%.

If you defer your retirement, contact the Benefits Resource Line for more information.

The Grant will be applied first to offset the cost of your and/or your spouse's/domestic partner's County health plan premium. Any remaining monthly Grant will be applied to your Medicare B premium reimbursement, if applicable. You are not eligible to receive the Medicare reimbursement if you're currently receiving Medicare reimbursement from another source.

If the total of your monthly County health plan premium and your monthly Medicare Part B premium reimbursement is less than the total monthly Retiree Medical Plan Grant, the excess Grant is forfeited.

Retirees who gain health coverage elsewhere following retirement and who wish to use their Grant to reimburse Medicare Part B premiums or health plan premiums will be required to enroll in Medicare once eligible. Both the subscriber and an eligible dependent must enroll and maintain their coverage in Medicare Parts A & B (Part A, if at no cost), even if they are actively working with coverage elsewhere. In addition, you must maintain enrollment in a County health plan until Medicare eligible. At that time you may disenroll from the County health plan and elect "Medicare Reimbursement only".

50% Reduction of the Grant when Medicare Eligible

Retirees who are eligible for both Medicare Parts A & B (Part A, if at no cost to you) will have a 50% reduction in their monthly Grant the first day of the month in which they turn 65 and therefore become eligible for Medicare.

7.5% Reduction or Increase in the Grant (Non-Safety Employees)

There will be a 7.5% reduction to the Grant for each year retiring before 60 years of age; and a 7.5% increase to the Grant for each year worked after age 60 up to age 70.

Survivor Benefits

If you're a survivor of a deceased employee or retiree, you may be eligible for coverage under a County retiree health plan and for a Retiree Medical Plan Survivor Grant. The Survivor Grant is equal to 50% of the Grant the deceased would have been eligible to receive. Once the survivor reaches age 65 and eligible for Medicare Parts A and B (part A, if no cost to you), will have a 50% reduction in their monthly Grant the first day of the month in which they turn 65 and therefore become eligible for Medicare.

Survivor Health Coverage

To be eligible for survivor health plan coverage, you must:

- Be covered under the deceased employee's or retiree's County health plan at the time of his or her death.
- Receive a monthly retirement allowance from OCERS.

Survivor Retiree Medical Grant Benefits

To be eligible for a Survivor Grant, you must:

- Be a survivor of a deceased Grant-eligible County employee or retiree.
- Receive a monthly retirement allowance from the OCERS, and
- Be covered under the employee's or retiree's County health plan at the time of his or her death.

Retiree Medical Plan Document

Please refer to the Third Amended and Restated County of Orange Retiree Medical Plan Document ("Retiree Medical Plan Document") for the specific terms and conditions of the Grant. If there are any discrepancies between the above summary and the Retiree Medical Plan Document, the Retiree Medical Plan Document will govern in all cases.

Before-Tax Deductions

The following deductions are taken before-tax, which means you may pay less in income taxes and have more take-home pay:

- Employee health care premiums.
- Dependent health care premiums.
- Part-time health care premiums.

If you do not want the tax advantage of before-tax deductions, call the Benefits Resource Line to elect after-tax deductions. Tax consequences may differ for benefits/deductions of domestic partners. Please consult your tax advisor for guidance.

Important Legal Information

Grandfathered Health Plans

The County of Orange believes each of the following plans is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (PPACA).

- Premier Wellwise PPO Health Plan.
- Premier Sharewell PPO Health Plan.
- Cigna HMO.
- Kaiser HMO.

As permitted by the Patient Protection and Affordable Care Act (PPACA), a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. However, grandfathered health plans must comply with certain consumer protections in PPACA, for example, the elimination of lifetime limits on benefits.

The protections in PPACA which do apply to these grandfathered plans and have been implemented are:

- Extension of dependent coverage for dependents until age 26.
- Elimination of individual lifetime maximums in the PPO health plans.
- Elimination of individual annual dollar limit for Preventive Care and the Mental Health/ Substance Abuse $50 per visit limit in the PPO health plans.

All other provisions of the act do not currently apply. If you have questions regarding the grandfathered health plan provision, or other provisions under the Act, you may contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

For information about your County of Orange health plans, you may contact the County of Orange Benefits Center at 1-866-325-2345.

Health Insurance Marketplace

PPACA requires all U.S. citizens and resident aliens to have medical coverage beginning January 1, 2014 (or pay a penalty). To make affordable coverage available to everyone, the government has created Health Insurance Marketplaces. On October 1, each state unveiled a "Health Insurance Marketplace" – which in California is called "Covered California." Residents may investigate health plans, and possibly enroll in a plan in their state's Marketplace; however, because the County already meets the standards for providing minimum coverage, most likely you will not take any action at this time.

- The County of Orange offers medical coverage that meets the minimum essential coverage and minimum value standards set by PPACA and meets the affordability requirement. **The Sharewell PPO plan meets the minimum value standard and is offered to employees at no cost.**
- You (and your dependents, as applicable) will most likely *not* be eligible for a subsidy or premium credit toward a Marketplace health plan because the County's Sharewell PPO plan meets the "minimum value" and "affordability" levels. This means County of Orange coverage likely provides a better value for you.
- You can still buy private medical insurance through the Marketplace, but you probably won't qualify for a discount on your private monthly premium if you are eligible to receive coverage through the County's plans.

The Federal healthcare web site, www.healthcare.gov, provides a link to the Marketplace for all 50 states. Information on the California marketplace can be found at www.coveredca.com.

Continuing Your Coverage Under COBRA

The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) gives you the right to choose continuation of health care coverage if you and/or your eligible dependents lose County coverage. You may continue health care coverage for up to 18, 29, or 36 months, depending on the situation and who is being covered. Within a couple of weeks of the loss of coverage, you will receive a separate COBRA notification explaining these rights.

If you think your or your dependents' health care coverage will end because an event occurred causing ineligibility under the plan, there are certain things you must do to continue coverage under COBRA. In some cases, you must notify the County of the event. If COBRA is an option for you, you must make an election and pay for coverage within certain time periods.

If you retire or die, the County will notify you and/or your dependents of your right to continue health care coverage under COBRA. This notification will explain in detail how COBRA works.

If you divorce or legally separate or your child loses dependent status under a group health plan, you or your covered dependents are responsible for notifying the County within 60 days from the date of these events. The County will then notify your dependents of their right to continue health care coverage under COBRA. This notification will explain in detail how COBRA works. COBRA rights will be forfeited if the County is not notified within 60 days of the qualifying event.

If your domestic partnership ends, your domestic partner and his or her children are not eligible for COBRA. However, a qualified beneficiary receiving COBRA coverage under the County plans may elect COBRA coverage for a domestic partner and his or her children.

For more information, call the Benefits Resource Line at the number listed under Helpful Information at the end of this guide.

Health Insurance Portability and Accountability Act (HIPAA)

The Federal Health Insurance Portability and Accountability Act (HIPAA) impose certain requirements on group health plans. Under HIPAA, a group health plan:

- Is limited in imposing pre-existing-condition exclusions.
- Must offer employee and dependents the opportunity to enroll outside Open Enrollment in certain situations.
- Can't discriminate on the basis of health status with respect to eligibility for plan participation and premium costs.
- Can't impose discriminatory lifetime or annual benefit limits on participants with mental illness.
- Must permit hospital admissions (if otherwise covered by the plan) of at least 48 hours in case of normal deliveries and 96 hours in the case of Cesarean sections.

Under HIPAA, the sponsor of a self-funded non-federal-governmental plan, such as the County's PPO plans, has the option to exempt the PPO plans from any or all of these requirements except for the certification requirement (see below). The County opted to exempt the PPO plans from HIPAA requirements in imposing lifetime or annual benefit limits on participants with mental illness. A summary of current health plan benefits, co-payments, and deductibles is included in this guide and is not affected by this exemption option.

The County's HMO plans comply with HIPAA.

Certification of County Group Health Plan Coverage

HIPAA also requires the County to provide certification of coverage for plan participants whenever County health insurance coverage has ended This certification will show the period the subscriber and dependents were covered under the County health plan. If, after the County coverage ends, a former health plan participant enrolls in another group health plan that excludes coverage for pre-existing medical conditions, the former plan participant may be required to provide the HIPAA certification.

The HIPAA certification will be mailed by the Benefits Center to the last known address each time coverage under one of the County's health plans ends. More information will be provided on the HIPAA certification at that time. Employees currently enrolled in a County health plan will not receive certification until coverage in one of the County health plans ends.

Women's Health and Cancer Rights Act of 1998

Under the Women's Health and Cancer Rights Act of 1998, you and your dependents' health plan will not restrict benefits if you or your dependent:

- Receives benefits for a mastectomy.
- Elects breast reconstruction in connection with a mastectomy.

Benefits will not be restricted provided that the breast reconstruction is in consultation with your or your dependent's physician and may include:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications in all stages of the mastectomy, including lymphedemas.

Benefits for breast reconstruction may be subject to appropriate annual deductibles and coinsurance provisions that are consistent with those established for other benefits under the plan.

Helpful Information

You can find answers to many of your benefit and enrollment questions through the Benefits Center Web Site or by calling the Benefits Resource Line. If you need additional information, you can contact the plans directly.

For Questions About…	Click or Call…
Benefits or Enrolling	
• Benefits Center Web Site	**www.benefitsweb.com/countyoforange.html**
• Benefits Resource Line	1-866-325-2345 Benefits Specialists are available Monday through Friday between 7:30 a.m. and 5:30 p.m. PT, except holidays TDD: 1-800-TDD-TDD4 (833-8334)
• Employee Benefits Web Site	**www.ocgov.com/hr/employeebenefits**
HCRA or DCRA	
• Benefits Center Web Site or Benefits Resource Line	**www.benefitsweb.com/countyoforange.html** 1-866-325-2345 Benefits Specialists are available Monday through Friday between 7:30 a.m. and 5:30 p.m. PT, except holidays TDD: 1-800-TDD-TDD4 (833-8334)
COBRA and Leave of Absence Continuation	
• Benefits Center Web Site or Benefits Resource Line	**www.benefitsweb.com/countyoforange.html** 1-866-325-2345 Benefits Specialists are available Monday through Friday between 7:30 a.m. and 5:30 p.m. PT, except holidays TDD: 1-800-TDD-TDD4 (833-8334)
Your Health Plans	
• American Specialty Health Plans (HMO chiropractic care)	**www.ashcompanies.com** 1-800-678-9133 P.O.Box 509002 San Diego, CA 92150-9002
• Cigna Health Plan HMO	**www.cigna.com/countyoforange** 1-800-244-6224 400 North Brand Blvd. Glendale, CA 91209
• Blue Shield of California Plan Administrators (claim administrator for the PPO plans and provider network)	**www.blueshieldca.com/oc** 1-888-235-1767 P O Box 272540 Chico, CA 95927-2540
• Kaiser Health Plan HMO	**www.kp.org/ca/oc** 1-800-464-4000 P.O. Box 1840 Corona, CA 91718-1840
Prescription Drugs	
• Catamaran Rx (for the Premier Wellwise PPO Plan)	**www.mycatamaranrx.com** 1-800-573-3583 P.O. Box 691569 Orlando, FL 32869
• Cigna Home Delivery Pharmacy	**www.mycignaplans.com** 1-800-835-3784
Vision Plan	
• Vision Service Plan (Cigna HMO)	**www.vsp.com** 1-800-877-7195 P.O. Box 997105 Sacramento, CA 95899-7105
Employee Assistance Program	
• Aetna Resources for Living	**www.horizonhealth.com** 1-800-221-0945
Dental Plan	
• Blue Shield of California Dental (Claims Administrator)	**www.blueshieldca.com/oc** 1-877-403-2273 P.O. Box 272590 Chico, CA 95920-2590
Short-Term Disability, Long-Term Disability, Basic Life, Additional Life, and Dependent Life	
• The Standard Insurance Company	**www.standard.com** 1-800-368-2859 P.O. Box 2800 Portland, OR 97208-2800
Basic AD&D and Voluntary AD&D	
• The Hartford Life Insurance Company	**www.thehartford.com** 1-888-563-1124 200 Hopmeadow Road Simbury, CT 06089

Other Questions

Here are other resources you can contact.

For Questions About…	
• 457 Defined Contribution Program	**www.countyoforangedcplan.com** 1-866-457-2254, press 2 Great West Retirement Services 18111 Von Karman Ave., Suite 560 Irvine, CA 92612
• OCERS retirement benefits	**www.ocers.org** 1-888-570-6277 Orange County Employees Retirement System (OCERS) 2223 Wellington Ave. Santa Ana, CA 92701
• Orange County Managers Association (OCMA)	1-714-953-6262 600 W. Santa Ana Blvd. Ste. 114-F P.O. Box 3405 Santa Ana, CA 92701

Network Directories Online

You can view network directories for the health plans on the Internet.

To view network directories for…	Go to…
Cigna Health HMO Plan	**www.cigna.com/countyoforange**
Kaiser Health HMO Plan	**www.kp.org/ca/oc**
Premier Wellwise Plan	**www.blueshieldca.com/oc**
Premier Sharewell Plan	**www.blueshieldca.com/oc**

This Enrollment Guide is only an overview of the benefit plans available to you. The plan documents and insurance policies for each plan provide the detailed, legal information about your coverage. If there is any difference between this guide and the plan documents or insurance policies, the plan documents and insurance policies will govern.