
BENEFITS HANDBOOK

2019 ORANGE COUNTY
WELLNESS
FOR **LIFE PLAN**



BENEFITS & WELLNESS

Human Resources Service Center Locations

For your convenience, there are eight HR Service Centers throughout the County. Please feel free to seek assistance at any location.

Admin Services & Office of Accountability

Internal Operations (IOC1) Building
450 East South Street
Orlando, FL 32801
Phone (407) 836-5823

Health & Family Services

2012 East Michigan Street
Orlando, FL 32806
Phone (407) 836-9322

Convention Center

South Concourse, Room S212
9899 International Drive
Orlando, FL 32801
Phone (407) 685-5799

Fire Rescue Headquarters

6590 Amory Court
Winter Park, FL 32792
Phone (407) 836-9000

Corrections

Cassady Building
2450 West 33rd Street
Orlando, FL 32839
Phone (407) 836-3519

Public Works

Main Building, 2nd Floor
4200 South John Young Parkway
Orlando, FL 32839
Phone (407) 836-7761

CEDS – Downtown

Administration Building, 2nd Floor
201 South Rosalind Avenue
Orlando, FL 32801
Phone (407) 836-5478

Utilities

Utilities Administration Building, 3rd Floor
9150 Curry Ford Road
Orlando, FL 32825
Phone (407) 254-9760

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Wellness for Life Plan

What is the Wellness for Life Plan?

The Wellness for Life Plan is the employee benefits program offered to eligible employees of Orange County. It is a plan that gives you the opportunity to choose between a variety of taxable and tax-free benefits, allowing you to customize your benefits to meet your needs. Section 125 of the Internal Revenue Code has authorized the pre-tax payment option.

The following depicts the tax treatment of benefits offered in the Wellness for Life Plan:

Pre-Tax

- Medical
- Dental
- Vision
- Supplemental Life
- Flexible Spending Accounts (FSAs)
- Health Savings Account (HSA)

Post-Tax

- Spouse Life
- Child Life
- Short-Term Disability

How do I enroll in the Wellness for Life Plan?

Complete and sign your new hire election form, then submit it with all required documentation within 30 days of your date of hire or benefits orientation. If you have group medical coverage elsewhere and decide not to enroll in medical benefits through Orange County you are still required to complete a form. You may contact your Human Resources Service Center for further information.

What is core coverage?

You have until the latter of 30 days from your date of hire to complete and turn in a new hire election form. Failure to submit a complete and signed form by the deadline will result in automatic enrollment in core coverage.

Core coverage is as follows:

- OrangePrime Plus (HDHP) medical coverage for the employee only (with no High Plan contribution)
- Long-term disability coverage in an amount equal to 60% of your annual salary (up to \$10,000 per month) after a 180-day waiting period
- Basic Life insurance equal to one times your annual salary
- Basic AD&D coverage equal to two times your annual salary

Opt Out Credit

Orange County Board of County Commissioners offers employees who opt out of the County's Cigna health insurance plans as a new hire, during annual open enrollment, or as a result of a qualified event (family status change), a credit of up to \$25 per pay period to help offset the cost of other optional benefits. The credit **cannot** be used to cover the cost of Spouse Life Insurance, Child Life Insurance or Short-Term Disability Insurance; nor can it be deposited into a Health Savings Account, Medical Flexible Spending Account, Limited Purpose Flexible Spending Account, or Dependent Care Flexible Spending Account. The credit may only be used to lower your benefit costs; the credit cannot be taken in cash.

If you have coverage under another group insurance plan, waive both of the County's Cigna plans, and complete open enrollment, the credit will be applied to other benefits in the following order:

1. TRICARE Supplement Plan (if applicable)
2. Dental
3. Vision
4. Supplemental Life Insurance and AD&D

How do I receive the Opt Out Credit?

To receive the Opt Out Credit, employees must meet one of the following criteria:

1. Make their **Open Enrollment** election during the open enrollment period and waive Cigna medical coverage or elect the TRICARE Supplement.
2. Make their **New Hire** election during the special 30 day enrollment period and waive Cigna medical coverage or elect the TRICARE Supplement
3. Make their **Qualified Event** enrollment election during the special 60 day enrollment period and waive Cigna medical coverage or elect the TRICARE Supplement

Are there Restrictions?

There are some important details that you need to know. First, there may be an impact to your Social Security benefits. Because you are paying less FICA taxes, less money is going into your personal Social Security account. The effect is minimal and the current tax savings is significantly greater than the reduction in future Social Security benefits. For more information about your personal situation and an estimate of your retirement benefits, contact the Social Security Administration. If you would rather pay your contributions on an after-tax basis, complete the Premium Conversion Waiver available at your Human Resources Service Center.

Second, if you choose to participate in the Wellness for Life Plan, your election is for the entire plan year. The Wellness for Life Plan year is January 1–December 31. The Internal Revenue Service permits employees to select or change their choices only once each plan year, during open enrollment, with the exception of qualified events. Qualified events that permit mid-year changes include:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of your spouse or child
- Significant change in coverage due to your spouse's employment
- Change in employment status that results in a change to benefits
- You, your spouse, or your dependent enrolls in or loses eligibility for Medicare or Medicaid
- Loss or gain of dependent eligibility

If one of these situations occurs, you have 60 days after the date of the event to change your benefits. Any change you make must be consistent with the event allowing you to make the change and documentation of the qualified event will be required.



Please note the following regarding qualified events:

In the event of a mid-year qualified event or at the time of retirement, employees will not be able to change plan type [e.g., from the OrangePrime Plus (HDHP) to the OrangePrime (LDHP), or vice versa] unless you qualify for a HIPAA Special Enrollment Rights. However, the following changes will be permissible if consistent with the event (*list is not all inclusive*):

- Changes to your medical, dental or vision coverage (due to loss or gain of eligibility)
- Changes to your TRICARE supplement (due to loss or gain of TRICARE eligibility)

If you would like more information about qualified event (family status change), contact your HR Service Center. For your added convenience, we have eight locations throughout the County. Please refer to the inside cover of this handbook for the location and contact information or reach out to Benefits@ocfl.net.

What else do I need to understand about the Wellness for Life Plan?

While the County is committed to offering quality benefits to employees, it reserves the right to amend or discontinue any of the benefits plans provided under the Wellness for Life Plan should federal or state regulations or the County's needs or ability to fund the plans change significantly in future years. This Benefits Handbook describes the Wellness for Life Plan in general terms. Should any conflict arise between the content of this handbook or any other enrollment materials and the plan documents, the terms of the plan documents will govern in all cases.

Tobacco/Nicotine Surcharge

In response to the increasing cost of delivering employee healthcare benefits and the overwhelming evidence that tobacco and/or nicotine usage is a leading cause of serious illness, Orange County assesses a tobacco/nicotine user surcharge of \$25 per pay period. The surcharge is applicable only to employees enrolled in either the OrangePrime Plus Plan (HDHP) or OrangePrime Plan (LDHP).



What is defined as “tobacco and or nicotine usage”?

Tobacco and/or nicotine usage is defined as the smoking or use of any tobacco and/or nicotine products, including but not limited to cigars, cigarettes, e-cigarettes, pipes, chewing tobacco, snuff, herbal tobacco products, and other smoking and/or nicotine material. *(Does NOT include Nicotine Replacement Therapy (NRT) products used for quitting)*. This surcharge is not intended for the rare celebratory use of such products, defined by four or fewer per year.

How do I waive the surcharge?

You must acknowledge your non-usage of tobacco and/or nicotine products at the time of acknowledgement (either via electronic signature during Open Enrollment or physical signature on the Tobacco/Nicotine Usage Affidavit) and must continue to remain tobacco free for the entire time you are covered by Orange County medical plan.

Are new hires subject to the Tobacco Surcharge?

Yes. New hires will be eligible to waive the surcharge if they complete the Tobacco/Nicotine Usage Affidavit within 30 days of their hire date. Otherwise, the surcharge will begin the same date as the commencement of medical coverage.

What if I start or quit using tobacco/nicotine products during the plan year?

If you start using tobacco and/or nicotine products, you must inform HR within 30 days and the surcharge will be effective immediately. If you are found to be using tobacco and/or nicotine products prior to informing HR, you will have the option to quit the use of tobacco and/or nicotine products immediately, or the surcharge will be assessed. If you quit using tobacco and/or nicotine products during the year, you must wait until open enrollment in order to waive the surcharge. Or upon completion of one of the two County approved cessation programs, the surcharge will be waived.

Are there penalties for violating the tobacco/nicotine free affidavit?

Employees who falsify the tobacco/nicotine affidavit may be subject to any of the following disciplinary actions:

- Verbal reminder
- Written reprimand
- Loss of Wellness for Life Plan Benefits
- Probation
- Termination of employment

If you are unable to meet the requirements under this program, we will make available a reasonable alternative standard for you to avoid this surcharge. Please contact Human Resources and we will work with you (and, if you wish, with your doctor) to find a wellness program that is right for you.

Eligibility & Rules

Who is eligible?

Regular full- and part-time employees (regular employees scheduled to work 20 hours or more per week) are eligible for group insurance plans offered under the Wellness for Life Plan.

Which family members are eligible?

- Spouses:
 - Employee's legally married spouse. Common Law marriage partners are not recognized by the state of Florida and are not eligible
 - Former spouses are not eligible under the plan, regardless of any legal settlement (However, separated spouses are eligible as there is no defined "legal separation" in the state of Florida)
- Children (birth to the beginning of the pay period following the end of the month they turn 26; eligibility for Child Life Insurance is different; please see page 37 for details):
 - Natural children
 - Legally adopted children
 - Children who have been placed for adoption
 - Stepchildren
 - Other children for whom the employee is the legal guardian or has legal responsibility for providing medical coverage as defined by a court order
- Children (age 26 to 30):
 - Refer to page 14 or details
- Children of covered dependent children (grandchildren):
 - Can be covered through the end of the month the child turns 18 months of age if the parent is covered under the plan
- Disabled Children:
 - Children considered to be disabled through Social Security Administration regardless of whether the child receives Social Security Income or not.
 - Single and incapable of self-care, dependent on employee for support due to physical or mental disability
 - Disability must occur before child eligibility ceases due to age

Am I required to provide proof of dependent eligibility?

Employees who add dependents within 30 days of hire, within 60 days of a qualified event, or during open enrollment, must provide proof of dependent eligibility and a copy of the Social Security card in order for the dependent to be added. Documentation must be submitted to an HR Service Center with the appropriate enrollment form.

Required Documentation for Spouse

Please provide clear copies or original documents. Illegible photocopies of your dependent documentation will not be accepted. Pictures taken from your camera or mobile device will not be accepted.

Spouse

Legal Marriage License/Certificate from a government or regulatory agency*, and

- If married within 12 months of the eligibility/coverage begin date, only **Legal Marriage License** (issued by a government/regulatory agency) is required;
- If married for greater than 12 months, a **Tax Return Transcript** of your most recently filed federal income tax return showing you filed as married, either jointly or separately. The tax return transcript is the only official record of the tax return that you filed with the IRS. A copy of your tax return (Form 1040) will not be sufficient. The Form 1040 can be falsified and is not an official record of what was filed with the IRS. You can request a copy of your transcript from the IRS at www.irs.gov/individuals/get-transcript or by calling the IRS at 800-908-9946.

**If married outside of the United States, marriage license must be officially translated by a translation organization before being submitted to your HR Service Center*

Note: *In addition to the dependent documentation listed above, your marriage date, spouse's date of birth, and spouse's social security number are required on the enrollment form.*

Required Documentation for Dependent Children

Please provide clear copies or original documents. Illegible photocopies of your dependent documentation will not be accepted. Pictures taken from your camera or mobile device will not be accepted.

Birth Child Under Age 26	Stepchild Under Age 26	Adopted Child or Child Placed for Adoption Under Age 26
<ul style="list-style-type: none"> Official Birth Certificate* <i>(Hospital certificate will not be accepted, parents must be listed)</i> 	<ul style="list-style-type: none"> Copy of birth certificate* or proof of other dependent relationship, <u>and</u> Copy of employee’s legal marriage license to stepchild’s parent, <u>and</u> Verification of current marital status (see above requirements for joint financial documentation) 	<ul style="list-style-type: none"> Adoption Certificate, <u>or</u> Placement Letter (document establishing placement preceding a formal adoption)
Child under Age 26 for Whom You Are the Legal Guardian	Child of a Covered Dependent (Grandchild) Under 18 months	Disabled Child
<ul style="list-style-type: none"> Proof of legal guardianship¹ 	<ul style="list-style-type: none"> Official Birth Certificate* or birth record <i>(covered dependent’s name must be listed as parent)</i>, <u>and</u> Verification that parent of child is eligible and covered as dependent child noted above 	<ul style="list-style-type: none"> Official Birth Certificate*, <u>and</u> Social Security Administration award letter or a recent Social Security Income statement, <u>and</u> Proof of continuous coverage (no break in coverage)

***If born outside of the United States, birth certificate must be officially translated by a translation organization before being submitted to your HR Service Center**

Note: Child may include various dependent relationships to the spouse (birth child, adopted child, guardianship, step-child, grandchild, etc.). Applicable proof shall be provided of such relationship equivalent to the documentation requirements of the employee’s biological dependents.

¹The most common way to establish legal guardianship is through a court order.

Dependent Eligibility Changes

It is the responsibility of the employee to notify departmental or central HR within **60 days** when there is a change in dependent eligibility, *especially if eligibility is lost*. Failure to drop ineligible dependents from the plan within 60 days is considered fraud against the plan and may result in disciplinary action, including fines for premiums and/or claims and/or employment termination.

Any employee who fails to provide the required information and documentation, falsifies information and documentation, or lists ineligible individuals as eligible dependents, shall cause his or her dependents to be removed from the County’s benefit plans. Additionally, that employee may be subject to disciplinary action up to and including termination of employment, may be required to reimburse the County for the benefits costs paid on behalf of the ineligible individual(s), and may be excluded from coverage altogether under the County’s benefits plans.

When does coverage begin?

Employees are eligible for the following coverage effective the date of hire:

- Medical (*with or without HSA**)
- Dental
- Vision
- Supplemental Life and AD&D
- Basic Life Insurance and AD&D
- Long Term Disability
- Florida Retirement System (FRS)
- Spouse Life Insurance
- Short Term Disability
- Child Life Insurance
- Flexible Spending Accounts
- Employee Assistance Program
- Deferred Compensation 457(b) Plan

**Special rules apply for HSAs. See HR for details.*

When does coverage end?

If	Coverage Ends
You stop working for Orange County, retire, pass away, or you no longer meet eligibility rules	The end of the pay period in which your employment or eligibility ends
You choose to stop coverage for yourself and/or your dependents because of a qualified status change	Upon approval, but no earlier than the first day of the first pay period after the new election form is completed and returned to HR
Your dependents no longer meet the eligibility requirements (other than child turns 26 or grandchild turns 18 months old)	Upon approval, but no earlier than the first day of the first pay period after the new election form is completed and returned to HR
You choose to stop coverage for yourself and/or your dependents during the open enrollment period	The last day of the current calendar year

When does coverage end? (Continued)

If	Coverage Ends
Your child turns 26	The beginning of the pay period following the end of the month in which the child turns 26
Your grandchild (child of a covered dependent) turns 18 months old	The beginning of the pay period following the end of the month in which the grandchild turns 18 months old

Leave of Absence (LOA)

Employees on leave of absence may have benefit options available to them. If you are on a leave of absence, it is important to keep track of your employment status and leave balances. Doing so will help you plan accordingly for your healthcare needs. The following chart explains the benefit provisions for employees on LOA.

Leave Category	Benefit Cost	Benefit Payment Method
FML, Paid	Active employee rates	Paycheck deduction
FML, Unpaid	Active employee rates	Employee should notify Payroll of unpaid status and send payments to Payroll
Non-FML, Paid	Active employee rates	Paycheck deduction
Non-FML, Unpaid	Active employee rates (0-90 days)	Employee should notify Payroll of unpaid status and send payments to Payroll
	COBRA rates (90 days or more)	Employee will receive COBRA enrollment materials and send payments to COBRA administrator

Can I change my benefit elections because of a Leave of Absence?

Commencing a leave of absence qualifies as a qualified event under the plan. Changes must be made within 60 days of going on leave. If you choose not to continue coverage during an unpaid leave of absence, and you return to work, you must re-enroll in the benefit plans for coverage to be effective the date of return. Medical underwriting applies (see life insurance section). You also have the option to make changes to your coverage within 60 days of the date you return to work. Your coverage will begin the date of your return and deductions will be taken for that entire pay period.

Optional Coverage for Dependents Age 26 - 30

Orange County offers medical, dental and vision coverage for dependent children between the ages of 26 and the end of the calendar year in which they turn age 30, in accordance with Florida Statutes. This optional coverage has different pricing and eligibility requirements than the coverage for dependents under the age of 26.



Who is eligible for this coverage?

In order to cover a dependent child after his/her 26th birthday, all of the following criteria must be met:

- Natural child or legally adopted child, and
- Between the ages of 26 and 30, and
- Unmarried, and
- Has no dependents of his/her own, and
- Does not have coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health plan, is not entitled to benefits under Medicare or Medicaid, and
- Resides in the state of Florida or is a full-time or part-time student

What coverage is available for these dependents?

Medical and pharmacy coverage is available for these dependents through Cigna. Dependents can choose between the OrangePrime Plus Plan (HDHP) and OrangePrime Plan (LDHP). The plan designs are the same as our regular medical plans for employees and dependents, except there will be no High Plan contribution from the County for those on the OrangePrime Plus Plan. Dependents may also elect a dental plan and vision coverage.

What is the cost for this coverage?

For these dependents, the full cost of the plan premium is required plus a 2% administrative fee. For 2019, that amount is \$659.09 per month for the OrangePrime Plus Plan (HDHP) or \$725.12 per month for the OrangePrime Plan (LDHP). Premiums for these dependents cannot be taken through employee payroll deductions. Instead, you will be billed directly by Chard Snyder, our third party administrator.

How do I sign-up?

Contact your Human Resources Service Center for enrollment information and assistance. After signing up, Chard Snyder will send payment coupons with the monthly payment amount for the elected plan(s).

Note: This coverage may be cancelled at any time by Orange County due to changes in legal requirements. In the event that the coverage is cancelled, all enrolled members will receive a written notification stating the effective date of the plan termination.

Benefit Plan Options

Medical Insurance

What medical plans are available?

Orange County offers two medical plans for you to choose from:

- OrangePrime Plus Plan, with HSA
[High Deductible Health Plan (HDHP)]
- OrangePrime Plan
[Low Deductible Health Plan (LDHP)]



Orange Prime Plus Plan (HDHP)

What are the main components of the OrangePrime Plus Plan (HDHP)?

The OrangePrime Plus plan is made up of two parts – the medical plan and the employer contribution:

1. The Medical Plan:

- Annual Deductible, 20% Coinsurance, and Out-of-Pocket Maximum
- Pharmacy coverage without a separate deductible
- Preventive care coverage of 100%, even before you reach your deductible
- Preventive Drugs covered outside of the deductible

2. The Employer Contribution:

- Helps off-set the OrangePrime Plus plan deductible
- Contribution based on level of medical coverage elected during Open Enrollment
- Up to \$750 contribution for employee only coverage
- Up to \$1,250 contribution for employee plus dependent(s) coverage
- Contribution can be made into a Health Savings Account (HSA) or if the employee is ineligible for an HSA, or does not have an open/active HSA account, then the funds will be issued via paycheck and are subject to applicable taxation rules.

What is an annual deductible?

An annual deductible is the amount of expenses that must be paid by you during the plan year before the insurance plan will start sharing costs. However, the OrangePrime Plus plan will still cover preventive care at 100%, even prior to reaching the deductible. The in-network deductible for 2019 is \$1,500 for those with employee only medical coverage and \$3,000 for those who cover dependents on the medical plan. When you are covering dependents on the plan, one member can meet the deductible for the entire family or it can be met by a combination of members.

What is coinsurance?

Coinsurance is the cost sharing between you and the plan that will occur after the deductible has been met. For 2019, the in-network medical coinsurance amounts are 20% your responsibility and 80% plan responsibility.

What is out-of-pocket maximum?

The out-of-pocket maximum is the most that you will have to pay in a year for deductible and coinsurance for covered medical and pharmacy benefits. It does not include premiums. It's like a safety net, to protect you from high costs in case you have a bad year. For 2019, the in-network out-of-pocket max is \$3,000 for those with employee only coverage and \$6,000 for those with dependents covered on the plan. When you are covering dependents on the plan, one family member can reach the out-of-pocket maximum for the entire family or it can be met by a combination of family members.

Is the deductible for medical separate from the pharmacy deductible?

No. The claims for in-network medical are combined with all claims for in-network pharmacy. Therefore, you can meet your deductible with medical alone, pharmacy alone, or a combination of medical and pharmacy claims. Keep in mind though, that preventive pharmacy drugs, as explained in the next section, do not count toward the deductible, but will count toward the out-of-pocket maximum.

Is there a pre-existing condition clause?

No. The plan does not have a pre-existing clause.

Do I need a referral to see a specialist?

No. The OrangePrime Plus plan is an open access plan, which means you have the freedom to access medical care at any time through any participating network physicians, including specialists, without a referral.

How much will medical coverage cost?

Costs for all benefits can be found on pages 51-53 of this guide.

Is there out-of-network coverage?

Yes. The OrangePrime Plus plan does allow you to access care out-of-network. However, you will have a separate deductible and out-of-pocket maximum for those services and it will not be combined with the expenses you have incurred in-network throughout the year. The out-of-network deductible, coinsurance, and out-of-pocket maximum amounts are listed on page 22 in the *Medical Plan Comparison Chart*.

Are pregnancy programs available?

Yes. Members on the OrangePrime Plus plan who enroll in the Cigna Healthy Pregnancies, Healthy Babies Program (HPHB) in their first trimester (defined as 0-13 weeks) or second trimester (defined as 14-26 weeks) of pregnancy and complete the entire program, including the post-delivery assessment, will receive a \$400 or \$200 deposit from the County into the employee's Health Savings Account (HSA), respectively. Dependent children can enroll in the program, but are not eligible for the incentive money. If the employee is ineligible for an HSA, or does not have an open/active HSA account, then the funds will be issued via paycheck and are subject to applicable taxation rules. The incentive will be paid out in

the middle of the following quarter after you have completed the outcome assessment through Cigna. **Employees must still be actively employed at the time of the deposit in order to receive it.**

HPHB program completed 1/1-3/31	HPHB program completed 4/1-6/30	HPHB program completed 7/1-9/30	HPHB program completed 10/1-12/31
\$200/\$400 paid in May	\$200/\$400 paid in August	\$200/\$400 paid in November	\$200/\$400 paid in February

Health Savings Account (HSA)

You must have an open, active HSA account in order to receive funding into your account

What is an HSA?

An HSA is a bank account that is used in conjunction with an HDHP. An HSA allows you to save and pay for eligible medical expenses that the HDHP does not cover. An HSA will:

- Help you pay for your eligible medical and pharmacy expenses today and in the future
- Reduce your taxes three ways:
 - Money deposited can be tax-free
 - You pay no tax on the interest you receive
 - Withdrawals for eligible expenses are tax-free
- Carry over from year to year and go with you if you change jobs

What are the eligibility requirements for an HSA?

According to the IRS, to be an eligible individual and qualify for an HSA, you must meet the following requirements:

- You must be covered under a high deductible health plan (HDHP)
- You must have no other health coverage that is not a high deductible health plan including TRICARE or TRICARE for Life
- You must not be covered by a general purpose Medical Flexible Spending Account (FSA) or a Health Reimbursement Account (HRA), either yours or your spouse’s (you can have a Limited Purpose Spending Account (LPFSA) and will have a separate debit card for this).
- You are not enrolled in Medicare
- You cannot receive VA medical benefits, unless for a service related disability, within the 3 months prior to making a contribution
- You cannot be claimed as a dependent on someone else's tax return (Note: filing married/jointly is not the same as being claimed as a dependent)

How do I open an HSA?

- Go to https://secure.hsabank.com/group_enrollment/enrollment.aspx?id=596000773
- Click “begin online enrollment”. Step one will require you to input your name, date of birth, social security number, address, and contact information. Step two will provide you with an opportunity to review your application. Step three is your confirmation – be sure to print a copy of your application for your records.

How do I receive reimbursement for my eligible expenses?

You will receive a debit card to pay for your eligible expenses directly at the point of sale.

How do I contribute to my HSA?

If you elect the OrangePrime Plus plan and an HSA through Cigna, you must first open a new HSA account. Then you will be able to contribute pre-tax dollars to your account through payroll deductions. Payroll deduction amounts can be started, changed, or stopped at any time during the year without reason. Simply obtain the change form from the OrangeNet Intranet or your HR Service Center, complete it, and send it to Payroll for processing.

In addition to payroll deductions, you can also contribute directly to your HSA by sending a check to HSA Bank or by making an online payment or online transfer to the account. Specific instructions on these contribution methods will be provided in the welcome kit you receive from HSA Bank after you open your HSA.

Will the County make a contribution into my Health Savings Account?

Yes! The County will make a contribution for employees who elect the OrangePrime Plus plan during open enrollment or as a new hire employee. As a new hire, proration rules apply (refer to the table below). If elected during open enrollment, you must apply for an HSA through Cigna no later than 11/02/2018. If you already have an HSA through Cigna, you need to ensure that the account is active and open by 11/02/2018. Accounts with a negative balance will be closed and unable to accept new employer contributions.

The purpose of the OrangePrime Plus plan contribution is to help off-set the deductible. For the 2019 plan year, the County will provide contributions, based on the medical coverage category of the employee at the time of funding. Those with employee only coverage can receive up to a \$750 contribution, while those that cover tax-qualified dependents on the plan can receive up to a \$1,250 contribution. For open enrollment elections, the contribution will occur in mid-January 2019 upon successful completion of the following requirements:

1. Elect the HDHP during open enrollment (between 10/01/2018-10/19/2018).
2. Elect to receive the contribution into an HSA during open enrollment.
3. Open an HSA account through the Cigna portal by 11/02/2018.
4. Still be an active, benefit-eligible employee at the time the HSA contributions are deposited in mid-January 2019.

Newly hired employees, who have selected the OrangePrime Plus plan, will receive a prorated employer contribution based on the chart below:

Level	If your benefits begin 1/1-3/31	If your benefits begin 4/1-6/30	If your benefits begin 7/1-9/30	If your benefits begin 10/1-12/31
Employee Only	\$750 paid in Q2	\$562.50 paid in Q3	\$375 paid in Q4	\$187.50 paid in Q1
Employee + Dependent(s)	\$1250 paid in Q2	\$937.50 paid in Q3	\$625 paid in Q4	\$312.50 paid in Q1

Note: Employees must still be actively employed at the time of the deposit in order to receive it.

What if I am not eligible for an HSA; can I still get the employer contribution?

If you do not meet the eligibility requirements to receive contributions into an HSA, or do not have an open/active HSA account, then the funds will be issued via paycheck and are subject to applicable taxation rules. Complete the HSA attestation and indicate that you are not eligible for the HSA plan. Funds will be issued via paycheck and are subject to applicable taxation rules.

Are new hires able to receive the employer contribution?

Yes, however you may receive a prorated amount based on your benefits effective begin date.

Is there a maximum contribution amount for HSA contributions?

Yes, the IRS sets the maximum contributions amounts on an annual basis. The contribution maximum includes all dollars that are added “into” your HSA during the year (*including* the County contribution and any other contributions you make independently or through payroll deductions). However, amounts that roll over from year to year are not included and can accumulate as high as you like. If you accidentally contribute more than the annual maximum to your HSA, you should contact HSA Bank regarding correcting this situation so that you don’t have to pay income tax or IRS penalties on the over-contribution.

- Employee only (single coverage): \$3,500
- Employee with dependents (family coverage): \$7,000

The maximum amount is based on the medical coverage you have, not how you file your taxes. For example, even if you file married/jointly or head of household, if you are only covering yourself (single coverage) on the medical plan, your maximum is \$3,500.

In addition, if you are 55 or older, you are allowed to make an additional “catch up” contribution amount of \$1,000 per year. If you and your spouse are both 55 or older (and both covered on the medical plan), then your spouse can also open up his/her own HSA through a bank of his/her choosing and put in an additional \$1,000 in catch up contributions. Note: your spouse cannot open up an HSA through Orange County’s Cigna plan unless your spouse is also an employee. For more information regarding HSA regulations, you should contact HSA Bank.

How soon do I have access to my HSA funds?

The HSA is very much like a checking account, in that the money has to be in the account before you can spend it. So, if the payroll deduction has not yet occurred, the funds will not be in the account for you to spend.

What are the limitations or restrictions if my spouse is also a County employee?

If you are married to another County employee, you have the option to choose the coverage that works best for your family. For example, you can each sign up for “employee only” coverage if you like or one can do “employee + spouse” and the other can “waive medical.” The choice is yours. Regardless of your coverage and HSA decision, your annual HSA contribution maximum for the 2019 plan year cannot exceed the family contribution limit of \$7,000.

If you and your spouse both keep your own County medical coverage, then both spouses are able to open an HSA and receive the County’s funding (assuming you both meet the requirements & are both otherwise eligible for the HSA). In other words, both individuals can have an HSA of their own, if they are

both primary subscribers on their medical plans. Keep in mind that if you keep your coverage separate (for example, if both select “employee only”), then you will each have your own deductible and out-of-pocket maximum for the plan year and the amounts cannot be combined together. However, if you choose “employee + spouse” or “employee + family” coverage, then only the main subscriber can open and fund the HSA through the County.

OrangePrime Plan (LDHP)

What are the main components of the OrangePrime Plan (LDHP)?

The OrangePrime Plan is made up of two parts – copays and deductible:

1. You pay copays year-round for the following services:
 - Doctor’s office visits
 - Specialist office visits
 - Outpatient Mental Health/Substance Abuse
 - Urgent Care
 - Prescriptions
2. The remaining medical services are subject to the following plan design:
 - You pay the Co-insurance of 20% after you meet the calendar year deductible for all other medical services
 - Co-pays and co-insurance amounts that you pay contribute to the out-of-pocket maximum
 - Preventive care coverage of 100%, even before you reach your deductible

What are the copays?

The copays for the OrangePrime Plan are detailed in the *Medical Plan Comparison Chart* on page 22 of this booklet. Copays do not count toward your deductible, but they do count toward your out-of-pocket maximum.

What is the deductible?

The in-network deductible for 2019 is \$750 for those with employee only medical coverage and \$1,500 for those who cover dependents on the medical plan. When you are covering dependents on the plan, one member can meet the deductible for the entire family or it can be met by a combination of members. With the OrangePrime Plan, none of the funds you spend on co-pays will count toward your annual deductible.

What is coinsurance?

Coinsurance is the cost sharing between you and the plan that will occur after the deductible has been met for all covered services that do not have a co-pay. For 2019, the in-network medical coinsurance amounts are 20% your responsibility and 80% plan responsibility.

What is the out-of-pocket maximum?

The out-of-pocket maximum is the most that you will have to pay in a year for deductible, co-pays and coinsurance for covered medical and pharmacy benefits. It does not include premiums. It’s like a safety net to protect you from high costs in case you have a bad year. For 2019, the in-network out-of-pocket max for the OrangePrime Plan is \$2,100 for those with employee only coverage and \$4,200 for those with dependents covered on the plan. When you are covering dependents on the plan, one family member can reach the out-of-pocket maximum for the entire family or it can be met by a combination of family members.

Do I still pay co-pays after I meet my out-of-pocket maximum?

No. With the OrangePrime Plan, co-pays will count toward your out-of-pocket maximum.

Is there a pre-existing condition clause?

No. This plan does not have a pre-existing clause.

Do I need a referral to see a specialist?

No. The OrangePrime Plan is an open access plan, which means you have the freedom to access medical care at any time through any participating network physicians, including specialists, without a referral.

How much will medical coverage cost?

Costs for all benefits can be found on pages 51-53 of this guide.

Is there out-of-network coverage?

Yes. The OrangePrime Plan does allow you to access care out-of-network. However, all out-of-network services will have a separate deductible and out-of-pocket maximum for those services and will not be combined with the expenses you have incurred in-network throughout the year. The out-of-network deductible, co-insurance, and out-of-pocket maximum amounts are listed on page 22 in the *Medical Plan Comparison Chart*.

Can I fund an HSA if I elect the OrangePrime Plan?

No. The OrangePrime Plan is not an HSA-eligible plan so you can no longer contribute to your HSA. However, if you have funds remaining in your HSA and switch to the OrangePrime Plan, you can continue to spend them on qualified health related expenses.

Are pregnancy programs available?

Yes. Members on the OrangePrime plan who enroll in the Cigna Healthy Pregnancies, Healthy Babies Program (HPHB) in their first trimester (defined as 0-13 weeks) or second trimester (defined as 14-26 weeks) of pregnancy and complete the entire program, including the post-delivery assessment, will receive a \$400 or \$200 incentive payment from the County. Dependent children can enroll in the program, but are not eligible for the incentive money. The funds will be issued via paycheck and are subject to applicable taxation rules. The incentive will be paid out in the middle of the following quarter after you have completed the outcome assessment through Cigna. **Employees must still be actively employed at the time of the deposit in order to receive it.**

HPHB program completed 1/1-3/31	HPHB program completed 4/1-6/30	HPHB program completed 7/1-9/30	HPHB program completed 10/1-12/31
\$200/\$400 paid in May	\$200/\$400 paid in August	\$200/\$400 paid in November	\$200/\$400 paid in February

Is there a financial contribution for the OrangePrime Plan?

No. Employees electing the OrangePrime Plan are not eligible for the High Plan contribution or the Opt Out Credit.

Medical Plan Comparison Chart

Note: Pharmacy Coverage is detailed in the next section of this booklet.

Benefit	OrangePrime Plus Plan (HDHP)		OrangePrime Plan (LDHP)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
DEDUCTIBLE <i>Individual/Family</i>	\$1,500 / \$3,000	\$3,000 / \$6,000	\$750 / \$1,500	\$3,000 / \$6,000
EMPLOYER CONTRIBUTION <i>Individual/Family</i>	Up to \$750 / \$1,250 <i>(proration rules apply)</i>		No employer contribution for this plan	
OUT-OF-POCKET MAX <i>Individual/Family</i>	\$3,000 / \$6,000	\$6,000 / \$12,000	\$2,100 / \$4,200	\$6,000 / \$12,000
COINSURANCE				
Preventive Care	\$0	***40% after Deductible	\$0	***40% after Deductible
Primary Care	20% after Deductible	*40% after Deductible	**\$20 co-pay	*40% after Deductible
Specialist	20% after Deductible	*40% after Deductible	**\$35 co-pay	*40% after Deductible
Inpatient Hospital Admission	20% after Deductible	*40% after Deductible	20% after Deductible	*40% after Deductible
Outpatient Surgery (Non-Hospital)	20% after Deductible	*40% after Deductible	**\$100 co-pay	*40% after Deductible
Outpatient Surgery	20% after Deductible	*40% after Deductible	20% after Deductible	*40% after Deductible
X-Rays, Lab, Diagnostics, CT, MRI, PET, Nuclear	20% after Deductible	*40% after Deductible	20% after Deductible	*40% after Deductible
Urgent Care	20% after Deductible	*20% after Deductible	**\$40 co-pay	*\$40 co-pay
Emergency Room	20% after Deductible	*20% after Deductible	20% after Deductible	*20% after Deductible
Ambulance	20% after Deductible	*40% after Deductible	20% after Deductible	*40% after Deductible
Home Healthcare	20% after Deductible	*40% after Deductible	20% after Deductible	*40% after Deductible
Durable Medical Equipment	20% after Deductible	*40% after Deductible	20% after Deductible	*40% after Deductible
Short-Term Rehabilitation/Therapy	20% after Deductible	*40% after Deductible	20% after Deductible	*40% after Deductible
MENTAL HEALTH / SUBSTANCE ABUSE				
Inpatient	20% after Deductible	*40% after Deductible	20% after Deductible	*40% after Deductible
Outpatient	20% after Deductible	*40% after Deductible	**\$35 co-pay	*40% after Deductible

* Out-of-network benefits are subject to reasonable and customary limitations. Any amount over reasonable charges will not be calculated toward your out-of-pocket maximum or deductible.

** OrangePrime plan copays do NOT apply to the deductible but are applied to the out-of-pocket maximum.

*** Out-of-network deductible does not apply to preventive care for dependents under the age of 16.

Details regarding specific eligibility, coverage exclusions, definitions, and other information are included in the full summary plan document.

Prescription Drug Coverage

What Prescription Drug Plan is available?

Anyone covered under either of the Cigna medical plans is also covered under a prescription drug plan administered by Cigna. There is no additional premium required for this coverage.



	OrangePrime Plus Plan			OrangePrime Plan		
Retail – 30-day supply	Preventive* Drugs: Before and after your deductible is met, you pay according to the 3-tier schedule below (<i>does not count toward your deductible, but does count toward your out-of-pocket max</i>). Treatment Drugs: You pay full price until your deductible is met. AFTER your deductible is met, you pay according to the 3-tier schedule below.			Preventive* and Treatment Drugs: Before and after your deductible is met, you pay according to the 3-tier schedule below. <i>(Note: Prescription copays do not count toward your deductible, but do count toward your out-of-pocket max on this plan.)</i>		
	Tier 1	Generic	\$10	Tier 1	Generic	\$10
	Tier 2	Preferred	10% + \$30	Tier 2	Preferred	10% + \$30
	Tier 3	Non-Preferred	10% + \$50	Tier 3	Non-Preferred	10% + \$50
Home Delivery – 90-day supply	Preventive* Drugs: Before and after your deductible is met, you pay according to the 3-tier schedule below (<i>does not count toward your deductible, but does count toward your out-of-pocket max</i>). Treatment Drugs: You pay full price until your deductible is met. AFTER your deductible is met, you pay according to the 3-tier schedule below.			Preventive* and Treatment Drugs: Before and after your deductible is met, you pay according to the 3-tier schedule below. <i>(Note: Prescription copays do not count toward your deductible, but do count toward your out-of-pocket max on this plan.)</i>		
	Tier 1	Generic	\$25	Tier 1	Generic	\$25
	Tier 2	Preferred	10% + \$75	Tier 2	Preferred	10% + \$75
	Tier 3	Non-Preferred	10% + \$125	Tier 3	Non-Preferred	10% + \$125

* Preventive drugs are prescription medications used to prevent or treat any of the following medical conditions: hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency and smoking cessation.

Is there a deductible for pharmacy?

- The OrangePrime Plus plan (HDHP) has a deductible for pharmacy benefits for non-preventive (treatment) drugs. You can reach your deductible and/or out-of-pocket max through both pharmacy and/or medical costs.
- The OrangePrime plan (LDHP) has no deductible for pharmacy benefits. However, pharmacy and medical costs do count towards your out-of-pocket max.

Will I be charged more for using brand-name drugs if a generic is available?

Yes. If a generic equivalent is available, but you fill the prescription with a brand drug, you will pay the generic co-pay plus the difference between the full cost of the brand and the generic.

What is Step Therapy?

It is a prior authorization program designed for you and your doctor to take one step at a time when choosing your medication. It works to help you find the most affordable medication appropriate for the treatment of a diagnosed condition, such as high cholesterol.

Often, you and your doctor have a choice of several different safe and effective prescription drugs to treat the same condition. Cost is often the biggest difference. Brand-name medications usually are the most expensive, while generic medications are the least expensive.

Several common ongoing medical conditions are subject to Step Therapy:

- High Blood Pressure
- Cholesterol Lowering
- Heartburn/ulcer
- Bladder Problems
- Osteoporosis
- Sleep Disorders
- Allergy
- Depression
- Skin Conditions
- Mental Health
- Non-Narcotic Pain Relievers
- ADD/ADHD
- Asthma
- Narcotic Pain Relievers

How Does Step Therapy Work?

For example, the **Cholesterol-Lowering (STATIN)** Step Therapy requires that at least one Tier 1 (generic) or Tier 2 (preferred brand) medication be used before a Tier 3 (non-preferred brand) medication is eligible for coverage without prior authorization. Tier 1 and Tier 2 medications can be used in any order without prior authorization.

Generics have the same quality, strength, purity and stability as their brand-name counterparts, yet are typically less expensive. If you have tried both Tier 1 and Tier 2 medications and your doctor determines they were not right for you due to medical reasons, then a Tier 3 medication would be the next choice. If both Tier 1 and Tier 2 medications were already tried, then a Tier 3 medication would be available without need for prior authorization for coverage. However, if your doctor believes your treatment plan requires a Tier 3 medication initially; your doctor can request prior authorization at any time.

Does Our Pharmacy Plan Have Home Delivery?

Yes. Home delivery through the Cigna Pharmacy allows you to receive a 90-day supply of maintenance medications through the mail at a reduced co-pay, once the deductible has been met, if applicable.

You can sign up for Home Delivery by mail or phone. To order by mail, have your physician write a prescription for a 90-day supply with refills, download an order form from myCigna.com, and mail the completed order form, prescription and payment to Cigna. To order by phone, have your medication, doctor's name and credit card information, and call 800-285-4812. Cigna will request a prescription from your doctor for a 90-day supply with refills.

Are smoking cessation drugs covered?

Yes, there are smoking cessation drug options in all three tiers.

Generic prescription smoking cessation medications are included at a \$0 co-pay and are excluded from the deductible.

TRICARE Supplement Plan

In addition to the two medical plans mentioned in the previous section, Orange County offers some employees the opportunity to enroll in the TRICARE Supplement Plan.



What is the TRICARE Supplement Plan?

TRICARE is the health insurance plan for members of the Armed Forces and their families. Orange County offers a *TRICARE Supplement Plan* as an optional benefit for employees who are already enrolled/entitled to the basic TRICARE health insurance due to their military affiliation. Orange County has contracted with Selman & Company to administer this plan on our behalf.

Who is eligible for the TRICARE Supplement Plan?

Employees may elect the TRICARE Supplement Plan if they meet the following eligibility requirements.

Eligible Members are under age 65 and include the following:

- Retired military receiving retired, retainer or equivalent pay
- Spouses, surviving spouses, some former spouses of a military retiree and Active-duty service member. (The former spouse must have been married to the military member for at least 20 years and not remarried)
- Reservists and National Guardsmen who are between the ages of 60 and 65 and have at least 20 years of creditable military service. Their eligible family members will also become eligible
- Qualified National Guard and Reserve members; TRICARE Reserve Select (TRS)

Are there any exceptions to the Age 65 Eligibility Rule?

- Participants/spouses over age 65 but are ineligible for Medicare. These Members must provide their HR Service Center with a copy of their Social Security Administration "Notice of Disallowance Statement"
- Participants/spouses who are over 65 but reside overseas. Since Medicare does not cover medical expenses incurred outside of the United States of America these individuals are eligible to enroll in the Supplement Plan. However, these individuals must be entitled to Medicare Part A and enrolled in Medicare Part B. Enrollment in Medicare results in automatic eligibility for TRICARE for Life.

Who is not eligible for the TRICARE Supplement Plan?

The following are eligible for a retail TRICARE Supplement policy, but not through the group coverage being offered by Orange County. These members will need to contact the SelmanCo's Customer Service Department at 1-800-638-2610, option 1.

- Families of disabled veterans who are eligible for CHAMPVA
- Active-duty service members, Reservists, National Guardsmen who are separating from active duty and their family members. These individuals have Transitional Assistance Management Program (TAMP) for 180 days after separating from active service

Can I cover my dependents on the TRICARE Supplement Plan?

Eligible dependents include spouses and unmarried dependent children up to age 21. If a full-time student up to age 23 or 26 if enrolled in the TRICARE Young Adult Program. In addition, incapacitated dependents may continue coverage past the policy age limits as long as TRICARE continues.

What happens to my TRICARE Supplement coverage when I turn age 65?

Coverage under the TRICARE Supplement plan will terminate automatically the month following a Member/spouse turning age 65 (Medicare age). For example, if the participant or spouse will become Medicare eligible on June 15th, his/her TRICARE Supplement coverage will terminate on July 1st. Notification of termination is sent 60 days prior to the participant (or spouse's) 65th birthday. The member may choose to continue the coverage for his/her family through portability.

Please note that Medicare is effective on the first of the month that an individual attains age 65. However, for individuals who were born on the 1st of the month, Medicare is effective on the first of the prior month.

Can I continue my TRICARE Supplement Plan once I terminate employment at Orange County?

Members who terminate employment may continue the supplement by "porting" their coverage and paying their monthly premiums directly to Selman & Company. Portability (Continuation of Coverage) letters are mailed to the terminating Member within two days of receipt of the termination date from the employer. Former Members who enroll on portability will pay 2% less in monthly premium dollars than they would enrolling under COBRA, since portability is offered at the same cost paid by the employer. There is no separate administration fee required. The portability/continuation of coverage letter will include the monthly rates.

Please note that portability does not apply to a Member, spouse or dependent child who no longer meets the Supplement eligibility requirements (e.g., a Member or spouse who attains age 65 and is eligible for Medicare or a dependent child who reaches age 21/23 and is no longer listed in DEERS).

Can I use the Opt-Out Credit to help pay for the TRICARE Supplement?

Yes. If you receive the County's Opt Out Credit by completing open enrollment premiums for the TRICARE Supplement are eligible to be offset by the Opt Out Credit. This is allowable, because you are still "opting out" of the County's self-insured health insurance plans through Cigna.

How much does the TRICARE Supplement cost?

Premiums for all benefit offerings are listed on pages 51-53 of this booklet.

How does the TRICARE Supplement Plan work?

See the benefit summary on the next page.

Is there a deductible?

Yes, the supplement plan has a \$100 individual/\$200 family deductible.

TRICARE Supplement Benefit Summary

Reimbursement of the annual TRICARE outpatient deductible under this plan is made only if the deductible is incurred after the effective date of coverage. It will be prorated if you are insured less than a year.



Care Required	TRICARE Select Insured is Responsible for	TRICARE Select Supplement Covers
Annual Deductible	Non-network: \$150 for individual and \$300 for family	50% of TRICARE Deductible
Inpatient Admission	<p>Network Provider: \$250 per day, or up to 25% hospital charge, whichever is less, plus 20% separately billed services</p> <p>Out of network: \$901 per day, or 25% hospital charge, whichever is less, plus 25% separately billed service</p>	<p>Network Provider: \$250 per day, or up to 25% hospital charge, whichever is less, plus 20% separately billed services</p> <p>Out of network: \$901 per day, or 25% hospital charge, whichever is less, plus 25% separately billed services</p>
Inpatient Care in Civilian Hospitals (doctor's care & other inpatient services)	<p>Network Provider: \$250 per day, or up to 25% hospital charge, whichever is less, plus 20% separately billed services</p> <p>Out of network: \$250 per day, or up to 25% hospital charge, whichever is less, plus 25% separately billed services</p>	<p>Network Provider: \$250 per day, or up to 25% hospital charge, whichever is less, plus 20% separately billed services</p> <p>Out of network: \$250 per day, or up to 25% hospital charge, whichever is less, plus 25% separately billed services</p>
Prescription Drugs: Civilian network pharmacy; up to a 30-day supply	Copayments: \$11 generic; \$28 brand name or \$53 formulary	Copayments: \$11 generic; \$28 brand name or \$53 formulary

Dental Insurance

What dental plans are available?

Orange County offers three dental plans through Cigna for you to choose from:

- Low Plan
- Middle Plan
- High Plan



What is the difference between the three dental plans?

The level of benefit varies depending on the plan selected.

- The **Low Plan** pays 100% of the maximum allowable charge for preventive and diagnostic care services with no deductible and has a schedule of maximum reimbursements for other covered services. This plan pays the same amount for services whether you are using an in-network or out-of-network dentist.
- The **Middle Plan** pays 100% of preventive and diagnostic care services with no deductible, 70% of basic services and 40% of major services for in-network or out-of-network coverage, after deductible.
- The **High Plan** pays 100% of preventive and diagnostic care services with no deductible, 80% of basic services and 50% of major services for in-network or out-of-network coverage, after deductible.

What about the network?

You will have access to the Cigna Dental PPO “Radius” network of general dentists and specialty dentists. The same network applies to all three dental plans. You can access the network directory by visiting Cigna.com.

What is a progressive plan maximum?

If you receive one preventive cleaning and oral exam during your plan year, your calendar year maximum will increase the next plan year by \$250. Year after year, when you remain enrolled in the plan and continue to receive preventive care (one preventive cleaning and oral exam), your annual dollar maximum will increase in the following year, until it reaches the level specified below.

In future plan years, different members of the same family may have different annual dollar maximums.

Is there a late entrant penalty?

No. The 2019 Cigna Dental plan does not have a late entrant penalty.

Dental Plan Comparison Chart

Benefits	Low Plan	Middle Plan	High Plan
Annual Maximum paid by insurance	\$1,000 per person per calendar year	\$1,000 per person per calendar year	\$1,500 per person per calendar year
Progressive Maximum	\$250 per year up to \$1,750	\$250 per year up to \$1,750	\$250 per year up to \$2,250
Calendar Year Deductible	\$50 per individual \$150 per family	\$50 per individual \$150 per family	\$50 per individual \$150 per family
Preventive Services - Oral exams, cleanings, routine x-rays, fluoride	100% - no deductible	100% - no deductible	100% - no deductible
Basic Services - Sealants; fillings; oral surgery; root canals; repairs to dentures, bridges and crowns	Paid according to Schedule of Benefits	Employee pays 30%, after deductible has been met	Employee pays 20%, after deductible has been met
Major Services - Periodontics, dentures, bridges, crowns, inlays, onlays	Paid according to Schedule of Benefits	Employee pays 60%, after deductible has been met	Employee pay 50%, after deductible has been met
Orthodontia - Coverage for eligible children only up to age 19	Not covered Select network orthodontists provide a 15% discount for adults. Contact your provider for more details.	Employee pays 60%, no deductible Lifetime limit of \$1,000 Select network orthodontists provide a 15% discount for adults. Contact your provider for more details.	Employee pays 50%, no deductible. Lifetime limit of \$1,000 Select network orthodontists provide a 15% discount for adults. Contact your provider for more details.

Details regarding specific eligibility, coverage exclusions, definitions, and other information are included in the full summary plan document.

Vision Insurance

Vision coverage is available for Orange County employees and their dependents. Provided by Humana (in coordination with Eye Med), the plan covers routine eye examinations, corrective lenses, frames, and contact lenses.

What are the benefits?

Plan Frequencies:

- Exam every 12 months
- Lenses every 12 months
- Frames every 24 months

If you choose contacts you will receive up to \$120 to cover your costs (15% off balance over \$120), no deductibles apply.

What are the network copayments?

In-Network copayments:

- Vision Examination: \$5
- Standard Plastic Lenses: \$15
- Tier 1-3 Progressive Lenses: \$110-\$135
- Standard scratch-resistance: \$0
- Standard anti-reflective coating: \$0
- Frames up to \$120 allowance (20% off balance over \$120)

Are there any restrictions or limitations?

If you use a Humana Insight participating network provider, you will receive full benefits. If you use a non-Humana Insight provider, your benefits will be reduced.

Could I have additional costs?

Yes, if you choose cosmetic extras such as tinted or oversized lenses, or if you elect additional professional services not covered under the plan.

Is LASIK vision correction covered?

Vision Care Plan has contracted with select LASIK facilities and eye doctors to offer LASIK at reduced fees. To take advantage of this plan enhancement, contact one of these network locations: TLC at 888-358-3937, LasikPlus at 1-866-757-8082, QualSight Lasik at 1-855-456-2020.

What is the difference between this plan and vision covered under our medical plans?

Each plan has a different level of benefit. Employees should compare the differences between the plans using the Vision Plan Comparison Chart on the next page, prior to making a decision as to which plan is better for them.

Vision Comparison Chart

Benefits	Humana Vision	
	In-Network	Out-of-Network ¹
Member Services Phone Number	877-398-2980	
Premium (Per Pay Period)	\$2.99 Single \$5.97 Employee +1 \$8.77 Employee + Family	
Exam Copay	\$5	Up to \$30 ¹
Materials Copay	\$15	N/A
Frames	\$120 retail allowance 20% off balance over \$120	Up to \$65 ¹
Standard Plastic Lenses Per Pair (after \$15 Materials Copay)	\$0 Single \$0 Bifocal \$0 Trifocal \$0 Lenticular	\$25 Single ¹ \$40 Bifocal ¹ \$60 Trifocal ¹ \$100 Lenticular ¹
Contact Lenses when Medically Necessary	\$0	\$200 ¹
Contact lenses (materials) when Elective	\$120 retail allowance 15% off balance over \$120	\$104
Contact lens Fitting and Follow-up *Standard Fit and follow-up	Pay no more than \$55 10% off Retail	Not covered
Contact lens Fitting and Follow-up *Premium Fit and follow-up	Mail Order: www.contactsdirect.com	Not covered
Quantity Limits	Exam and materials every 12 months Frames every 24 months	Exam and materials every 12 months Frames every 24 months
Laser Vision Correction	Discounts available through TLC, LasikPlus and Qualsight Lasik	N/A

¹ Vision benefits received from non-Humana In-Sight Network Providers are reimbursed by filing a claim. Reimbursable amounts are listed on this schedule..

Details regarding specific eligibility, coverage exclusions, definitions, and other information are included in the full summary plan document.

Life Insurance

What coverage is available?

Through The Standard Insurance Company, Orange County offers four options of Group Life Insurance coverage to all benefits-eligible employees: Basic Employee Life with Accidental Death and Dismemberment (AD&D) Insurance, Additional Employee Life with AD&D Insurance, Spouse Life with AD&D Insurance, and Child Life.



Basic Employee Life with AD&D Insurance

The County provides, at no cost to you, an amount of Basic Life Insurance equal to your annual base pay rounded up to the next multiple of \$1,000, to a maximum of \$200,000. Medical underwriting is not required for basic life insurance. As part of this coverage, the following services are available at no charge:

Log on to www.standard.com/mytoolkit. User name is "assurance".

- **Travel Assistance**
Services include a full range of medical, travel, legal and emergency transportation services when you travel more than 100 miles from home or internationally on trips up to 180 days.
- **Estate-Planning Assistance**
Online tools, found in the Legal Forms section, walk you through the steps to prepare a will and create other documents, such as living wills, power of attorney, health care agent forms and living trusts.
- **Health and Wellness**
Timely articles about nutrition, stress management and wellness help employees and their families lead healthy lives.
- **Funeral Arrangements**
Use the website to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.
- **Identity Theft Prevention**
Check the website for ways to thwart identity thieves and resolve issues if identity theft occurs.
- **Additional Services and Resources are available to Beneficiaries (see flyer for more details).**

What is AD&D Insurance?

Included with Basic Life Insurance, Additional Employee Life Insurance and Spouse Life Insurance is Accidental Death and Dismemberment (AD&D) Insurance. AD&D Insurance pays a benefit in addition to life insurance if the cause of death is due to a covered accident. The benefit is equal to two times the Life amount. For example, an employee with \$34,000 of Basic Life Insurance would have \$68,000 of Basic AD&D Insurance in addition to the \$34,000 of Basic Life Insurance, and a spouse with \$50,000 of Spouse Life Insurance would have \$100,000 of AD&D Insurance in addition to the \$50,000 of Spouse Life Insurance. AD&D insurance also pays benefits for the loss of sight, speech or hearing, hand or foot, thumb and index finger on same hand, para, hemi or quadriplegia, resulting from a covered accident. The amount payable for certain losses is less than 100% of the AD&D Insurance Benefit.

Employee and Spouse AD&D Insurance also includes the following benefits:

- **Seat Belt Benefit**

If you or your spouse die as a result of an automobile accident for which an AD&D Insurance Benefit is payable for loss of life and were wearing and properly using a seat belt at the time of the accident, the beneficiary named will receive an additional benefit equal to the lesser of (1) \$10,000, or (2) the AD&D insurance benefit payable for loss of your life.

- **Air Bag Benefit**

The beneficiary named will receive an additional benefit up to \$10,000 if you or your spouse die as a result of an automobile accident for which a Seat Belt benefit is payable for loss of life, the automobile was equipped with an Air Bag System, the deceased was seated in the driver's or passenger's seating position intended to be protected by the Air Bag System, and the Air Bag System deploys.

- **Child Care Benefit** *(This only applies to the Employee)*

If you die as a result of an accident for which an AD&D benefit is payable, up to \$10,000 will be paid to your spouse to cover the child care expenses incurred within 36 months after the date of your death for all children under age 13 in order for your spouse to work or to obtain training for work. The child care provider must be licensed and not a member of your family.

- **Career Adjustment Benefit** *(This only applies to the Employee)*

If you die as a result of an accident for which an AD&D benefit is payable, your spouse will receive up to \$10,000 to cover tuition expenses within 36 months after the date of your death, exclusive of room and board, books, fees, supplies and other expenses, if he or she is registered and in attendance at an accredited institution of higher education or trades training program for the purpose of obtaining employment or increasing earnings.

- **Higher Education Benefit** *(This only applies to the Employee)*

If you die as a result of an accident for which an AD&D benefit is payable, within four years after the date of your death, each of your qualified children who are registered and in full-time attendance at an accredited institution of higher education beyond high school within 12 months after the date you die will receive up to \$20,000 to cover tuition expenses at an accredited institution of higher education, exclusive of board and room, books, fees, supplies and other expenses.

- **Occupational Assault Benefit** *(This only applies to the Employee)*

Up to \$25,000 will be paid to you if you suffer a loss for which an AD&D Insurance Benefit is payable while actively at work and the loss is a result of an act of physical violence against you that is punishable by law and is evidenced by a policy report.

- **Public Transportation Benefit**

Up to \$200,000 will be paid if you or your spouse die as a result of an accident for which an AD&D Insurance Benefit is payable for the loss of life and the accident occurs while the deceased is riding as a fare-paying passenger on public transportation.

Additional Employee Life and AD&D Insurance

Eligible employees may apply for Additional Life insurance in increments of \$10,000, up to five times their annual base pay, but not to exceed \$300,000. Included with Additional Employee Life is AD&D Insurance, which provides a benefit that equals twice the amount of Additional Life Insurance elected.



Evidence of Insurability: In the following situations, the life insurance carrier requires applicants to complete a medical underwriting form (Medical History Statement) regarding past health history:

- Newly hired employees: Medical underwriting is not required unless your additional life insurance request is in excess of \$200,000 or you apply for coverage more than 31 days after the day you become eligible.
- Open Enrollment: Evidence of Insurability (EOI) is required:
 - Members not currently enrolled can go from \$0 to \$10,000 without submitting for EOI, unless previously declined.
 - Amounts in excess of the \$200,000 guaranteed issue
 - Members enrolled in Additional Life Insurance, who have not been previously declined, requesting more than \$10,000 of coverage
 - Members enrolled in Additional Life Insurance, who have been previously declined, the entire requested increase is subject to EOI
- Qualified Event: Any request to elect or increase additional life insurance with a qualified event requires medical underwriting, unless:
 - The qualified event was due to a change in employment status that affects eligibility and the employee is newly eligible for benefits.
- Reinstatement of Benefits: Any of the following requests to reinstate or increase additional life insurance will require medical underwriting
 - If you ceased to be a member for more than 90 days
 - If your Life Insurance ends because you have not made your premium payment
 - If you converted your Life Insurance

How do I designate beneficiaries?

To designate beneficiaries for your Life and AD&D benefits, complete the Beneficiary Designation Form included with your new hire materials or available from your HR representative. Your Basic Life Insurance and your Additional Life Insurance may have separate beneficiaries. Your beneficiary designation must be the same for your Life Insurance and AD&D Insurance death benefits. You may assign multiple primary and contingent beneficiaries, as long as the percentages are in whole numbers, equal to 100 percent. The contingent beneficiaries will only receive a benefit if none of the primary beneficiaries survive you. You can change your beneficiaries at any time by contacting your HR representative.

Are insurance benefits reduced as the insured grows older?



Yes, the amount of insurance payable is reduced to a percentage of the eligible or elected amount. Reductions are effective January 1st of the following year. These reductions apply to Basic Employee Life and AD&D Insurance, Additional Employee Life and AD&D Insurance, and Spouse Life and AD&D Insurance as follows:

Employee/Spouse Age	Percentage
65 through 69	65%
70 through 74	50%
75 and up	35%

Can I receive my life insurance while still living?

Both the Basic Employee Life policy provided by the County and the Additional Employee Life Insurance include an Accelerated Benefit that allows an insured employee with a Qualifying Medical Condition to receive up to 75% of the amount of the insured's life insurance not to exceed \$500,000. A Qualifying Medical Condition is a terminal illness or physical condition that is reasonably expected to result in death within 12 months. AD&D Insurance benefits will be reduced if an Accelerated Benefit is paid. The receipt of this benefit may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlements, so you should consult your tax or legal advisor before you apply for an Accelerated Benefit.

Can I take my life insurance with me when I leave the County?

If your life insurance ends because your employment with the County ends, you may be eligible to "port" (or buy) Group Life Insurance coverage without being subject to medical underwriting. This portability option applies to Basic and Additional Life/AD&D, Spouse Life/AD&D and Child Life Insurance.

If your life insurance ends or is reduced for any reason other than non-payment of premiums, you may be eligible to "convert" some or all of your coverage to an individual Whole Life Insurance policy without being subject to medical underwriting. This conversion option applies to Basic and Additional Life, Spouse Life and Child Life Insurance. AD&D insurance is not eligible for conversion.

How much does it cost to Port or Convert my insurance?

Portability has smoker and non-smoker rates. The rates are different than the rates used in the group policy. Conversion rates are based on your state of residence and age when you apply for coverage. Please contact The Standard for detailed rate information.

How much time will I have to Port or Convert my insurance?

You will have 60 days after your employment terminates to apply and pay the premium for portability. For conversion, you will have 60 days after your coverage was reduced or ended. If you die during the 31-day period after the date your insurance ends or is reduced, your beneficiaries will be paid a death benefit equal to the maximum amount you had a right to port or convert, whether or not you applied for either option. For additional information call 1-800-378-4668, ext 6785.

Spouse Life and AD&D Insurance

Employees can purchase life insurance for spouses in increments of \$10,000 up to \$250,000, not to exceed the total amount of the Employee Basic and Additional Life Insurance. Included with Spouse Life is AD&D Insurance, which provides a benefit that equals twice the amount of life insurance elected for the employee's spouse. *(Please note: Employees earning less than \$20,000, who do not elect Additional Employee Life coverage, may purchase increments of \$5,000 up to \$20,000 of spouse life coverage.)*

The rates for Spouse Life and AD&D Insurance are the same as Additional Employee Life Insurance and are based on your spouse's age.



Evidence of Insurability: In the following situations, the life insurance carrier requires applicants to complete a medical underwriting form regarding past health history:

- Newly hired employees: Medical underwriting is not required unless the Spouse Life Insurance request exceeds \$50,000 or you apply for coverage more than 31 days after the day you become eligible. .
- Open Enrollment: Evidence of Insurability (EOI) is required:
 - Spouses not currently enrolled can go from \$0 to \$10,000 without EOI, unless previously declined and provided they were not eligible during the preceding annual enrollment.
 - Spouse can increase by \$10,000 without EOI, unless previously declined, up to the \$50,000 guaranteed issue
 - Amounts in excess of the \$50,000 guaranteed issue
 - Spouses enrolled in Spouse Life Insurance, who have been previously declined, the entire requested increase is subject to EOI
- Qualified Event: Any request to elect or increase Spouse Life Insurance due to a qualified event requires EOI, unless the family status change was due to a marriage and the request was not greater than \$50,000.
- Reinstatement of Benefits: Any request to reinstate or increase Spouse Life Insurance will require EOI if you have been on leave without benefits for more than 90 days and have not made your premium payments, with the exception of military leave, or have previously converted coverage.

Child Life Insurance

Employees can purchase Dependent Life insurance for their eligible dependent children. All eligible children will be insured for the same amount. Parents who both work for Orange County may only cover their children under one parent. The coverage options for Child Life Insurance are \$5,000 and \$10,000, but cannot exceed 100% of the total amount of the Employee Basic and Additional Life Insurance.

Eligibility for child life insurance:

- Unmarried children from live birth through age 25
- Unmarried stepchildren and the child of your spouse through age 25 if living with you
- Unmarried disabled children
- Grandchildren cannot be covered by child dependent life insurance



Evidence of Insurability: Medical underwriting is not required to insure your eligible dependent children.

NOTE: This book provides a brief overview of your Life Insurance and AD&D Plans. For a complete explanation (including the exclusions, limitations, and reductions of your coverage) please refer to your Certificate of Coverage. You can view and print a copy of the Life Insurance Certificate of Coverage from CountyFiles on the OrangeNet Intranet site. If you do not have Intranet access, you can request a copy of the Certificate of Coverage from your HR Service Center.

This information was written in non-technical language and is not intended as a complete description of the Group Life and AD&D Insurance plans offered by The Standard. Employees should refer to their Certification of Coverage, which will contain more detailed information. The controlling provisions are in the Standard Insurance Company's group policy. This information does not modify that document or the insurance in any way.

Disability Insurance

The Standard Insurance Company is Orange County's provider for Long-Term Disability (LTD) and Short-Term Disability (STD) coverage.



Long-Term Disability (LTD)

The County provides this benefit at no cost to you. The LTD plan pays an amount equal to 60% of your salary to a monthly maximum of \$10,000 (reduced by Deductible Income) upon completion of a 180-day waiting period. Since LTD premiums are paid by the County, the LTD benefits paid to employees are considered taxable.

What is deductible income?

Deductible income is income you receive, or are eligible to receive, from other sources. It includes but is not limited to the following (see your Certificate of Coverage for more details):

- Sick pay, annual or personal leave pay, severance pay, or other salary continuation, including donated amounts. Vacation pay is not a source of deductible income.
- Workers' Compensation benefits
- Social Security benefits, including those benefits that your spouse or children receive or are eligible to receive because of your disability or retirement
- Disability or retirement benefits from your employer's retirement plan
- Amount you receive or are eligible to receive because of a state disability benefit law or similar law
- Amount from any employment compensation law or similar act or law

When am I considered disabled?

For the first 36 months for which LTD Benefits are paid, you are considered disabled if, as a result of physical disease, injury, pregnancy, or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation and you suffer a loss of at least 20% of your pre-disability earnings when working in your own occupation. You are not disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

Thereafter, you are considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation which you are able to perform, whether due to education, training, or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 60% of your pre-disability earnings within twelve months following your return to work, regardless of whether you are working in that or any other occupation.

How long can LTD benefits continue?

If you become continuously totally disabled before age 62, LTD benefits can continue until age 65, or 3 years 6 months, if longer. If you become continuously totally disabled at age 62 or older, LTD benefits can continue for a limited time.

Age	Maximum Benefit Period
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 years 9 months
67	1 years 6 months
68	1 years 3 months
69	1 year

Assisted Living Benefit (Providing Added Income for the Severely Disabled)

The benefit is available for employees to whom LTD benefits are payable, whose condition is expected to last 90 days or more and who are experiencing the following limitations associated with their severe disability:

- The employee is unable to safely and completely perform two or more Activities of Daily Living* without assistance, or
- The employee requires supervision for health or safety due to severe cognitive impairment.

The Assisted Living Benefit is an additional 20% of your pre-disability earnings not to exceed \$3,333. It is not reduced by deductible income.

**The six Activities of Daily Living are bathing, continence, dressing, eating, toileting and transferring.*

Short-Term Disability (STD)

Employees have the option of enrolling in and paying premiums for an STD plan. The STD plan pays employees an amount up to 60% of their pre-disability salary to a weekly maximum of \$2,500 (reduced by Deductible Income – see definition of deductible income above). STD premiums are deducted from employee pay after taxes, so STD benefits paid to employees are non-taxable.

When do STD benefits begin, and how long will they last?

STD benefits begin once you have exhausted all County paid sick, term, personal, and vacation leave and have met the required waiting period.

Example: You are enrolled in the 15 day wait period benefit but you have 30 days of time on the books. Apply for your STD benefit immediately as it takes some time to process the claim and you may be eligible for a \$25 weekly benefit, while exhausting your County time. Upon approval of your STD claim, the effective date will be the beginning of your disability. Once your County time is exhausted, your STD benefit will begin to pay out unless you have already returned to work.

Because everyone’s situation is different, there are five STD plan options – or waiting period buy-down options – to choose from. The waiting period buy-down options are 15, 30, 60, 90, and 120 calendar days. Before selecting the STD plan that best meets your needs, you should review and consider how much leave time you have accrued. STD benefits continue until you are no longer disabled, to the end of the maximum benefit period, or until LTD benefits begin, whichever happens first.

Benefit Waiting Period	Maximum Benefit Period:
120 day wait	9 weeks
90 day wait	13 weeks
60 day wait	18 weeks
30 day wait	22 weeks
15 day wait	24 weeks

What is the cost of STD coverage?

STD is calculated based on the amount of weekly benefit you would receive. A formula for calculating your premium is provided on page 49 of this booklet.

Do I need to make an STD Election?

All benefits-eligible employees are automatically enrolled in the LTD Plan with the 180-day waiting period. However, employees who would like short term coverage must make an election for the STD Plan with the waiting period they desire.



Evidence of Insurability: In the following situations, the STD carrier requires applicants to complete a medical underwriting form (Medical History Statement) regarding past health history:

- **Newly hired employees:** Medical underwriting is not required for newly hired employees electing STD coverage within 31 days of becoming eligible.
- **Open Enrollment:** Evidence of Insurability (EOI) is required:
 - Members not currently enrolled can elect the 120-day plan without EOI, as long as they have not previously been denied. If you are not currently enrolled for STD coverage and want to elect a benefit waiting period shorter than 120 days, EOI is required (ie. from no coverage to the 90-day, 60-day, 30-day, or 15-day plan).
 - Members currently enrolled for STD coverage who want to elect a shorter benefit waiting period may buy down by one tier without EOI (ie. 90-day plan to the 60-day plan). If you want to elect a benefit waiting period shorter than one tier down, EOI is required (ie. 90-day plan to the 30-day plan is subject to EOI. If denied, coverage defaults back to the 90-day plan)
- **Qualified Event:** Any request to elect or reduce the STD waiting period due to a qualified event will require EOI.
- **Reinstatement of Benefits:** Any request to reinstate or reduce the STD waiting period will require EOI if you have been on leave without benefits for more than 90 days.

NOTE: This book provides a brief overview of your LTD and STD Plans. For a complete explanation (including the exclusions, limitations and reductions of your coverage) please refer to your Certificate of Coverage. You can view and print copies of the LTD and STD Certificates of Coverage in from CountyFiles on the OrangeNet Intranet site. If you do not have Intranet access, you can request a copy of the Certificate of Coverage from your HR Service Center.

This information is written in non-technical language and is not intended as complete descriptions of the LTD and STD Insurance plans offered by The Standard. Employees should refer to their Certificates of Coverage, which will contain more detailed information. The controlling provisions are in the Standard Insurance Company's group policy. This information does not modify that document or the insurance in any way.

Flexible Spending Accounts

The County offers three Flexible Spending Accounts: a Medical Flexible Spending Account (Medical FSA), a Limited Purpose Flexible Spending Account (LPFSA) and a Dependent Care Flexible Spending Account (DCFSA). Chard Snyder is Orange County's administrator for Flexible Spending Accounts.



Medical Flexible Spending Account (FSA)

The Medical FSA allows you to set aside pre-tax dollars to pay for your portion of covered expenses, as well as eligible expenses not covered by your medical, dental or vision insurance.

How does this program work?

You determine how much you wish to deduct from your paycheck each pay period to go into this account. You can contribute as little as \$15 per pay period and as much as \$2,650 per plan year. *The \$2,650 maximum does not include any contributions you may receive from the County.* You need to estimate expenses carefully. Unused funds will only carry over until March 15th of the next plan year. This is a “use it or lose it” plan so any remaining funds after that date will be forfeited (lost).

The contributions made to the Medical FSA can be used for your portion of covered expenses and eligible expenses incurred by you or your eligible dependents. Eligible dependents for the Medical FSA are generally defined as those individuals who you can claim as a dependent on your federal income tax returns. Eligible dependents under the Medical FSA do not need to be covered under the Wellness for Life benefit plans.

What types of expenses are considered eligible for reimbursement?

The following is a partial list of the types of expenses that may be eligible for reimbursement if not paid by insurance. A listing of eligible items can be found online: <http://www.chard-snyder.com/eligible-expenses/healthcare-eligible-expenses.html>. If you would like more information, please call Chard Snyder.

- Chiropractic care
- Contact lenses
- Dental copayments
- Eyeglasses
- Hearing aids
- Medical copayments
- Medical deductibles and coinsurance
- Occupational therapy
- Orthodontia
- Prescription drug copayments
- Some over-the-counter drug items, *with a note from your doctor*
- Speech therapy
- Vision copayments

Who is eligible to elect a Medical FSA?

For the 2019 plan year, you can elect a Medical FSA if:

- You are on the OrangePrime Plus Plan (HDHP) but are ineligible for an HSA and are not electing a Limited Purpose FSA; or
- You are on the OrangePrime Plan (LDHP) and are not electing a Limited Purpose FSA; or
- You are on the TRICARE Supplemental Plan and are not electing a Limited Purpose FSA; or
- You are waiving all County medical coverage and are not electing a Limited Purpose FSA

How do I receive reimbursement for my eligible expenses?

You will receive a debit card from Chard Snyder to pay for your eligible expenses directly at the point of sale.



Always save your receipts! Chard Snyder may also request you submit receipts for purchases you have made with your debit card, so they can ensure they are for eligible items only. If receipts are not submitted, your expenses may be considered taxable.

Another reimbursement option is to pay for your expenses up front and then submit a claim form along with your receipts to Chard Snyder. A reimbursement check will then be mailed to you within 2 to 3 weeks. Employees may also be able to elect direct deposit as their preferred method of reimbursement. Direct deposit delivers funds into your personal bank account rather than waiting for a paper check. Interested employees should contact Chard Snyder for details.

What is the advantage of enrolling in this plan?

This benefit offers you the opportunity to set aside money on a pre-tax basis for predictable or unpredictable non-covered medical expenses, thus offering you significant tax savings.

Can I submit claims after I stop participating in the Medical FSA?

When your Medical FSA participation ends, you may submit claim forms only for expenses incurred up to the date your participation ended. You have 90 days from your termination date, to submit for reimbursement. For example, if you terminate employment or retire and your Medical FSA participation ends on July 24, you may receive reimbursements for eligible expenses you incurred through July 24. You may continue to use your FSA funds after you terminate employment or retire only if you continue the plan and pay premiums through COBRA.

Can I have a Medical FSA and a Dependent Care FSA at the same time?

Yes. The IRS allows you to have a Medical FSA and a Dependent Care FSA at the same time. However, you cannot have a Medical FSA and a Limited Purpose FSA at the same time.

What else do I need to know?

By using the Medical FSA to help pay for predictable health care expenses, you may end up with more net income. Remember, you must plan carefully to take advantage of this program. Make sure you do not put more into the account than you will use during the plan year because unused funds *cannot* be returned to you. Also, you cannot make changes to your deductions during the plan year unless you experience certain qualifying events. Contact your HR Service Center for more information.

Plan Deadlines

The plan year runs from January 1st through December 31st. You can continue to incur expenses through March 15th of the following year. You have until June 15th of the following year to submit claims incurred January 1st through March 15th (15 months).

Need more information?

Contact Chard-Snyder at 1-800-982-7715, via email at askpenny@chard-snyder.com, or online at www.chard-snyder.com.

Limited Purpose Flexible Spending Account (FSA)

The Limited Purpose Flexible Spending Account (LPFSA) is traditionally paired with a Health Savings Account (HSA) and allows you to set aside pre-tax dollars to pay for your portion of covered expenses, as well as eligible expenses not covered by your dental or vision insurance. The LPFSA *cannot* be used for medical expenses.

How does this program work?

You determine how much you wish to deduct from your paycheck each pay period to go into this account. You can contribute as little as \$15 per pay period and as much as \$2,650 per plan year. You need to estimate expenses carefully. Unused funds will only carry over until March 15th of the next plan year. This is a “use it or lose it” plan so any remaining funds after that date will be forfeited (lost).

The contributions made to the LPFSA can be used for your portion of covered expenses and eligible expenses incurred by you or your eligible dependents. Eligible dependents for the LPFSA are generally defined as those individuals who you can claim as a dependent on your federal income tax returns. Eligible dependents under the LPFSA do not need to be covered under the Wellness for Life benefit plans.

What types of expenses are considered eligible for reimbursement?

The following is a partial list of the types of expenses that may be eligible for reimbursement if not paid by insurance. A listing of eligible items can be found online: <http://www.chard-snyder.com/eligible-expenses/healthcare-eligible-expenses.html>. If you would like more information, please call Chard Snyder.

- Vision copayments
- Eyeglasses
- Contact lenses
- Dental deductible
- Dental copayments
- Orthodontia

Who is eligible to elect a Limited Purpose FSA?

The Limited Purpose FSA can be used by those with an HSA to increase their tax savings or by those without an HSA who cannot open a Medical FSA. Enrollment into this plan, does not require participation in the County’s medical plans.

How do I receive reimbursement for my eligible expenses?

You will receive a debit card from Chard Snyder to pay for your eligible expenses directly at the point of sale.



Always save your receipts! Chard Snyder may also request you submit receipts for purchases you have made with your debit card, so they can ensure they are for eligible items only. If receipts are not submitted, your expenses may be considered taxable.

Another reimbursement option is to pay for your expenses up front and then submit a claim form along with your receipts to Chard Snyder. A reimbursement check will then be mailed to you within 2 to 3 weeks. Employees may also be able to elect direct deposit as their preferred method of reimbursement. Direct deposit delivers funds into your personal bank account rather than waiting for a paper check. Interested employees should contact Chard Snyder for details.

What is the advantage of enrolling in this plan?

This benefit offers you the opportunity to set aside money on a pre-tax basis for predictable or unpredictable non-covered dental and vision expenses; thus, it can offer you a significant savings on your income taxes.

Can I submit claims after I stop participating in the Limited Purpose FSA?

When your Limited Purpose FSA participation ends, you may submit claim forms only for expenses incurred up to the date your participation ended. You have 90 days from your termination date, to submit for reimbursement. For example, if you terminate employment or retire and your Limited Purpose FSA participation ends on July 24, you may receive reimbursements for eligible expenses you incurred through July 24. You may continue to use your FSA funds after you terminate employment or retire only if you continue the plan and pay premiums through COBRA.

Can I have an LPFSA and a Dependent Care FSA at the same time?

Yes. The IRS allows you to have an LPFSA and a Dependent Care FSA at the same time. However, you cannot have a Medical FSA and a Limited Purpose FSA at the same time.

What else do I need to know?

By using the LPFSA to help pay for predictable dental and vision expenses, you may end up with more net income. Remember, you must plan carefully to take advantage of this program. Make sure you do not put more into the account than you will use during the plan year because unused funds *cannot* be returned to you. Also, you cannot make changes to your deductions during the plan year unless you experience certain qualifying events. Contact your HR Service Center for more information.

Plan Deadlines

The plan year runs from January 1st through December 31st. You can continue to incur expenses through March 15th of the following year. You have until June 15th of the following year to submit claims incurred January 1st through March 15th (15 months).

Need more information?

Contact Chard-Snyder at 1-800-982-7715, via email at askpenny@chard-snyder.com, or online at www.chard-snyder.com.

Dependent Flexible Spending Account (DCFSA)

The Dependent Care Flexible Spending Account (DCFSA) allows you to reimburse yourself on a pre-tax basis for child care or adult dependent care expenses for eligible dependents that are necessary to allow you and your spouse to work, look for work, or attend classes as a full-time student. *Please note that this is not a health care flexible spending account for dependents.*

How does the program work?

You determine how much you wish to deduct from your paycheck each pay period to go into this account. You can contribute as little as \$15 per pay period and as much as \$5,000 per plan year. You need to estimate expenses carefully, as funds will only carry over until March 15th of the next plan year. This is a “use it or lose it” plan so any remaining funds after that date will be forfeited (lost).

How do I receive reimbursement for my eligible expenses?

As you incur dependent day care expenses, you will pay out of pocket, then submit a claim form along with your receipts for reimbursement. The amount eligible for reimbursement cannot exceed the current contribution amount. Note: You will not receive a debit card for this plan.

Who is considered an eligible dependent?

Your eligible dependents are defined as your tax dependent under age 13, or your spouse or tax dependent of any age (including, but not limited to, your parents and parents-in-law) who is mentally or physically incapable of caring for himself or herself. This dependent must depend on you for more than 50% of their support and be claimed as a dependent on your federal income tax return. Enrollment into this plan, does not require participation in the County’s medical plans.

What are the restrictions to consider if my spouse is also contributing to a Dependent Care FSA?

- If you are married and file a joint tax return and your spouse does not contribute to a dependent care FSA, you may contribute up to \$5,000.
- If your spouse does contribute to a Dependent Care FSA, you can contribute up to \$5,000 **COMBINED** per family.
- If you are married and file a joint tax return and your spouse earns less than \$5,000 annually, you may contribute up to your spouse’s annual earnings.
- If you are married and you and your spouse file separate tax returns, you may contribute up to \$2,500 and your spouse may also contribute up to \$2,500 to a separate Dependent Care FSA account.

Plan Deadlines

- The plan year runs from January 1st through December 31st. You can continue to incur expenses through March 15th of the following year. You have until June 15th of the following year to submit claims incurred January 1st through March 15th (15 months).

Need more information?

Contact Chard-Snyder at 1-800-982-7715, via email at askpenny@chard-snyder.com, or online at www.chard-snyder.com.

Spending Accounts – Comparison Chart

	Health Savings Account (HSA)	Medical Flexible Spending Account (FSA)	Limited Purpose Flexible Spending Account (FSA)	Dependent Flexible Spending Account (FSA)
<i>Eligibility</i>	<ul style="list-style-type: none"> • OrangePrime Plus required • IRS criteria (page 16) 	<ul style="list-style-type: none"> • OrangePrime or OrangePrime Plus • Do not need to be on County Medical • Cannot be contributing to an HSA 	<ul style="list-style-type: none"> • OrangePrime or OrangePrime Plus • Do not need to be on County Medical 	<ul style="list-style-type: none"> • OrangePrime or OrangePrime Plus • Do not need to be on County Medical
<i>Eligible Expenses</i>	Medical, RX, Dental, Vision, & Durable Medical Supplies	Medical, RX, Dental, Vision, & Durable Medical Supplies	Dental & Vision only	Dependent care services
<i>Maximum Contribution</i>	\$3,500 / \$7,000 (reduced by County contribution)	\$2,650 (not impacted by County contribution)	\$2,650 (not impacted by County contribution)	\$5,000
<i>Fund availability</i>	Upon deposit	Front loaded	Front loaded	Upon deposit
<i>Forfeitures</i>	n/a	March 15th	March 15th	March 15th
<i>Accessibility</i>	Debit card, check, pay online	Debit card or submit claim for reimbursement	Debit card or submit claim for reimbursement	Submit claim for reimbursement

ComPsych Employee Assistance Program

The County's Employee Assistance Program, Guidance Resources by ComPsych, was designed with your personal needs and those of your family in mind. Some of the diverse services you'll benefit from include:



- Counseling services from licensed professionals
- Free confidential assistance for employees and family members residing with the employee
- Short-term problem resolution
- Referrals to community resources
- 24-Hour Access
- Multiple site locations
- Unlimited telephonic financial consultations with ComPsych's staff of financial professionals
- Unlimited telephonic legal consultations with ComPsych's staff of attorneys
- Articles and resources online

How can ComPsych help?

ComPsych has experience with a wide variety of personal problems, including:

- Marital/Family concerns
- Financial problems
- Alcohol/Drug use
- Managing stress
- Coping with grief or loss
- Parent/Child conflicts
- Depression
- Workplace problems
- Time Management

How does ComPsych work?

For counseling services, simply call ComPsych and a specialist will help meet your needs by matching you with a counselor near your home or work. The counselors are all licensed, seasoned professionals, who are available to you 24 hours a day.

If counseling services are not needed, you can still obtain a variety of information and services available at www.guidanceresources.com. The website includes articles regarding family, work, community, health and financial matters.

Do I have to have Cigna medical in order to use ComPsych?

No. All full or part time regular employees who work at least 20 hours or more are considered “benefits eligible” and are able to use ComPsych services. You do not have to be covered on any of the medical plans in order to use ComPsych. Medical is completely separate from ComPsych services.

What are the counseling services of ComPsych?

You’ll start with a clinical assessment, conducted by a licensed professional, to determine the level and type of counseling that will help you. Should short-term therapy be needed, you will work with a counselor by engaging in a number of therapy sessions. You have six free sessions per issue. If long-term therapy is required, every effort will be made to refer you to a qualified resource outside of ComPsych that will be approved by your insurance.

What is the cost?

There is no cost to you for any of the Guidance Resources services. The program is provided by the county as a part of your employee benefits.

Who will know I used ComPsych?

Our ComPsych provider is under the strictest confidentiality guidelines mandated by law for licensed counselors. The ComPsych plan provides utilization reports with aggregate statistical information only and your use of ComPsych services is strictly confidential.

Can my family members use ComPsych?

Your family is encouraged to utilize ComPsych as well. Your personal problems affect your family and your family’s problems can also affect you and your job performance.

Can I continue to use services through ComPsych after I terminate from the County?

Yes, you and your family will have continued access to the services for up to 90 days after your last day of work.

Deferred Compensation

What is Deferred Compensation?

Orange County's Deferred Compensation Plan (457(b) Plan) provides an excellent way for you to invest for retirement while reducing your federal tax liability. Vanguard is the County's sole Deferred Compensation Plan provider.



The 457(b) Plan is designed for long-term savings and investment towards retirement, and the Plan has limited availability to withdraw funds during employment with Orange County. The money accumulated in your account(s) can be distributed to you after you have terminated your employment with Orange County.

Why participate in the 457(b) Plan?

The 457(b) Plan provides a unique benefit to you by giving you the ability to set aside money for your retirement on a "partially" pre-tax basis through payroll deductions. This benefit enables you to pay less tax while you save and invest for retirement. All contributions into your 457(b) Plan account are not subject to federal income tax, but they are subject to federal FICA, Social Security, and Medicare taxes. Since you don't pay taxes at the time you make the contribution into the program, you will pay taxes during retirement at the time you begin making withdrawals. Note: The annual maximum contribution amount may change annually, Vanguard can help you remain within the IRS guidelines.

Is there an after-tax contribution option?

Yes. Orange County's 457(b) Plan through Vanguard also offers a Roth after-tax investment option. Participants can choose to invest in the regular pre-tax account, the Roth after-tax account, or a combination of both account types. After you have terminated employment with Orange County, Roth assets, including any earnings, can be withdrawn tax-free if the plan participant is age 59½ or older and the Roth Account has been established for at least five years.

Investing in a Roth Account may not be right for everyone, as it depends greatly on your individual circumstances, including your current and estimated future tax rates. We recommend that you consult a tax advisor before taking any action.

When I retire, can I roll my lump sum payouts into Vanguard?

Yes. In reference to Lump Sum payouts, when a retiree receives their final payout for Personal or TERM time, they can increase their Vanguard deduction to up to 100% in order to have the entire check deposited into their Deferred Compensation plan. Consult your tax professional about the benefits of rolling your lump sum payments over into Vanguard.

How do I enroll?

You can enroll anytime, there is no specific enrollment period and no qualifying events are required. However, your personal information will not be sent to Vanguard until after your first pay check. Once Vanguard has received your information from the County, you can enroll online at <http://ocf.vanguard-education.com/ekit>.

Important Information

2019 Wellness for Life Plan Premiums

Medical and Pharmacy Premiums			<i>Bi-Weekly Rates</i>
Cigna	Total Premium	Employee Contribution	County Contribution
HDHP Employee only	\$298.23	\$3.06	\$295.17
HDHP Employee + spouse	\$651.21	\$100.43	\$550.78
HDHP Employee + child(ren)	\$600.99	\$91.85	\$509.14
HDHP Employee + family	\$888.45	\$205.14	\$683.31
LDHP Employee only	\$328.11	\$15.75	\$312.36
LDHP Employee + spouse	\$693.10	\$119.04	\$574.06
LDHP Employee + child(ren)	\$644.88	\$110.22	\$534.66
LDHP Employee + family	\$942.58	\$229.89	\$712.69

TRICARE Supplement Premiums			<i>Bi-Weekly Rates</i>
Selman & Company	Total Premium	Employee Contribution	County Contribution
Employee only	\$31.15	\$31.15	\$0
Employee + spouse	\$61.15	\$61.15	\$0
Employee + child(ren)	\$61.15	\$61.15	\$0
Employee + family	\$82.38	\$82.38	\$0

Dental Premiums			<i>Bi-Weekly Rates</i>
Cigna	Total Premium	Employee Contribution	County Contribution
Low Employee only	\$5.45	\$5.45	\$0
Low Employee + 1	\$11.11	\$11.11	\$0
Low Employee + 2 or more	\$20.33	\$20.33	\$0
Middle Employee only	\$9.50	\$9.50	\$0
Middle Employee + 1	\$19.68	\$19.68	\$0
Middle Employee + 2 or more	\$37.01	\$37.01	\$0
High Employee only	\$15.47	\$15.47	\$0
High Employee +1	\$31.51	\$31.51	\$0
High Employee + 2 or more	\$57.26	\$57.26	\$0

Vision Premiums			<i>Bi-Weekly Rates</i>
Humana CompBenefits Vision Care Plan	Total Premium	Employee Contribution	County Contribution
Employee only	\$2.99	\$2.99	\$0
Employee + 1	\$5.97	\$5.97	\$0
Employee + 2 or more	\$8.77	\$8.77	\$0

Employee Additional Life/AD&D and Spouse Life/AD&D Premiums*			<i>Bi-Weekly Rates</i>
Standard Insurance Company (rates are per \$10,000 of coverage) <i>Age as of 01/01/2018:</i>	Total Premium	Employee Contribution	County Contribution**
Under 30	\$0.37	\$0.37	\$0
30-34	\$0.46	\$0.46	\$0
35-39	\$0.74	\$0.74	\$0
40-44	\$1.11	\$1.11	\$0
45-49	\$1.57	\$1.57	\$0
50-54	\$2.31	\$2.31	\$0
55-59	\$2.63	\$2.63	\$0
60-64	\$3.32	\$3.32	\$0
65-69***	\$6.51	\$6.51	\$0
70 & up***	\$12.88	\$12.88	\$0

* AD&D premiums are included with Additional Life and Spouse Life premiums

** Basic Employee Life Insurance is paid by the County

***Age reductions apply

Employee/Spouse Age	Percentage
65 through 69	65%
70 through 74	50%
75 and up	35%

Child Life Insurance Premiums			<i>*Bi-Weekly Rates</i>
Standard Insurance Company	Total Premium	Employee Contribution*	County Contribution
\$5,000 per eligible child	\$0.16	\$0.16	\$0
\$10,000 per eligible child	\$0.32	\$0.32	\$0

* Employee contribution includes all eligible children

Short-Term Disability Premiums			<i>*Bi-Weekly Rates</i>
Standard Insurance Company (rates are per \$10 of covered weekly benefit – see formula)	Total Premium	Employee Contribution	County Contribution*
120 calendar day waiting period	\$0.037	\$0.037	\$0
90 calendar day waiting period	\$0.055	\$0.055	\$0
60 calendar day waiting period	\$0.097	\$0.097	\$0
30 calendar day waiting period	\$0.125	\$0.125	\$0
15 calendar day waiting period	\$0.143	\$0.143	\$0

*Long Term Disability Insurance is paid by the County

Formula for calculating Short-Term Disability bi-weekly premium:

1. Divide your gross annual salary by 52 (this gives you your weekly gross salary).
2. Multiply your gross weekly salary by 60%.
3. Divide that number by 10.
4. Multiply that number by the rate shown above for the STD waiting period you selected to get your bi-weekly premium.

Notice of COBRA Continuation Coverage Rights

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.



The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under this law, the Orange County Board of County Commissioners (OCBCC) is required to offer covered employees and covered family members the opportunity for a temporary extension of health coverage (called “Continuation Coverage”) at group rates when coverage under the plan would otherwise end due to certain qualifying events.

Qualifying Events for Covered Employee

If you are the employee of OCBCC, you may have the right to elect this continuation coverage if you lose your group health coverage because of a termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours of employment.

Qualifying Events for Covered Spouse and Dependent Children

If you are the covered spouse of an employee of OCBCC covered under the flexible benefits program, you may have the right to elect continuation coverage for yourself if you lose group health coverage under the flexible benefits program because of any of the following reasons:

1. A termination of OCBCC employee’s employment, or reduction in hours of employment with OCBCC
2. The death of OCBCC employee
3. Divorce
4. OCBCC employee becomes entitled to Medicare
5. Dependent Child ceases to be a “dependent child” under the terms of the plan

Under the law, it is the responsibility of the employee, spouse, or other family member to inform your Human Resources Service Center of a divorce, or child losing dependent status under the terms of the plan. This notification must be made within 60 days from whichever date is later – the date of the event or the date of the end of coverage under the plan. ***If this notification is not completed in a timely manner, right to continuation of coverage may be forfeited.***

Election Period and Coverage

Once Human Resources Service Center has been notified that a qualifying event has occurred, the covered individuals will be notified of their right to elect continuation coverage. The covered individual will then have 60 days from loss of coverage or notification, whichever is later, to elect coverage by completing and returning the COBRA election form. If the covered individual does not elect continuation coverage within this election period, right to continue health insurance will end. ***This is the maximum period allowed to elect COBRA, as the plan does not provide an extension of the election period beyond what is required by law.***

Length of Continuation Coverage

18 Months:

1. Termination of employment or reduction in work hours
2. Social Security Disability (which can be extended to 29 months if the Social Security Administration determines the date of disability to go back to the date of the qualifying event)
3. Another 18 month extension can occur if *during the 18 months* of continuation coverage, a second event takes place (divorce, death, Medicare entitlement, or dependent child ceasing to be a dependent)

24 Months:

1. Veteran's Benefit Improvement Act signed on December 10, 2004 amended Uniformed Services Employment and Reemployment Rights Act (USERRA)
2. Requires employers to provide 24 months (previously 18 months) of COBRA coverage to individuals called to active duty.

36 Months (if the original event causing the loss of coverage is one of the following):

1. Death
2. Divorce
3. Medicare entitlement
4. Dependent child ceasing to be a dependent under the plan terms

A COBRA participant will pay monthly the employer/employee premium plus a 2% administration charge. Non-payment is cancellation of coverage.

Other Options

There may be other coverage options for you and your family. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

If You Have Questions

Questions concerning the flexible benefit program, your COBRA continuation coverage rights, or premium rates please contact Chard Snyder at (800) 982-7715. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

2019 Monthly COBRA Rates

Medical Plans	EE Only	EE + Spouse	EE + Child(ren)	EE + Family
HDHP	\$659.09	\$1,439.17	\$1,328.19	\$1,963.48
LDHP	\$725.12	\$1,531.74	\$1,425.20	\$2,083.10

Dental Plans	EE Only	EE + 1	EE + 2 or more
Low	\$12.06	\$24.56	\$44.93
Middle	\$20.99	\$43.49	\$81.78
High	\$34.20	\$69.65	\$126.54

Vison Plan	EE Only	EE + 1	EE + 2 or more
Coverage	\$6.61	\$13.20	\$19.38

**All monthly COBRA rates include a 2% administrative fee.*

Social Security Number Collection Disclosure

Pursuant to Section 119.071(5), Florida Statutes, Orange County Government is requesting your social security number (SSN) for one or more of the following purposes: to comply with federal laws requiring the County to report income and SSNs for all employees and eligible retirees to whom it pays compensation; to maintain internal identification and to track records for use in administering payroll, tax reporting and benefits processing; to verify employment status, history and eligibility; to conduct background checks and drug test screening.



Orange County Government is dedicated to ensuring the proper handling of confidential information relating to its employees and to ensuring their privacy.

Use and Disclosure of Protected Health Information (PHI)

Orange County Government may use and disclose protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

A. Use and Disclosure of Summary Health Information

Plan Administrator may disclose, or permit its designated health insurance issuer or HMO to disclose, Summary Health Information about Covered Persons to Plan Sponsor, if Plan Sponsor requests Summary Health Information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
2. Modifying, amending or terminating the Plan.

Summary Health Information about Covered Persons obtained pursuant to this Plan Document by any Plan Administrator, Third Party Administrator, health insurance issuer, or HMO may be used or disclosed by Plan Sponsor only for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
2. Modifying, amending or terminating the Plan.

B. Use and Disclosure of PHI

The Plan is permitted to use or disclose an individual's PHI without an authorization for:

1. Treatment – includes but is not limited to the provision, coordination or management of health care and related services by one or more health care providers.
2. Payment – includes but is not limited to activities related to health care providers obtaining reimbursement for services and to health plans obtaining premiums and fulfilling responsibilities for providing health care coverage.

Activities include but are not limited to:

- Determining eligibility
- Adjudicating claims, claim audits, investigating and resolving payment disputes
- Billing and collection
- Coordination of benefits
- Review for medical necessity, justification of charges
- Utilization review
- Disclosure to reporting agencies (limited to identifying information for member and provider and/or health plan and payment history)

3. Health Care Operations – certain administrative, financial, legal and quality improvement activities such as:

- Quality assessment activities
- Evaluation of provider and Plan performance (accreditation, certification, credentialing, licensing)
- Underwriting and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance or risk relating to health care claims.
- Conducting or arranging for medical review, legal and auditing services, including fraud and abuse detection and compliance programs
- Business planning and development, such as conducting cost-management and planning analyses related to managing and operating the Plan
- Business management and general administrative activities such as:
 - Implementation and compliance with HIPAA
 - Customer service
 - Resolution of internal grievances
 - Sale or transfer of assets

The Plan Sponsor agrees to the following:

1. Plan Sponsor shall not use or disclose PHI other than as permitted or required by their Plan Document or as required by law.
2. Plan Sponsor shall ensure, through a written agreement that any agents, including a subcontractor (“Business Associate”), to whom it provides PHI received from Plan Administrator agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.
3. Plan Sponsor agrees not to use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual.
4. Plan Sponsor agrees to notify Plan Administrator in writing within a reasonable time after becoming aware of any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted under this subsection.
5. Upon receipt of a written request signed by Covered Person, Plan Sponsor may afford the Covered Person the right to access and obtain a copy of his or her PHI in accordance with HIPAA’s access requirements.
6. Covered Persons may request that the Plan Sponsor amend the PHI maintained in a designated record set in accordance with HIPAA, so long as such requests are in writing and provide a reason to support the requested amendment.
7. Upon receipt of written request by Covered person, Plan Sponsor agrees to provide Covered Person a written accounting of disclosures of PHI made by Plan Sponsor in accordance with HIPAA.
8. Plan Sponsor agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan Administrator available to the Secretary and Health and Human Services or his designee for purposes of determining compliance by the Plan Administrator with the Standards for Privacy of Individually Identifiable Health Information.

9. If feasible, Plan Sponsor agrees to return or destroy all PHI received from the Plan Administrator that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
10. Plan Sponsor agrees to make reasonable actions to maintain adequate separation from Plan Administrator.
 - a. Plan Sponsor shall grant only the Director of Insurance, Employee Benefits Manager and Employee Benefits Specialists access to Covered Person's PHI to be disclosed under this subsection IX.6.
 - b. Plan Sponsor agrees to restrict the access to, and use of PHI by the employees referenced in subsection IX.6 (H) (1) to the "plan administration functions: that the Plan Sponsor performs for, or on behalf of, the Plan Administrator. "Plan administration functions" do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan or the Plan Sponsor.

Plan Sponsor agrees to take reasonable steps to prevent use or disclosure of the PHI other than as provided for by this subsection IX.6 (H). Plan Sponsor agrees to mitigate, to the extent practicable, any harmful effect that is known to Plan Sponsor of a use or disclosure of PHI in violation of this subsection IX.6 (H) by reporting to the Director of Insurance any use or disclosure of the PHI in violation of this subsection IX.6 (H) within ten (10) days of the Plan Sponsor's discovery of such unauthorized use and/or disclosure.

Medicare Creditable Coverage Notice

Important Notice from Orange County Government About Your Prescription Drug Coverage and Medicare.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Orange County Government and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Orange County Government has determined that the prescription drug coverage offered by Orange County Government's medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Is it mandatory for me to join Medicare as an Active employee of Orange County Government?

No, as an active employee you can defer your Medicare Enrollment until the time of your retirement. However, if you defer it beyond retirement, you will face a late entrant penalty from Medicare.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, please keep in mind that *you cannot also be enrolled in the Orange County Medical Plan.*

The Orange County Government plan provides comprehensive prescription drug coverage through retail and mail providers. For the OrangePrime Plus Plan (HDHP), the copayments are as follows once the plan deductible has been met:

	Generic	Preferred Brand	Non-Preferred Brand
Retail 30 Days	\$10.00	10% + \$30.00	10% + \$50.00
Mail Order 90 Days	\$25.00	10% + \$75.00	10% + \$125.00

Preventive drugs are covered as above before and after the deductible is met, do not count toward the annual deductible, but do apply to the out-of-pocket maximum.

For the OrangePrime Plan (LDHP), there is no deductible for prescription coverage:

	Generic	Preferred Brand	Non-Preferred Brand
Retail 30 Days	\$10.00	10% + \$30.00	10% + \$50.00
Mail Order 90 Days	\$25.00	10% + \$75.00	10% + \$125.00

Note: If you request a brand name drug when a chemically equivalent generic is available, you will be required to pay the full amount of the difference in the cost of the generic drug and the brand name drug, plus the applicable generic co-pay.

Remember that your current Orange County Government coverage pays for other health expenses, in addition to prescription drugs, and you will not be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

Once you retire, if you do decide to join a Medicare drug plan and drop your current Orange County Government health plan, be aware that you and your dependents will not be able to get this coverage back

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your coverage with Orange County Government and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the Orange County Government Benefits team at Benefits@ocfl.net for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Orange County Government changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 1, 2018
Name of Entity/Sender:	Orange County Government
Contact:	Human Resources
Address:	P.O. Box 1393 Orlando, FL 32802
Phone Number:	407-836-5661
Email:	benefits@ocfl.net

Children’s Health Insurance Program Notice

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx x	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

<p align="center">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>	<p align="center">WASHINGTON – Medicaid</p> <p>Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473</p>
<p align="center">TEXAS – Medicaid</p> <p>Website: http://gethipptexas.com/ Phone: 1-800-440-0493</p>	<p align="center">WEST VIRGINIA – Medicaid</p> <p>Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p align="center">UTAH – Medicaid and CHIP</p> <p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>	<p align="center">WISCONSIN – Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002</p>
<p align="center">VERMONT– Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>	<p align="center">WYOMING – Medicaid</p> <p>Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531</p>
<p align="center">VIRGINIA – Medicaid and CHIP</p> <p>Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282</p>	

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Plan Contact Information

<p>Medical and Prescription Drug Plan Cigna Group: 3337200 Member Services: 1-800-CIGNA24 www.mycigna.com <i>(for help with mycigna.com, call 1-800-284-8346)</i> Ask a Nurse: 1-800-CIGNA24 Healthy Babies: 1-800-615-2906 Delivery Pharmacy: 1-800-285-4812 Fax your claim to: 1-859-410-2422</p>	<p>FSA, COBRA, ACA, or Retiree Coverage Chard Snyder <u>Flexible Spending Accounts</u> <ul style="list-style-type: none"> Member Services: 1-800-982-7715 Fax: 1-888-245-8452 <u>COBRA/ACA/Retiree</u> <ul style="list-style-type: none"> Member Services: 1-888-993-4646 Fax: 1-888-245-8452 www.chard-snyder.com</p>
<p>Health Savings Account HSA Bank 1-800-CIGNA24 www.mycigna.com</p>	<p>Short Term Disability (STD) Standard Insurance Group: 641718-D Member Services: 1-800-368-2859 Fax: 1-800-378-6053</p>
<p>Dental Cigna Group: 3337200 Member Services: 1-800-CIGNA24 www.mycigna.com</p>	<p>Long Term Disability (LTD) Standard Insurance Group: 641718-E Member Services: 1-800-368-1135 Fax: 1-971-321-8400</p>
<p>Vision Care Plan Humana Group: 1007800 (Eyemed) Plan: 7741123 Member Services: 1-877-398-2980 www.Humana.com</p>	<p>Life Insurance and AD&D Standard Insurance Group: 641718-F Member Services: 1-800-628-8600</p>
<p>Florida Retirement System (FRS) Pension Plan or Investment Plan Member Services: 1-866-446-9377 www.myfrs.com</p>	<p>Deferred Compensation 457(b) Plan Vanguard Group: 078082 Participant Services: 1-800-523-1188 http://ocf.vanguard-education.com/ekit</p>
<p>Employee Assistance Program (EAP) ComPsych Guidance Resources Program Company ID: ORANGECOUNTY Member Services: 1-855-221-8925 https://guidanceresources.com/groWeb/login/login.xhtml</p>	<p>TRICARE Supplement Plan Selman & Company Group: 0001640 Member Services: 1-800-638-2610 Option 1 www.asicorporation.com</p>
<p style="text-align: center;">For additional assistance with your benefits, contact Benefits@ocfl.net</p>	

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