Retiree Medical Plan

Benefits Enrollment Guide

2019

Contents

Introduction

The County of Orange offers a Retiree Medical Plan for retired individuals and their eligible dependents who receive a monthly Orange County Employees Retirement System (OCERS) retirement pension. The program is also available to the surviving spouse, domestic partner, or covered dependent of a deceased County of Orange retiree if you receive a monthly OCERS retirement pension.

The Retiree Medical Plan includes County of Orange health plans, available to both in-state and out-of-state residents. Additionally, the Plan includes a Retiree Medical Grant for eligible individuals. If you retire with at least 10 years of continuous eligible County service and are at least age 50 at the time of retirement, you may be eligible for the Grant, which offsets the cost of your retiree medical insurance rates. You may use the Grant toward County health plan rates and/or reimbursement toward your Medicare Part B premium (if eligible).

California state law allows the Retiree Medical Plan to fund the Grant from an Internal Revenue Code Section 401(h) Trust account established by the County of Orange. The Retiree Medical Plan, including the Grant, is neither a vested nor an entitled benefit and is not guaranteed. The Grant may be reduced or discontinued at anytime. The Board of Supervisors annually determines whether or not to continue the Retiree Medical Plan.

The health plans available to you are outlined in this guide. This guide is intended to be used as a resource. For complete information, refer to the health plan documents and Retiree Medical Plan Document that is available through the Benefits Center website or by calling the Benefits Center. To the extent there are any discrepancies between this guide, the health plan documents, and the Retiree Medical Plan Document, the health plan documents and the Retiree Medical Plan Document will govern in all cases. Please read your materials carefully in order to choose the plan(s) that best meet your needs.

Retiree Checklists – What You Need to Do!

Review the appropriate checklist carefully to ensure you complete all the necessary steps to maintain your eligibility for the Retiree Medical Plan (if applicable) and receive the coverage and rates that you desire.

The following checklists explain what you need to do to enroll in a retiree health plan if you are:

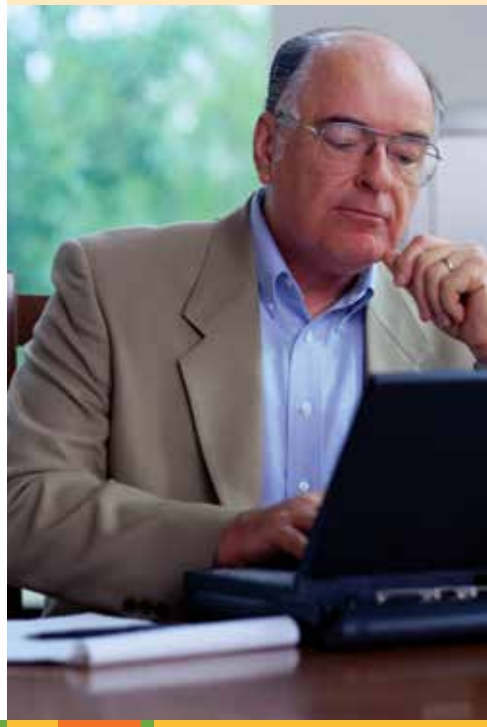
1. A soon-to-be new retiree;
2. Making your Open Enrollment election; or
3. If you and/or your spouse will be turning age 65 soon.

Your specific steps will vary based upon the above.

Some of the steps you take may include submitting documents that verify dependent eligibility and/or Medicare enrollment. Your enrollment materials will contain these forms or explain how to get them.

If you fail to provide required documentation, your health coverage and/or costs will be affected significantly. So, carefully review and take action on all these steps.

See the rest of this Benefits Enrollment Guide for details about the steps you need to take as well as information that will help you make the best enrollment decisions.



Checklist: If You Are a New Retiree

Enrolling in a retiree health plan is just one part of the retirement process. When you are ready to retire, take the following steps:

- ☐ **Notify the Orange County Employees Retirement System (OCERS) of your intent to retire.** It is strongly recommended that you do this at least 60 days before your desired retirement date. OCERS will notify the County of Orange Benefits Center and this will initiate a series of communications to let you know what you need to do—and by when—to enroll in a retiree health plan and receive your Retiree Medical Grant (if eligible).
- ☐ **Carefully review the Intent to Retire package that will be sent to your home.** You will receive it within 30 days after you declare your intent to retire. Among other things, the package includes a copy of the Retiree Quick Start Brochure and a personalized Benefits Summary Statement that explains your retiree health plan options, rates, requirements, instructions, and your enrollment form.
- ☐ **Enroll in Medicare if you are 65 or older.** Ideally, you should enroll in Medicare 90 days before your intended retirement date to ensure that your Medicare coverage is in place by the time you retire. To learn more about Medicare or to enroll in Medicare, call the Social Security Administration at **1-800-772-1213** or visit **www.ssa.gov**.
  - If you elect a Medicare Advantage Plan which requires Centers for Medicare and Medicaid Services (CMS) approval, failure to have Medicare enrollment in place at retirement (if age 65) may result in your paying a higher cost and being enrolled into the Wellwise Retiree PPO health plan while your Medicare is being finalized. (Medicare Advantage Plans require CMS approval and Medicare assignment prior to enrollment.)
  - *If you are eligible for Medicare Part B only*, you can only enroll in certain plans, and you should immediately call the Benefits Center toll-free at **1-800-858-7266** and advise the Benefits Center. They will require you to provide verification of your Medicare Part B only. You can find the Medicare Part B only health plans in the Your Retiree Health Plan Options section.
- ☐ **Attend pre-retirement meetings.** These meetings explain what you need to know and do about your Retiree Medical Plan.
  - Attend an OCERS pre-retirement meeting.
  - Attend a County New Retiree Benefits Orientation on or before the date you have declared your intent to retire. Visit the Employee Benefits website at **www.ocgov.com/gov/hr/eb** for the location, time and more information.
- ☐ **Contact the health plans you are considering.** If you have any questions about a specific health plan's benefit, doctors and hospitals, coverage areas or procedures, you may contact that plan directly. See the Resources and Contact Information section for health plan telephone numbers and website addresses. **Remember, even if your preferred doctor is not in, or leaves the plan network, you may not change health plans until the next Open Enrollment!**
- ☐ **Make your retiree health plan election as soon as possible to avoid delays in approval.** You have **30 calendar days** from the issue date on your Intent to Retire package to accept the automatic benefits coverage shown on your Benefits Summary Statement or return your enrollment form to make a new retiree health plan election.
  - If you are enrolled in the Cigna HMO health plan as an employee, you must make a new health plan election as Cigna is not offered as a retiree health plan.

☐ **Log into verify current coverage or view resource documents**

- **The Benefits Center website.** Visit the website 24 hours a day, 7 days a week to enroll. Log in at **https://countyoforange.ielect.com**. You will have a new Username and temporary PIN when you log in to the website for the first time. After you log in, you will be prompted to change the temporary PIN.
  1. Go to **https://countyoforange.ielect.com**
  2. Enter:
     - Username: First 4 letters of your last name (or full last name, if shorter) + last 6 digits of your Social Security number
     - PIN: Your birthday (MMDDYYYY)
  3. Follow the instructions to create a new PIN and security question, then click "Save."

     If you have any questions or need assistance call a Benefits Specialist at **1-800-858-7266**.
- **The Benefits Center.** Call the Benefits Center toll-free at **1-800-858-7266**. Benefits Specialists are available to answer your questions Monday through Friday, from 5:00 a.m. to 8:00 p.m. PT, except holidays. TTY and translation services are available.

☐ **Review your Benefits Confirmation Statement for accuracy and special instructions immediately upon receipt.** You will have 10 business days from the date of your Benefits Confirmation Statement to report any errors to the elections you made. If you fail to notify the Benefits Center within the 10-business day correction period, you will be unable to change your elections until the next Open Enrollment or until you experience a Qualified Life Event. You are solely responsible for informing the Benefits Center of any errors in your benefits election.

☐ **Submit any required documentation and forms to complete the enrollment process.**

- Complete the Medicare Advantage enrollment process (if applicable); Medicare Advantage Plans require approval from CMS and you will not receive the coverage and rates associated with these plans until approved;
- Submit documents that verify Medicare enrollment; and/or
- Submit documents that verify dependent eligibility.
- Verification documents may be sent by fax, U.S. Mail, or uploaded online at the Benefits Center website.

☐ **Pay your monthly health plan rates**

You will be billed automatically on a monthly basis for your share of health plan rates. You will receive a monthly invoice for your health plan rate until your pension deductions begin. This may take up to 90 days. If you do not pay the invoice for your monthly rates, your coverage will be terminated. After the initial transition period, your health plan rate will automatically be deducted from your monthly OCERS pension.

☐ **Convert your life insurance coverage**

If you have life insurance through your labor organization, contact that organization. If you have life insurance through the County, contact the plan administrator within 31 days after your retirement date. You may be eligible to continue certain life insurance benefits under an individual policy once your employment ends.

Portability of insurance allows eligible insured employees to continue their coverage after leaving the County. You must meet certain criteria to be eligible for portability. If you are not eligible for portability, you may elect the conversion option. Contact the plan administrator for additional information.

Checklist: Making Your Retiree Open Enrollment Elections

- [ ] **Use this Benefits Enrollment Guide.** This Benefits Enrollment Guide provides an overview of your retiree health plan options and describes the enrollment process. It explains what you need to know and do to ensure that you successfully enroll in the coverage that best meets your needs.

  If you are eligible for Medicare—or will become eligible soon—this Benefits Enrollment Guide also helps you understand how the Retiree Medical Plan works with Medicare.

- [ ] **Review your Benefits Summary Statement and the other enclosed documents.** Your Benefits Summary Statement is enclosed with the Retiree Quick Start Brochure and One Page Benefit Summaries. Other documents that you may need to enroll are enclosed as well. The information in these documents explains your coverage, your options and costs, dependent coverage, important requirements, and more.

- [ ] **Talk to a Benefits Specialist.** Call the Benefits Center toll-free at **1-800-858-7266**. Benefits Specialists are available Monday through Friday, from 5:00 a.m. to 8:00 p.m. PT, except holidays. TTY and translation services are available.

  - Benefits Specialists can answer questions about your current coverage, your coverage options, dependent coverage, rates, any required documentation, and the enrollment process. They are also available year-round to answer your Retiree Medical Plan-related questions.

- [ ] **Attend an Open Enrollment meeting.** A series of Open Enrollment meetings will take place at various County locations. Representatives will be available in person to review your benefits options with you and answer your questions.

- [ ] **Contact the health plans you are considering.** If you have questions about a specific health plan's benefits, doctors and hospitals, coverage areas or procedures, you may contact that plan directly. See the Resources and Contact Information section for health plan telephone numbers and website addresses. **Remember, even if your preferred doctor is not in, or leaves the plan network, you may not change health plans until the next Open Enrollment!**

- [ ] **Make your Open Enrollment election as soon as possible to avoid delays in approval.**

☐ **Log in or call to enroll.**

- **The Benefits Center website.** Visit the website 24 hours a day, 7 days a week. Log in at **https://countyoforange.ielect.com**. You will have a new Username and temporary PIN when you log in to the website for the first time. After you log in, you will be prompted to change the temporary PIN.
  1. Go to **https://countyoforange.ielect.com**
  2. Enter:
     - Username: First 4 letters of your last name (or full last name, if shorter) + last 6 digits of your Social Security number
     - PIN: Your birthday (MMDDYYYY)
  3. Follow the instructions to create a new PIN and security question, then click "Save."

     If you have any questions or need assistance call a Benefits Specialist at **1-800-858-7266**.
- **The Benefits Center.** Call the Benefits Center toll-free at **1-800-858-7266**. Benefits Specialists are available to take your enrollment elections Monday through Friday, from 5:00 a.m. to 8:00 p.m. PT, except holidays. TTY and translation services are available.

☐ **Review your Benefits Confirmation Statement for accuracy and special instructions.**

You will receive a Benefits Confirmation Statement at your mailing address shortly after you enroll (or at the end of the enrollment period if you did not make any elections). You will have 10 business days from the date of your Benefits Confirmation Statement to report any errors to the elections you made. If you fail to notify the Benefits Center within the 10-day correction period, you will be unable to change your elections until the next Open Enrollment or until you experience a Qualified Life Event. You are solely responsible for informing the Benefits Center of any errors in your benefits election.

☐ **Submit any required documentation and forms to complete the enrollment process.**

- Complete the Medicare Advantage process (if applicable): Medicare Advantage plans require approval.
- If you add new dependents, submit documents that verify dependent eligibility.
- Document may be sent by fax, U.S. Mail, or uploaded online at the Benefits Center website.

WANT TO ACTIVATE YOUR RETIREE HEALTH PLAN?

If you deferred your retirement and now want to activate your retiree health plan, call the Benefits Center and speak to a Benefits Specialist. You are required to do this within **30 calendar days** of activating your OCERS pension. When you call, identify yourself as a County of Orange deferred retiree.

Checklist: You and/or Your Dependent Spouse Will Be Turning Age 65

- [ ] **Enroll in Medicare**. Ideally, you should enroll in Medicare 90 days before your 65th birthday to have your Medicare coverage in place by your birthday. If you do not do this, your coverage and costs will be affected significantly.

  - *If you are eligible for Medicare Part B only*, you can only enroll in certain plans and *y*ou are eligible for Medicare Part B only, you should immediately call the Benefits Center toll-free at **1-800-858-7266** and advise the Benefits Center. They will require you to provide verification of your Medicare Part B only. You can find the Medicare Part B only health plans in the *Your Retiree Health Plan Options* section.
  - Failure to have Medicare enrollment in place at retirement (if age 65) and/or by your 65th birthday may result in your paying a higher cost and being enrolled into the Wellwise Retiree PPO health plan while your Medicare is being finalized. (The other plans require CMS approval and Medicare assignment **prior** to enrollment.) If your enrollment is not completed or approved, you must remain in the Wellwise Retiree PPO health plan until the next Open Enrollment. See Medicare Part D and Creditable Coverage section on page TBD for additional information.

- [ ] **Review the Retiree Turns 65 package** that will be sent to your mailing address 90 days before your 65th birthday. The package includes an enrollment form, a Retiree Quick Start Brochure, One Page Benefit Summaries, and your Benefits Summary Statement containing your new costs and options, and explains how to enroll in retiree health plan options for Medicare-eligible retirees. Carefully review "The Importance of Enrolling and Maintaining Your Medicare" document.

- [ ] **Contact the health plans you are considering.** If you have questions about a specific health plan's benefits, doctors and hospitals, coverage areas or procedures, you may contact that plan directly. See the Resources and Contact Information section for health plan telephone numbers and website addresses. **Remember, even if your preferred doctor is not in, or leaves the plan network, you may not change health plans until the next Open Enrollment!**

- [ ] **To enroll**

  Complete and return the enclosed Enrollment Form within **90 calendar days** from the issue date on your packet. To enroll dependents you will need to include their Social Security Number, legal name, relationship, gender, birthdate, documents to verify eligibility, and the Dependent Verification Form. To enroll yourself and/or your dependents in the Anthem Blue Cross or Scan HMOs you will need a Primary Care Physician (PCP) provider number, the Medicare ID number and the Medicare effective date for you and your Medicare eligible dependents.

  Unless you take action in the 90-calendar day window from the issue date of your packet, you will receive the automatic benefits coverage. You will be unable to make changes to your benefits until the next Open Enrollment period, or following another Qualified Life Event (QLE) that allows you to make a change to your benefits. Please refer to the Retiree Quick Start Guide for information on enrolling dependents for medical plan coverage. Refer to the end of this guide for resources including contact information for health plans.

☐ **Review your Benefits Election Summary for accuracy and special instructions.**

You will receive an Election Summary at your mailing address shortly after you enroll (or at the end of the enrollment period if you did not make any elections). You will have 10 business days from the date of your Election Summary to report any errors to the elections you made. If you fail to notify the Benefits Center within the 10-day correction period, you will be unable to change your elections until the next Open Enrollment or until you experience a Qualified Life Event. You are solely responsible for informing the Benefits Center of any errors in your benefits election.

☐ **Submit any required documentation and forms to complete the enrollment process.**

If you do not do this, your coverage and costs will be affected significantly. This documentation may include verification of Medicare coverage, verification of dependent eligibility, and/or special enrollment forms for certain health plan options. Verification documents may be sent by fax, U.S. Mail, or uploaded online at the Benefits Center website: **https://countyoforange.ielect.com**

For further information, see *"How the Retiree Medical Plan Works with Medicare"* section and *"If You and/or Your Eligible Dependent Are Turning 65 This Year"* in the *"Your Retiree Health Plan Options"* section.

IMPORTANT NOTE ABOUT PENDING ELECTIONS:

Review your Election Summary carefully. Enrollment in some plans requires approval by CMS. If you are not approved, or in some cases while waiting for approval, you may be automatically enrolled in a different plan.

It Is Time to Enroll in Your Benefits

It is time to enroll in a County of Orange retiree health plan. You have received Benefits information because:

- You are currently enrolled in a retiree health plan and it is Annual Benefits Open Enrollment, which is your once-a-year opportunity to make changes or
- You are a new retiree and need to enroll in a retiree health plan for the first time or
- You or your spouse will soon be age 65 and will have new plan options and costs to consider and Medicare enrollment requirements to meet.

This Benefits Enrollment Guide explains your options, tells you what you need to think about as you consider your options, and explains how to make changes to your current coverage or enroll for the first time. It also explains important requirements and actions you must take to avoid potential impact to your costs or enrollment.

Please carefully read this Benefits Enrollment Guide, refer to your Benefits Summary Statement, One Page Benefit Summaries and any additional forms and information included in your package.

You are required to take action and submit any required documentation by the deadline shown on your Benefits Summary Statement and/or your Benefits Confirmation Statement. **If you do not do this, your cost may be affected significantly and you will receive the automatic benefits coverage shown, which may not meet your needs. Your Retiree Medical Grant may also be suspended.** You will not be able to change your coverage until next year's Open Enrollment period or unless you experience a Qualified Life Event (QLE). (See *"When You Can Change Your Coverage"* in the *"How to Enroll"* section for more information.)

Questions?

If you have any questions about your coverage, or your options or the enrollment process, you may:

- Visit the Benefits Center website 24 hours a day, 7 days a week at **https://countyoforange.ielect.com**. You can view plan information, compare plans, find answers to frequently asked questions, and much more. You will have a new Username and temporary PIN when you log in to the website for the first time. After you log in, you will be prompted to change the temporary PIN.

  1. Go to **https://countyoforange.ielect.com**
  2. Enter:
     - Username: First 4 letters of your last name (or full last name, if shorter) + last 6 digits of your Social Security number
     - PIN: Your birthday (MMDDYYYY)
  3. Follow the instruction to create a new PIN and security question, then click "Save".

  If you have any questions or need assistance call a Benefits Specialist at **1-800-858-7266.**

- Call the Benefits Center toll-free at **1-800-858-7266**. Benefits Specialists are available Monday through Friday, from 5:00 a.m. to 8:00 p.m. PT, except holidays. TTY and translation services are available.

You will need your Username and personal identification number (PIN) to access the Benefits Center website or you can call and speak with a Benefits Specialist for assistance.

RETIREE MEDICAL PLAN

The County of Orange Retiree Medical Plan, including any Grant, is described in and governed by the "Third Amended and Restated County of Orange Retiree Medical Plan Document, Effective August 1, 1993, Amended and Restated August 12, 2008, and June 23, 2009," which is available through the Benefits Center website, or by calling the Benefits Center. To the extent there are any discrepancies between this summary document and the Retiree Medical Plan Document, the Retiree Medical Plan Document will govern in all cases.

The Board of Supervisors makes retiree medical benefits (including the Grant program) available at its sole discretion. There are no vested rights to any specific benefit, and there are no guaranteed benefits in the future. Thus, retiree medical benefits are made available each year under the Plan and may be terminated or changed at the Board's discretion. Further, the Board approves, in its sole discretion, the health plan rates applicable to the various health plans.

The Retiree Medical Plan pays the authorized Grant on a nontaxable basis from an Internal Revenue Code Section 401(h) Trust maintained as part of the Retiree Medical Plan. The Retiree Medical Plan permits the Trust to pay a post-retirement health insurance Grant. Again, there is no legal requirement to provide any post-retirement health insurance program or Grants. The Board of Supervisors annually determines whether to continue the Retiree Medical Plan.

Need Help Making Your Enrollment Decisions?

Use This Benefits Enrollment Guide

This Benefits Enrollment Guide provides an overview of your retiree health plan options and requirements, and describes the enrollment process. It explains what you need to know and do to ensure that you successfully enroll in the coverage that best meets your needs.

If you are eligible for Medicare—or will become eligible soon—this Benefits Enrollment Guide also helps you understand how the Retiree Medical Plan works with Medicare and what you must do to receive reduced rates and a Retiree Medical Grant (if eligible).

Review Your Enrollment Packet

In your package you will have your Election Summary enclosed with other documents that you may need to review and complete. The information in these documents explains your coverage, costs, options, requirements, dependent coverage and more.

Talk To A Benefits Specialist

Call the Benefits Center toll-free at **1-800-858-7266**. Benefits Specialists are available Monday through Friday, from 5:00 a.m. to 8:00 p.m. PT, except holidays. TTY and translation services are available.

Benefits Specialists can answer questions about your current coverage, your coverage options, dependent coverage, rates, any required documentation and the enrollment process. They are also available year-round to answer your questions.

Convenient Online Tool – Uploading Documents

The Benefits Center website (**https://countyoforange.ielect.com**) features easy-to-use tools that can help you make your enrollment decisions. The website is available 24 hours a day, 7 days a week, from any computer, laptop, tablet, or mobile phone that has Internet access, so you can use it when it is convenient for you. You will have a new Username and temporary PIN when you log in to the website for the first time. After you log in, you will be prompted to change the temporary PIN.

1. Go to **http://countyoforange.ielect.com**
2. Enter:
   - Username: First 4 letters of your last name (or full last name, if shorter) + last 6 digits of your Social Security number
   - PIN: Your birthday (MMDDYYYY)
3. Follow the instructions to create a new PIN and security questions, then click “Save”.

If you have any questions or need assistance call a Benefits Specialist at **1-800-858-7266**.

Tools on the website include:

- **Document Upload Feature**
  You have the ability to upload any required documentation or correspondence directly to the Benefits Center website. Click on "Docs" on the top navigation bar of the website. Follow the directions to upload documents to your account.

Contact The Health Plans You Are Considering

If you have questions about a specific health plan's benefits, coverage areas or procedures, you may contact that plan directly. See the Resources and Contact Information section of this guide for health plan telephone numbers and website addresses.

Learn About Medicare Requirements

Understand the health plan enrollment and approval process and requirements for retirees with Medicare. See the "*How the Retiree Medical Plan Works with Medicare"* section for more information.

To get detailed information about Medicare or to enroll in Medicare, call the Social Security Administration at **1-800-772-1213** or visit **www.ssa.gov**.

Medicare Beneficiary Identifier (MBI)

Medicare is a federal health insurance program regulated by the Centers for Medicare and Medicaid Services (CMS). The CMS is taking a step to protect Medicare beneficiaries from identity theft and Medicare fraud by removing Social Security numbers from Medicare cards. The CMS is assigning all Medicare beneficiaries a Medicare Beneficiary Identifier (MBI) which is a unique number that contains a combination of numbers and uppercase letters.

The CMS started mailing the new cards in April 2018. All Medicare cards containing Social Security numbers are expected to be replaced by April 2019.

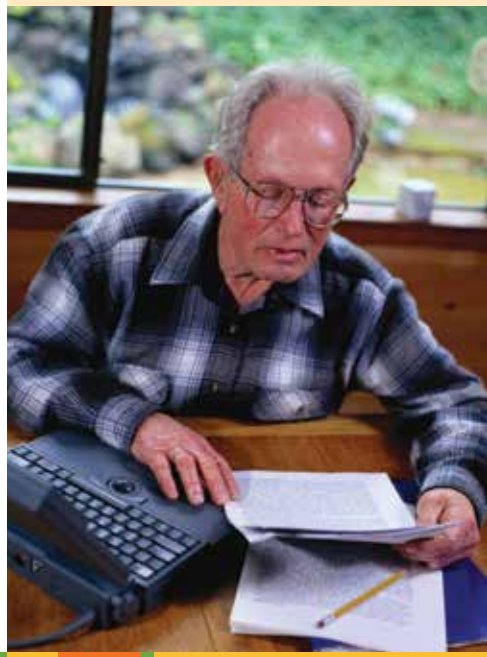
If you are a retiree currently enrolled in a County of Orange Medicare health plan, please provide the County of Orange with a your new Medicare card that has your MBI number, so that we can update our records.

You can submit a copy of your new Medicare card using one of the following options:

Online: Log in to the Benefits Center website: https://countyoforange.ielect.com. Go to the "Docs" tab and follow the instructions to upload the necessary documents.

Secure Fax: 1-800-803-1636

Mail: County of Orange Benefits Center
3090 Bristol Street Suite 200
Costa Mesa, CA 92626



How to Enroll

After you decide on the coverage you want, you are ready to enroll. This section describes the enrollment process; read it carefully before you enroll to know what to expect.

IMPORTANT: You are required to enroll by the deadline shown on your enrollment package.

Get ready to enroll

Before you call, log in or return your enrollment form, make sure you have the following information with you:

- Your **Social Security number** and your **personal identification number (PIN)**.
- • **Your Enrollment Package, Benefits Summary Statement** and the other documents, use these documents as a reference while you are enrolling.
- If you are enrolling in an HMO (except for the Kaiser HMO), you are required to select a Primary Care Physician (PCP) for each covered person and enter the **PCP's identification number**.
  - You can find PCP ID numbers on the Benefits Center website by following the links to individual health plans. If you do not select a PCP, your health plan will assign one to you.

During Annual Open Enrollment log in or call to enroll

- **The Benefits Center website.** Visit the website 24 hours a day, 7 days a week to enroll. Log in to **https://countyoforange.ielect.com**.
- **The Benefits Center.** Call the Benefits Center toll-free at **1-800-858-7266**. Benefits Specialists are available to take your enrollment elections Monday through Friday, from 5:00 a.m. to 8:00 p.m. PT, except holidays. TTY and translation services are available.

New Retirees and Retirees Turning 65 return enrollment form sent to you

- You will be sent an enrollment package that contains an enrollment form. Please complete and return the enrollment form within the given deadline noted.

Review your Benefits Confirmation Statement or Election Summary

You will receive a Benefits Confirmation Statement or Election Summary at your mailing address shortly after you enroll (or at the end of the enrollment period if you did not make any changes to your automatic benefits coverage). Immediately review this statement carefully to ensure it is accurate.

If you make elections and do not receive a Benefits Confirmation Statement/Election Summary within 10 business days, call the Benefits Center and speak with a Benefits Specialist. You have 10 business days from the date on your statement to report any errors in the elections you have made.

Submit required documentation

Your Benefits Confirmation Statement/Election Summary will tell you if you need to submit any additional documentation, including:

- Documents that verify Medicare enrollment; and/or
- Documents that verify dependent eligibility.

Any required forms will be included in the package you receive with your Election Summary Statement or Benefits Confirmation Statement. See the *"How the Retiree Medical Plan Works with Medicare"* section, the *"Covering Your Dependents"* section and *"When You Can Change Your Coverage"* in the *"How to Enroll"* section for more information about this documentation.

IMPORTANT: Your enrollment will not be complete until you submit the required documents. If you do not submit them, your coverage and costs will be affected significantly and coverage for you or your dependents of certain benefits under the County of Orange Retiree Medical Plan could be suspended or terminated.

Pay your monthly health plan rates

Your health plan rate is deducted automatically from your OCERS pension payment. If at anytime your pension amount will not cover your health plan rate, you will receive a monthly invoice from the Billing Administrator. You must pay each invoice by the due date or your coverage will be terminated.

If your enrollment choices increase or decrease your health plan rate or Retiree Medical Grant amount, your next pension payment may not immediately reflect these changes because of monthly processing schedules. If this occurs, your following pension payment will reflect your new rate and/or Grant amount as well as any applicable adjustment for the prior month.

IMPORTANT: If you do not receive an invoice, or if your health plan rate is not deducted from your pension payment, call the Benefits Center and speak with a Benefits Specialist to ensure your coverage is not terminated.

If you are a new retiree: You will receive a monthly invoice for your health plan rate until your pension deductions begin. This may take up to 3 invoices. Note that you will not experience a lapse in coverage as you transition from an employee to a retiree. Your employee coverage ends on the last day of the month in which you separate from County employment; your retiree coverage begins the next day. Your coverage will continue without a lapse as long as you make your elections, pay each invoice by the due date, and complete your enrollment requirements as instructed.

LOST OR FORGOT YOUR PIN?

You need your Username and personal identification number (PIN) to access the Benefits Center website and to enroll in your benefits. If you have forgotten your PIN, you can do an immediate reset by:

- Visiting the Benefits Center website at **https://countyoforange.ielect.com**, and clicking on the "Forgot PIN?" link. Follow the instructions to change your PIN. When you create your new PIN you will also be asked to establish a security question. The security question can be used to reset your PIN online.
- Calling the Benefits Center at **1-800-858-7266**.

Simply follow the instructions.

Tips for a Successful Enrollment

- Review the enclosed documents carefully to make sure the coverage you select meets your needs. These materials include important information, requirements, updated costs, and options for your enrollment this year.
- If you need help understanding your enrollment options, review the Benefits Center website, speak with a Benefits Specialist, and/or contact the health plans you are considering directly.
- Enroll by the deadline shown on your enrollment package. Consider enrolling early to avoid rushed decisions, confusion, or last-minute questions.
- Submit any required documentation. If you or your spouse are age 65, or you are enrolling dependents, you will be required to submit additional documents to complete the enrollment process. ***If you do not do this, your coverage and your costs will be affected significantly.***

IMPORTANT: If you do not provide the required documentation as instructed and/or enroll in Medicare as required, or if you do not pay your invoices for your monthly rates, your enrollment in the Retiree Medical Plan, including the Grant (if eligible) may be suspended or terminated.

- Attend an Open Enrollment meeting or a new retiree orientation. Watch for information about meetings in your area or call the Benefits Center for details. Representatives will be on-site to review your benefit options with you and answer your questions.
- If you report a Qualified Life Event (QLE) between October and December, speak with a Benefits Specialist to ensure that your coverage will be correct for the rest of the current year and the next year. This may mean that you must make a current year enrollment change, and make the same change to the upcoming plan year through Open Enrollment. You should receive two Benefits Confirmation Statements. Review both statements carefully to ensure that your enrollment change is correct for both the current year and the upcoming year. See the *"When You Can Change Your Coverage"* section for more information on QLEs.

Effective Date for New Medicare-Eligible Dependents

If you are enrolled in a Medicare Advantage plan and are adding a new dependent who is age 65 or older, call the Benefits Center and speak with a Benefits Specialist to confirm the effective date of your dependent's coverage. Enrollment requirements and effective dates vary from plan to plan.

ACTION NEEDED: ARE YOU MARRIED TO A COUNTY RETIREE OR EMPLOYEE?

If you are a retiree married to a County employee (RME), you have enrollment options:

- If you are a retiree married to a County employee, you are eligible to enroll as a dependent on your legal spouse/domestic partner's County health plan. You may elect to enroll:
  - *Individually* with your Retiree Medical Grant; or
  - *As a dependent* under your legal spouse's/domestic partner's County health plan.
    - If you elect coverage as a dependent, your Retiree Medical Grant will be temporarily suspended. If you later enroll in a retiree health plan (during the next Annual Benefits Open Enrollment period or within 30 calendar days after a QLE such as a divorce), your Grant will be reinstated at the start of the new plan year or on the first of the month following the QLE.
- Regardless of your choice, you are both required to make your elections by calling the Benefits Center and speaking with a Benefits Specialist. You may not enroll online. Your enrollment will not be complete until you submit your RME enrollment form, available on the Benefits Center website or by calling the Benefits Center.
- The employee will pay the normal bi-weekly rates for dependent coverage while you are enrolled.

If you are a County retiree married to another County retiree (RMR):

- If you and your legal spouse/domestic partner enroll in the same plan, one of you is required to be enrolled as a subscriber and the other as a dependent; however, your Grants (if eligible) will be combined toward the rates the subscriber pays for this coverage.
- Or you may enroll in different plans and use your Grants separately.
- Regardless of your choice, you are both required to make your elections by calling the Benefits Center and speaking with a Benefits Specialist. You may not enroll online. Your enrollment will not be complete until you submit your RMR enrollment form, available on the Benefits Center website or by calling the Benefits Center.
- During Open Enrollment, if you decide to maintain your RME/RMR relationship but decide to switch health plans you must submit a new RME/RMR form to the Benefits Center by the last day of Open Enrollment.

ID Cards and Claim Forms

You will receive a new identification (ID) card when you first enroll as a new retiree, or if you change plans during the enrollment period. If you need a replacement card or the information on the card is incorrect, contact your health plan directly.

If you are required to submit a claim to receive plan benefits, you may request forms from the Benefits Center or from the health plan.

What To Do if You Move

If you move, call the Benefits Center and speak with a Benefits Specialist to report your change of address so that you will continue to receive important information from the Benefits Center and your health plan. Also, notify other organizations with which you are affiliated, including OCERS. The Benefits Center and OCERS do not share address information.

If you move out of area

If you are enrolled in an HMO and move outside your plan's network, you will be required to enroll in another HMO if one is available in your area or in one of the PPO plans. When you report your change of address, you will be notified if your current plan is no longer available. If you do not make another election, you will be enrolled automatically in the Wellwise Retiree PPO.

WHEN YOU CAN CHANGE YOUR COVERAGE – QUALIFIED LIFE EVENTS

The elections you make remain in effect for the entire year, until the next Annual Benefits Open Enrollment period. However, you may be allowed to make changes during the year if you experience certain QLEs. These include:

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

When you experience a QLE, you are not allowed to change health plans unless you move to a location where your health plan is not available.

You are required to make coverage changes within 30 calendar days of the QLE. This is required by all health plans. **If you do not report a newly eligible dependent within 30 days of the event, you will not be able to add the new dependents until the next Open Enrollment.**

If you do not report a dependent who becomes ineligible within 30 days of the event:

- Coverage for ineligible dependents may be retroactively terminated within 30 days of the qualified life event.
- You will not receive a refund for the rates you paid towards coverage for any ineligible dependent who is not terminated from your health plan within 30 days of the event.
- You may be responsible for repayment of the Retiree Medical Grant (if applicable) paid towards dependent rates retroactive to the date of ineligibility.
- You may be financially responsible for the cost of any medical services that may have been provided after the dependent lost eligibility.
- The dependent may become ineligible for continuation of coverage through COBRA.

Covering Your Dependents

Eligible Dependents

You may cover certain dependents under your County of Orange retiree health plan. These dependents include your:

- Spouse or domestic partner. Same-sex spouses who are legally married in a state that recognizes same-sex marriage may be enrolled as a legal spouse. (Employer contributions to health premiums for a domestic partner may be treated as taxable {imputed} income.) For more information about Domestic Partners, see the *"Covering a Domestic Partner and His or Her Children"* section.
- Children who are younger than 26. This includes stepchildren, foster children, children placed with you for adoption, legally adopted children, and children of your domestic partner. (Employer contributions to health premiums for children of an employee's domestic partner may be treated as taxable {imputed} income if you cannot claim the child as a dependent.)
  - The term "children" does not include your dependent child's children or child's spouse.
- Incapacitated child who is older than 26, dependent on you for support, and who was incapacitated before his or her 26th birthday. The child did not have to be covered by the County of Orange at the time he or she became incapacitated if this happened before his or her 26th birthday.

Required Documentation

As part of the enrollment process, you will be asked to provide: 1) your dependent's Social Security number at the time you enroll him/her if older than age one; and 2) documentation to prove that your dependents are eligible for coverage within sixty (60) calendar days of the event that made your dependent eligible. Refer to the Eligibility Definitions and Required Documentation list in your Benefits Confirmation Statement package for required documentation. Follow the instructions and complete the forms provided in your Benefits Confirmation Statement package once you enroll a new dependent. You may need to provide:

- A marriage certificate;
- A birth certificate; or
- Tax return documentation or documents showing joint debt that verifies ongoing marriage status.

You also will be required to provide Medicare enrollment documentation for dependents who are Medicare-eligible. See the *"How the Retiree Medical Plan Works with Medicare"* section for more information.

IMPORTANT: Once your dependent is enrolled in a County retiree health plan, you must report any changes to his or her eligibility for coverage (e.g., divorce). All changes must be reported within 30 calendar days of the event.

Adding new dependents

When you enroll a new dependent who is over age one, you must provide that dependent's Social Security number to the Benefits Center. In addition, you are required to provide documentation which verifies that he or she is eligible for coverage. More details about dependent eligibility and a list of acceptable documentation are included in this package as well as on the Benefits Center website at **https://countyoforange.ielect.com**.

Documentation Deadline

You have 60 calendar days from the date of the event that made you or your new dependent eligible for coverage to submit the Dependent Verification Form and any other required documentation to the Benefits Center.

After you submit your documentation, you will receive a Benefits Confirmation Statement.

If you miss the 60-calendar-day deadline, the dependent's coverage will be canceled at the end of the month in which the 60-day period ends, even if you already have received an ID card. You will not be able to enroll your dependent until the next Annual Benefits Open Enrollment period or unless you experience a QLE.

See *"When You Can Change Your Coverage"* in the *"How to Enroll"* section for more information about QLEs.

Covering a Domestic Partner and His or Her Children

In California, a domestic partnership is established when two people file a Declaration of Domestic Partnership with the Secretary of State and meet several legal requirements. The partners are required to:

- Share a common residence;
- Be at least 18 years old;
- Not be blood-related in a way that would prevent them from being married to each other in California; and
- Be of the same-sex, unless one partner is older than 62 and is eligible for Social Security retirement benefits.

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

Establishing a domestic partnership is considered a QLE. See *"When You Can Change Your Coverage"* in the *"How to Enroll"* section for more information about QLEs.

When you enroll, you are required to provide a copy of your domestic partnership declaration from the state in which it was filed.

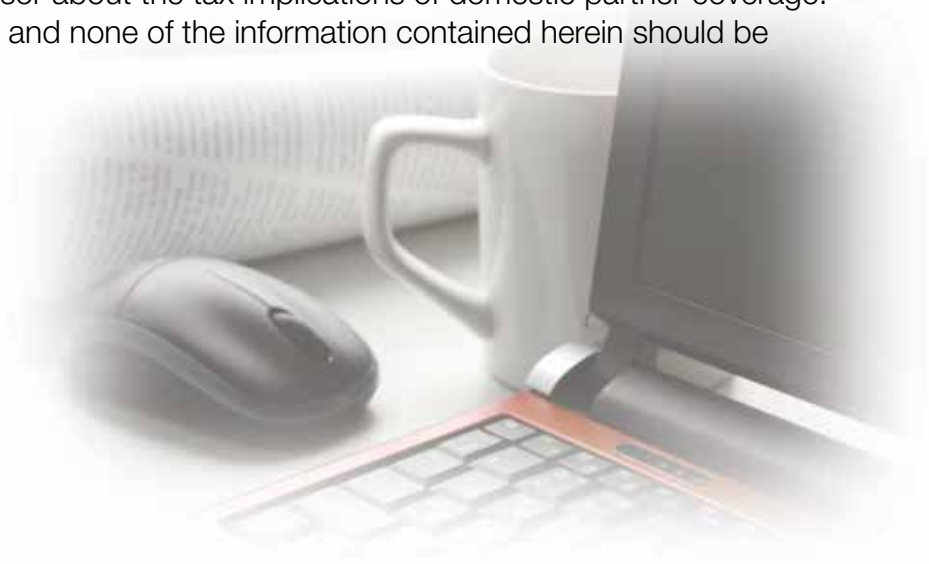
If you and your domestic partner are both benefit-eligible County employees or retirees, see *"Action Needed: Are You Married to a County Retiree or Employee?"* in the *"How to Enroll"* section for dual enrollment guidelines.

Tax impact of enrolling a domestic partner

Do you claim your covered domestic partner and his or her children as dependents on your federal income tax return? If not, you are required to pay federal tax on the County's contributions toward the cost of their coverage. The County's contribution toward the cost of coverage is the amount of the Retiree Medical Grant that is reimbursed to you toward the cost of your domestic partner's coverage and/or Medicare Part B. The value of these contributions is reported to the IRS as imputed income on a federal Form 1099.

The County's contributions are not subject to California income taxes. Please be aware that tax laws vary from state to state.

Consider consulting with your tax advisor about the tax implications of domestic partner coverage. The County cannot provide tax advice and none of the information contained herein should be considered tax advice.



Retiree Medical Grant

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

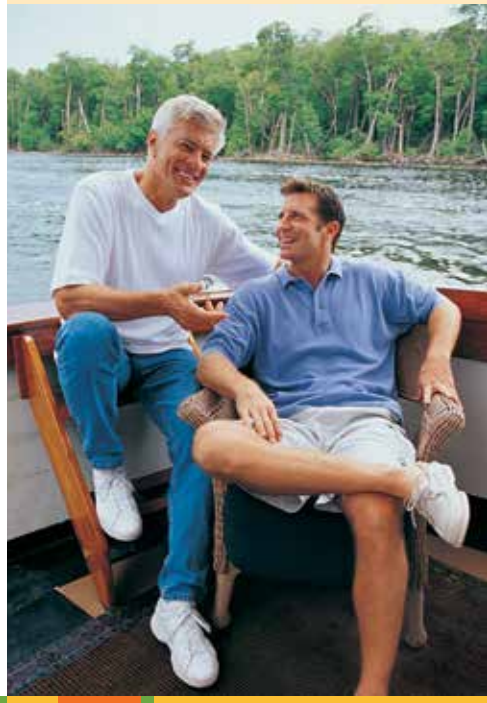
To be eligible for the Grant, you are required to:

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

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

American Federation of State, County and Municipal Employees (AFSCME) Retirees

The Grant applies only to current ASCME retirees who were represented by American Federation of State, County and Municipal Employees (AFSCME) with a retirement date prior to September 30, 2005. If you retired prior to September 30, 2005, and you were an AFSCME Eligibility Worker on the date of your retirement, you may be eligible to receive a Retiree Medical Grant (Grant) provided by the County of Orange to use toward the cost of your County health plan and/or your Medicare Part B premiums (if applicable). If you were an AFSCME Eligibility Worker and retired on or after September 30, 2005, and you were an AFSCME Eligibility Worker on the date of your retirement, you are eligible to participate in the County health plans if you were enrolled when you retired; however, you are not eligible to receive any benefits under the Retiree Medical Plan, including the grant benefits.



7.5% reduction or increase in the Grant*

This section does not apply if you were retired before the Board approved the 2006 Retiree Medical Plan Restructuring changes.

If you retire before age 60, there will be a 7.5% reduction to the Grant for each year before 60 years of age; if you retire after age 60 there will be a 7.5% increase to the Grant for each year worked after age 60, up to age 70. If you retire at age 60 there will be no age adjustment. Safety retirees will not be subject to the 7.5% reduction or increase. Service and Non-Service Connected Disability Retirees do not receive the 7.5% age adjustment.

* The effective date may vary depending on your bargaining unit or employer (County, Special District, or Court).

50% reduction of the Grant when Medicare-eligible*

This section does not apply if you and your spouse were both retired and age 65 at the time the Board approved the 2006 Retiree Medical Plan Restructuring changes.

Retirees who are eligible for both Medicare Parts A & B (Part A, if at no cost to you) will have a 50% reduction in the monthly Grant the first day of the month in which you reach age 65 and become eligible for Medicare. If you pay for both Medicare Parts A&B, you will not have a 50% reduction in your monthly Grant.

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

If the total of your monthly County health plan rate and your monthly Medicare Part B reimbursement is less than the total monthly Grant, the excess amount of the Grant is returned to the Retiree Medical Trust.

Retirees who gain health coverage elsewhere following retirement and wish to use the Grant to reimburse the Medicare Part B premium or health plan rates are required to enroll in Medicare once eligible. Both you and your eligible dependent(s) are required to enroll and maintain coverage in Medicare Parts A (if eligible at no cost) & B, even if you are actively working with coverage elsewhere. In addition, you are required to maintain enrollment in a County health plan until Medicare-eligible.

At that time, you may disenroll from the County health plan and elect Medicare Reimbursement only. However, once you disenroll from a County health plan you cannot re-enroll at a later date. **Please note:** if you disenroll from County health coverage before you reach age 65 and are eligible for Medicare, you will be disenrolling permanently and you will not be allowed to use your Grant for Medicare Part B premium reimbursement once you become eligible for Medicare. If you disenroll at age 65 or older, you will be disenrolling permanently from a County health plan and will be eligible to use your Grant, if applicable, for Medicare Part B Reimbursement.

Medicare Part B Premium Reimbursement: If you currently receive a Medicare Part B Reimbursement, this will continue through the end of the year. Effective the first of the New Year, you will receive the Standard Medicare Part B premium based on the new plan year Medicare Part B Premium schedule as announced by the Centers for Medicare & Medicaid Services (CMS). However, if you are

notified by the Social Security Administration that your cost will be different, then you will need to provide a copy of your statement to the Benefits Center in order to receive a Medicare Part B reimbursement more than the Standard.

Survivor Benefits

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

Survivor Health Plan Coverage

To be eligible for survivor health plan coverage, you are required to:

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

Survivor Retiree Medical Grant Benefits

To be eligible for a Survivor Grant, you are required to:

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

OCERS must notify the Benefits Center in order to establish continuation of health insurance coverage as a survivor. If you do not receive survivor benefits information from the Benefits Center within 30 calendar days of meeting with OCERS, please call the Benefits Resources Line and speak with a Benefits Specialist.

Retiree Medical Plan Document

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

How the Retiree Medical Plan Works with Medicare

When you become eligible for Medicare, your County of Orange retiree health plan options and rates change.

What follows is an overview of how your retiree health plan works with Medicare. The enrollment process includes steps that will help you complete your enrollment successfully.

If you are already retired, you should enroll in Medicare 90 days before you turn 65 to ensure that your Medicare coverage is in place by your birthday. This will help you to enroll successfully in a retiree health plan when you are ready to do so.

If you are planning to retire and you are already 65 or older, you should enroll in Medicare 90 days before your intended retirement date to ensure your Medicare coverage is in place when you retire.

Note: If you are still working and not yet retired from the County, you should enroll in Medicare Part A; it is not necessary to enroll in Part B until you retire. However, once you retire and you reach age 65 you must enroll in Medicare Part A if you are eligible at no cost, and you must enroll in Medicare Part B and pay the required Medicare Part B premiums to be eligible for the Retiree Medical Grant and the lower retiree health plan rates for Retirees enrolled in Medicare. Even if you are employed and retired from the County of Orange you must still be enrolled in Medicare Part A if you are eligible at no cost, and Medicare Part B.

To learn more about Medicare or to enroll in Medicare, call the Social Security Administration at **1-800-772-1213** or visit **www.ssa.gov**.

About Medicare

You generally are eligible to enroll in Medicare when you turn 65. Medicare coverage has three parts:

- Part A, which covers many major medical expenses, including hospitalization costs;
- Part B, which covers physician's office visits and most outpatient hospital services; and
- Part D, which is a voluntary prescription drug program.

Generally, Part A is free, and everyone pays a monthly premium for Part B. County of Orange retirees must be enrolled in Medicare Part A if eligible at no cost. All County of Orange retirees must be enrolled in Medicare Part B.

Medicare Part D is a voluntary prescription drug benefit. The County of Orange health plans, with the exception of the Sharewell Retiree PPO plan, offer prescription drug coverage that is equal to or better than Medicare Part D benefits. Therefore, if you are enrolled in a County health plan other than the Sharewell Retiree PPO plan, you should not enroll in Medicare Part D. See the Medicare Part D and creditable coverage section for more details.

Medicare Assignment and Medicare Advantage Plan Requirements

When you enroll in a Medicare Advantage plan, you are required to assign your Medicare benefits to the plan. Your health care providers agree to accept Medicare-approved amounts as payment. You simply pay the co-payment and deductible amounts. **When you assign your Medicare benefits to a plan, you are required to use health plan doctors and facilities in the plan's network.**

The Wellwise Retiree PPO and Sharewell Retiree PPO plans are available for retirees who do not want to assign their Medicare benefits to a plan.

To be eligible for a Medicare Advantage plan, you are required to enroll—and remain enrolled in—Medicare Part A and Part B. You will need to provide a copy of your signed Medicare card and—if you have been enrolled in Medicare for some time—out on the Social Security website, you can obtain a letter showing your current coverage or a statement showing that you have paid Medicare premiums in the current plan year.

IMPORTANT: If you do not enroll in and/or maintain your Medicare Part B as required, you will be required to pay the higher non-Medicare health plan rates and your Retiree Medical Grant will be suspended. You will not be able to re-enroll in a Medicare Advantage plan until the next Annual Benefits Open Enrollment period or unless you experience a QLE that allows you to change plans.

Medicare Advantage Enrollment Process and CMS Approval

The Centers for Medicare and Medicaid Services (CMS) is required to approve your enrollment in a Medicare Advantage plan. For that reason, you should make your election the month before your retirement date or 65th birthday to ensure a smooth enrollment and approval process.

- You will need to provide Medicare ID number(s) for you (and any dependents, if applicable) when changing your Medicare Advantage Plan or enrolling in a County of Orange Medicare Advantage Plan for the first time.

IMPORTANT: Your selected health plan may need to contact you to clarify your Medicare information. If you receive any written requests or phone calls from your selected health plan, it is critical that you respond immediately, or your enrollment may not be approved. In addition, carefully review the instructions and information on every Benefits Confirmation Statement you receive throughout the enrollment and final approval or denial process.

Medicare Part D and Creditable Coverage

If you enroll in one of the County-offered Medicare Advantage plans or in the Wellwise Retiree PPO,do not enroll in a separate Medicare Part D plan. The County retiree health plans (except the Sharewell Retiree PPO plan) offer prescription drug coverage that is equal to or better than Medicare drug plans. This coverage is called creditable coverage.

Each year, the Benefits Center will send you a letter of creditable coverage. This letter proves that you have prescription drug coverage and will enable you to enroll in a Medicare Part D plan in the future, if and when you disenroll from your County health plan or enroll in the Sharewell Retiree PPO plan - without penalty.

IMPORTANT: If CMS denies your enrollment in a Medicare Advantage plan, you and your dependents will be automatically enrolled in the Wellwise Retiree PPO plan. If you are enrolled in the Wellwise Retiree PPO plan and have a Medicare Part D plan, you will become ineligible for the Wellwise Retiree PPO plan. You will receive a letter explaining that you have sixty (60) calendar days from the date on the letter to provide proof of disenrollment from the Medicare Part D plan. If the County does not receive proof of disenrollment from the Medicare Part D plan, you and any dependents will be automatically enrolled in the Sharewell Retiree PPO plan until the following Open Enrollment. You will be responsible for any rate differences, and you may be required to pay for any service you received once you became ineligible for the plans.

The Sharewell Retiree PPO's prescription drug coverage is not considered to be creditable coverage under Medicare Part D. If you enroll in this plan, you should enroll in a Medicare Part D plan as well, to obtain additional prescription drug benefits. If you enroll in the Sharewell Retiree PPO and do not enroll in a Medicare Part D plan, you may be subject to late enrollment penalties by CMS if you enroll in another health plan in the future.

Mixed Family Enrollees

If you are not eligible for Medicare but your dependent is—or if you are eligible and your dependent is not—you may enroll in separate plans with the same health plan. For example:

- The person with Medicare may enroll in the Anthem Blue Cross Custom PPO and the person without Medicare may enroll in the Anthem Blue Cross Traditional HMO plan.
- The person with Medicare may enroll in the Anthem Blue Cross Senior Secure HMO and the person without Medicare may enroll in the Anthem Blue Cross Traditional HMO.
- The person with Medicare may enroll in the Anthem Blue Cross Senior Secure HMO and the person without Medicare may enroll in the Anthem Blue Cross Select HMO.
- The person with Medicare may enroll in the Kaiser Senior Advantage plan and the person without Medicare may enroll in the Kaiser Retiree HMO.
- You both may enroll in the Wellwise Retiree PPO plan or the Sharewell Retiree PPO plan.

If CMS does not approve the Medicare-eligible participant's enrollment in a Medicare Advantage plan, your original elections are no longer valid. You will receive an updated Benefits Confirmation Statement/Election Summary reflecting your new automatic benefits coverage as well as your new rate and effective date.

See your Benefits Summary Statement for your Mixed Family options and rates.

Checklist for Medicare Enrollees

- ☐ Be sure to enroll in and maintain your Medicare coverage as required.
- ☐ Submit verification of Medicare as required for you and any Medicare-eligible dependents.
- ☐ You will need to provide Medicare ID number(s) for you (and any dependents, if applicable) when changing your Medicare Advantage Plan or enrolling in a County of Orange Medicare Advantage Plan for the first time.
- ☐ Follow the enrollment and approval process by carefully reviewing all Benefits Confirmation Statements/Election Summaries
- ☐ Avoid higher rates, automatic benefits coverage plans, and suspension of your Retiree Medical Grant (if eligible) by following all instructions.
- ☐ Call the Benefits Center to check the status of your enrollment or ask any questions.

Your Retiree Health Plan Options

What follows is a brief summary of your retiree health plan options. See the individual plan One Page Summaries for more details about each plan's benefits. Review this information carefully to make sure you understand your choices and make the selections that best meet your needs.

The retiree health plan options include health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Your options vary depending on whether or not you are eligible for Medicare and where you live.

About Health Maintenance Organizations (HMOs)

HMOs provide a comprehensive array of services, including preventive care, but **you are required to use providers in the HMO network** to receive a benefit. The network includes doctors, hospitals, and other health care providers and facilities that have contracted with the HMO to provide care at lower rates.

HMOs also feature:

- Minimal co-payments for most services;
- No claim forms;
- Coverage for preventive services such as annual physicals, well-woman care and immunizations; and
- No lifetime maximums.

HMOs, require you to live within the plan's service area. You may be required to select a Primary Care Physician to coordinate your medical care. Also, some plans offer features that are available only in certain areas. **Before you enroll in an HMO, contact the plan to confirm that you live within its service area.** See the *"Resources and Contact Information"* section for plan telephone numbers and website addresses. Your Benefits Summary Statement will show you which HMO plans you are eligible for based upon your current address. Provider changes within a plan network occur as a normal course of business and are not considered a QLE that permits a mid-year change in a health plan.

About Preferred Provider Organizations (PPOs)

Preferred provider organizations (PPOs) allow you the freedom to choose the provider of your choice each time you need care, whether or not he/she is a member of the PPO network, and you have comprehensive coverage no matter where you need care – locally, regionally, or nationally. In general, you receive a higher level of benefits when you visit a provider in the PPO network. You do not need to select a Primary Care Physician to coordinate your care and you may see a specialist anytime you wish.

About Medicare Advantage Plans

All health plans offered to Medicare-eligible retirees are Medicare Advantage plans, with the exception of the Wellwise Retiree PPO plan and the Sharewell Retiree PPO plan. You must be enrolled in Medicare Parts A and B to be eligible to enroll in a Medicare Advantage Plan.

Medicare Advantage plans require that you assign your Medicare benefits to that health plan. When you assign your benefits to a plan:

- The doctors and other health care providers agree to accept the amount paid by your health plan as payment. You simply pay the co-payment and deductible amounts.
- You must use the health plan doctors and facilities that are in the plan's provider network.

The Wellwise Retiree and Sharewell Retiree PPO plans will continue to be offered for those who do not want to assign their Medicare benefits to a Medicare Advantage health plan.

For more information, see *"How the Retiree Medical Plan Works with Medicare*."

Your health plan options

This chart lists your options along with some key features to consider.

Health Maintenance Organizations (HMOs)		Preferred Provider Organizations (PPOs)	
If you are Medicare-eligible	If you are not Medicare-eligible	If you are Medicare-eligible	If you are not Medicare-eligible
Medicare Advantage Plans:* • Kaiser Senior Advantage+^ • SCAN+ • Anthem Blue Cross Senior Secure+	• Kaiser • Anthem Blue Cross Traditional+^ • Anthem Blue Cross Select^	Medicare Advantage Plans:* • Anthem Blue Cross Custom+ • Anthem Blue Cross Standard+ Non-Medicare Advantage Plans: • Wellwise Retiree+^ • Sharewell Retiree^	• Wellwise Retiree+^ • Sharewell Retiree^
HMO features:		PPO features:	
• Provide benefits only for in-network services, except in an emergency. • Require you to live in the plan's service area. • Include prescription drug benefits. + These plans require you to choose a primary care physician (PCP), who coordinates all your care.		• Provide network and non-network benefit. • Let you choose your providers. • Provide national coverage. + These plans include a prescription drug plan. The Sharewell Retiree PPO requires you to satisfy the annual deductible before the plan pays for prescription drugs.	

** The Medicare Advantage HMOs and PPOs described in this Benefits Enrollment Guide assume that you are enrolled in Medicare Parts A and B (except Kaiser which also allows retirees enrolled in Medicare Part B only) and require that you assign your Medicare benefits to the plans.*

***Important:** If you and your dependent(s) are not all Medicare-eligible, see Mixed Family enrollees in the How to Enroll section.*

^ If you are enrolled only in Medicare Part B, you may enroll in these plans only. See "If You Are Eligible for Medicare Part B Only" for more information.

Features to Consider When Making Your Enrollment Decisions

In addition to the benefits listed in the individual plan One Page Summaries, your HMO and PPO options offer special benefits for participants. They also have different processes and requirements. Consider these benefits and requirements, as well as the information in the One Page Summaries, to help you decide which plan is best for you.

HMO Options

Anthem Blue Cross Traditional and Select HMOs (you are NOT Medicare-eligible or only eligible for Medicare Part B)

- To receive a benefit, your PCP is required to authorize, provide, and/or arrange all your care. This does not include emergency treatment, well-woman exams, and mental health services. You may schedule an appointment with an OB/GYN in the same medical group as your PCP without a referral.
- At the time of your appointment, present your ID card and pay a small co-payment.
- You are required to fill prescriptions at a contracted retail pharmacy, or you may order up to a 90-day supply of maintenance medications through the plan's Home Delivery Program.
- In an emergency, seek care at the nearest hospital. Call (or have the doctor or a family member call) your PCP or the plan within 48 hours to receive benefits.

Anthem Blue Cross Senior Secure HMO (Medicare Advantage)

You may enroll in the Senior Secure HMO if you live in Fresno, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Francisco, Santa Barbara, or Ventura counties. This plan features:

- Emergency inpatient and outpatient care. You would call 911 or go to the closest emergency facility for immediate treatment.
- The SilverSneakers Fitness Program, which offers opportunities to join fitness programs at a gym or at home. It also offers health education seminars.
- A 24/7 Nurse Line and Health Line Audiotape Library.
- Anthem SeniorCentric 360° Health Programs.

Kaiser HMO (you are NOT Medicare-eligible) and Kaiser Senior Advantage HMO (Medicare Advantage or only eligible for Medicare Part B)

- Your services are required to be provided by Kaiser providers; however, you do not have to choose a PCP when you enroll.
- When you need care, contact your Kaiser PCP or the Kaiser Appointment Center in your area. At the time of your appointment, present your ID card and pay a small co-payment.
- You do not need a referral for some specialists, including OB/GYN, internal medicine, optometry and mental health providers (varies by location).
- You are required to fill prescriptions at Kaiser pharmacies, which are located at Kaiser medical offices. You pay a small co-payment for up to a 100-day supply. Your coverage also includes dental prescriptions.
- In an emergency, seek care at the nearest hospital. Call (or have the doctor or a family member call) Kaiser as soon as possible to receive benefits.

SCAN HMO (Medicare Advantage)

- To receive a benefit, your PCP is required to authorize, provide, and/or arrange all your care. This does not include emergency treatment.
- You are required to fill prescriptions at a contracted retail pharmacy, or through the plan's mail-order program.

Benefit plan highlights:

- $15 co-pay for Primary Care Physician/Specialists
- $100 co-pay for hospital admission
- Generous prescription drug plan
- Hearing aid allowance
- Chiropractic care
- Vision services
- SilverSneakers - Gym Membership

In addition, SCAN offers Independent Living Power™, which includes services that are designed to keep you healthy and independent. These services can help when you are recovering from a hospital stay or need support during a long-term illness. The program, which offers up to $500 a month in benefits is available if you live in approved zip codes within the Los Angeles, Orange, Riverside, and San Bernardino counties.

PPO Options

Anthem Blue Cross PPO Options (Medicare Advantage)

The County offers two Medicare Advantage PPO plans from which to choose:

- Anthem Blue Cross Custom PPO
- Anthem Blue Cross Standard PPO

A few highlights of the Anthem Blue Cross PPO health plans:

- Preferred provider organizations (PPOs) give you the freedom to choose any doctor, whether or not he or she is a member of the PPO network. You do not need to select a Primary Care Physician to coordinate your care and you can see a specialist anytime you wish.
- The Standard PPO provides a less expensive option that has many of the same plan features as the Custom PPO plan. The Standard PPO plan has co-payments for in-network services and a 30% co-insurance for most out-of-network services. Please refer to the individual plan one-page summaries included in your package and on the website for more details.

Wellwise Retiree and Sharewell Retiree PPO Health Plans (you are NOT eligible for Medicare OR you are enrolled in Medicare but you do not want to enroll in a Medicare Advantage plan)

- The plans are administered by Blue Shield of California. The nationwide network includes more than 5,700 hospitals and 706,000 physicians. To find a doctor or hospital, search the provider directory on Blue Shield of California's website or call Blue Shield of California's Customer Service Center.
- When you need care, visit the provider of your choice. Deductibles and co-insurance amounts for network and non-network providers vary by plan in addition to network and non-network maximum allowed amounts. In general, you receive a higher level of benefit for in-network services.
- When you visit a network provider, present your ID card. The provider files the paperwork for your claim and you receive a bill for your deductible and/or co-insurance amount.
- When you visit a non-network provider, you may have to pay upfront, and you are responsible for all expenses above the Usual, Reasonable, and Customary charge including an amount above the non-network maximum allowed amounts.
- The plans pay 100% of eligible expenses after you meet your out-of-pocket maximum per calendar year per participant and/or per family. This applies to both network and non-network services. You may be responsible for any additional non-network expenses above the Usual, Reasonable, and Customary charge. You are responsible for 100% of expenses that are not eligible under the plan.
- For services obtained at non-network Ambulatory Surgery Centers and Dialysis centers in California, the plan pays up to a maximum allowable amount per day for facility charges. You may be responsible for any costs that exceed the maximum allowable amount if you choose to visit a non-network facility for such services.
- If you are scheduled for a hospital stay or surgery, contact the claims administrator to obtain pre-certification. This ensures that you will receive the highest level of benefits.
- In an emergency, go to the nearest hospital and call (or have the doctor or a family member call) Blue Shield of California's Customer Service Center within two business days. Services that meet the "Emergency" definition stated in the Plan documents will be paid at the higher network benefit regardless of whether you received services at a network facility.
- If you require transplant services or hip or knee replacement surgery, it is strongly recommended that you utilize a Blue Shield Center of Distinction facility to ensure you are receiving the highest quality of services. For any bariatric surgery services received within California, it is required that you go to a Blue Shield Center of Distinction facility in order for the services to be covered by the plan.
- The Wellwise Retiree PPO provides you with an opportunity to receive a $50 year-end, taxable cash incentive for a non-smoking subscriber.

Telehealth or Teladoc Services

Utilize technology to receive 24/7 access to U.S. Board certified physicians for primary care services consultation. Telehealth physicians can provide diagnosis and treatment for urgent and routine non-emergency medical conditions and can also issue prescriptions for certain medications. This is an optional service available to the member. The consultation fee (currently $40) is subject to in-network deductibles and coinsurance.

Health Savings Account Compliance

If you are not yet eligible for Medicare, the Sharewell Retiree PPO plan is a Health Savings Account (HSA) compliant health plan. The Plan design complies with an HSA, high deductible plan but without the Health Savings Account contribution. Retirees may establish their own HSA to which they may contribute and pay Sharewell coinsurance, deductibles, and qualified health care expenses on a non-taxable basis. Individuals can set-up a Health Savings Account through financial institutions. Please consult your financial advisors for details regarding HSAs and the tax implications before establishing an account.

Sharewell Retiree PPO prescription drug benefits

Blue Shield of California administers prescription drug coverage for this plan. You can fill your prescriptions at any retail pharmacy. If you obtain prescription drugs at a Blue Shield Participating Pharmacy, you can obtain medication at Blue Shield's contracted rate.

To obtain prescription drugs at a Participating Pharmacy at the contracted rate, you must present your Blue Shield ID Card. With the presentation of your Blue Shield ID card, outpatient prescription drugs obtained at a Participating Pharmacy, or Specialty Drugs obtained from a Specialty Pharmacy through the use of the Blue Shield ID number, are paid as shown in the Sharewell Retiree Plan Document.

Until the Calendar Year Deductible has been satisfied, you are responsible for paying 100% of the Blue Shield contracted rate. Once the Calendar Year Deductible has been satisfied, you are responsible for paying the 20% co-insurance for the Blue Shield contracted rate for each new and refill prescription drug. The pharmacy will collect from you the applicable co-insurance at the time the prescription is obtained.

If you obtain prescription drugs at a Non-Participating Pharmacy, you must first pay all charges for the prescription and submit a completed Prescription Drug Claim Form to Blue Shield for reimbursement. After the Calendar Year Deductible amount has been satisfied, you will be reimbursed as shown in the Sharewell Retiree Plan Document.

Wellwise Retiree PPO prescription drug benefits

OptumRx administers prescription drug coverage for this plan. OptumRx offers discount prices on name brand and generic drugs with no annual deductible and no claim forms. OptumRx has a network of more than 68,000 pharmacies throughout the country, including most major pharmacies such as Walgreens, Rite-Aid, Sav-on, CVS, and Costco.

With the OptumRx Retail90 Program, you can get a 90-day supply of your maintenance medications at select retail locations. Your doctor is required to authorize a 90-day supply (note that by law, some medications may not be available in 90-day supplies). For more information, visit the OptumRx website at **OptumRx.com** or call **1-800-573-3583** toll-free.

You also may use the OptumRx Mail Order Program.

Drug Formulary

The Wellwise Choice PPO plan through OptumRx has a prescription formulary which is a list of covered drugs classified into tiers. Choosing drugs in lower tiers may cost you less as shown in the chart on the next page.

The formulary may exclude certain drugs from coverage when OptumRx has determined a lower costing therapeutically equivalent (comparable clinical effectiveness and safety) drug exists. If your prescriber believes that it is Medically Necessary for you to take the excluded drug, a Prior Authorization request can be submitted to OptumRx.

The most up-to-date formulary including a list of Preferred and Non-Preferred Drugs is available on the OptumRx website.

Drug Type	The Plan Pays	The Covered
Preventive Products	100%	0%
Tier 1 – Lower cost/commonly used Generic Drugs. May also include some low-cost brand-name drugs.	80%	20%
Tier 2 - Preferred Drugs (many common brand-name drugs): When a generic equivalent does not exist or the prescriber specifically requests the brand-name drug.	75%	25%
Tier 2 - Preferred Drugs (many common brand-name drugs): When a generic equivalent exists, but Covered Person requests the brand-name drug.	80% of generic cost	20% of generic cost, plus cost differential[1]
Tier 3 - Non-Preferred Drugs (mostly higher cost brand-name drugs): When a generic equivalent does not exist or prescriber specifically requests the brand-name drug.	70%	30%
Tier 3 - Non-Preferred Drugs (mostly higher cost brand-name drugs): When a generic equivalent exists, but Covered Person requests the brand drug.	80% of generic cost	20% of generic cost, plus cost differential[1]
Specialty Pharmacy Drugs (see Program description below)	The remaining percentage of the cost of the covered drug	The percentage of the cost and any cost differential[1] required of the covered person for Specialty Drugs as stated directly above for the respective covered Tier1 - Generic, Tier 2 -Preferred, or Tier 3 - Non-Preferred up to a maximum of $150 required of the covered person per 30-day supply.
OUT-OF-POCKET PRESCRIPTION DRUG MAXIMUM BENEFIT: The maximum amount of Prescription Drug coinsurance for which a Covered Person is responsible during a Plan Year.	$4,100 individual $8,200 family	

1 If the Covered Person requests a Brand-Name Drug when a Generic Drug equivalent is available, the Covered Person is responsible for paying the difference between the Participating Pharmacy contracted rate for the Brand-Name Drug and its Generic Drug equivalent, as well as the applicable Drug co-insurance. This differential in cost (Brand-Name vs. Generic) that the Covered Person must pay is not included in the Calendar Year maximum out-of-pocket prescription drug benefit. If the prescription specifies a Brand-Name Drug and the prescriber has written "Dispense as Written" or "Do Not Substitute" on the prescription, or if a Generic Drug equivalent is not available, the Covered Person is only responsible for paying the applicable Brand-Name Drug co-insurance.

The Wellwise Retiree plan pays 100% of covered eligible prescription drug charges after a participant has met the prescription drug out-of-pocket maximum amount of $4,100 individual or $8,200 family for a calendar year. Refer to your Wellwise Retiree Plan Document for details.

If you obtain a prescription outside the network because of an emergency, you pay the cost of the prescription and then send a claim form, with attached receipts, to Blue Shield of California for reimbursement.

Step Therapy – This program requires that, for certain medical conditions, one or more prerequisite medications must be tried first before other medications will be covered, unless medical exception authorization is received. Refer to the Wellwise Retiree Plan Document for details.

If You are Eligible for Medicare Part B Only

If you or your dependents are covered by Medicare Part B only and do not qualify for Medicare Part A, different health plan options and rates may apply.

- You are required to inform the Benefits Center that you are enrolled only in Medicare Part B, and you are required to maintain your Part B enrollment even if you do not qualify for Medicare Part A.
  - If you do not do this, you will be enrolled automatically in the Wellwise Retiree PPO plan, your rates will increase to those for retirees without Medicare and your Retiree Medical Grant (if eligible) will be suspended. You also may owe the difference in rates retroactive to the date your Part B coverage lapsed.
- Your enrollment options include the Anthem Blue Cross Traditional HMO, the Anthem Blue Cross Select HMO, the Kaiser Senior Advantage HMO, the Wellwise Retiree PPO or the Sharewell Retiree PPO.

If You and/or Your Eligible Dependent are Turning 65 This Year

Are you and/or a dependent enrolled in a Retiree health plan and turning 65 this year? If so, you will be eligible for new options and costs. You will receive a package 90 days prior to the 65th birthday. Carefully review the instructions, requirements, and deadlines in this package. You should make your election at least a month before your actual birthday to ensure a smooth enrollment and approval process. If you do not make an election, you will be enrolled in the automatic benefits coverage shown on your Benefits Summary Statement until the next Open Enrollment.

IMPORTANT: You are required to be enrolled in Medicare to enroll in Medicare Advantage plans. If you are not, or if you do not provide documentation of your enrollment, **you and your dependents automatically will be enrolled in the higher-rate Wellwise Retiree PPO** until your Medicare enrollment is finalized and/or you provide the required documentation. Your Retiree Medical Grant (if eligible) will be suspended.

Watch your home mail for your **Retiree Turns 65** package, which you will receive about 90 days before your 65th birthday. This package reminds you to enroll in Medicare and contains information about the health plan options and costs for retirees who are eligible for Medicare.

For more information, see the *"How Your Retiree Health Plan Works with Medicare"* section.

Review the checklist "You and/or Your Dependent Spouse Will Be Turning Age 65" at the front of this guide for important steps.

Resources and Contact Information

For Questions About…	Click or Call…
Benefits or Enrolling, COBRA & Direct Billing	
Benefits Center website	**https://countyoforange.ielect.com**
Benefits Center	**1-800-858-7266** Benefits Specialists are available Monday through Friday from 5:00 a.m. and 8:00 p.m., PT, except holidays The Benefits Center also handles COBRA & Direct Billing inquiries.
Employee Benefits	**www.ocgov.com/gov/hr/eb** **1-714-834-6282**
Your Health Plans	
American Specialty Health Plans (Kaiser and SCAN chiropractic care)	**www.ashcompanies.com** **1-800-678-9133** P.O. Box 509002 San Diego, CA 92150-9002
PPO Health Plans	
Blue Shield of California Plan Administrators (Claim administrator for the Wellwise Retiree and Sharewell Retiree PPO plans and provider network)	**www.blueshieldca.com/oc** **1-888-235-1767** P.O. Box 272540 Chico, CA 95927-2540 7:00 a.m to 7:00 p.m.
HMO Health Plans	
Anthem Blue Cross HMO health plans (Traditional & Select)	**www.anthem.com/ca/countyoforange** **1-877-359-9653** P.O. Box 60007 Los Angeles, CA 90060-0700
Kaiser Health Plan HMO	**http://my.kp.org/oc/** **1-800-464-4000** P.O. Box 7004 Downey, CA 90242
Medicare Advantage Health Plans	
Kaiser Senior Advantage	**http://my.kp.org/oc/** **1-800-443-0815** Kaiser California Service Center P.O. Box 232400 San Diego, CA 92193
SCAN Medicare Advantage HMO Plan	**www.scanhealthplan.com/countyoforange** **1-800-559-3500** 3800 Kilroy Airport Way, Suite #100 Long Beach, CA 90806
Anthem Blue Cross Senior Secure HMO Plan	**www.anthem.com/ca/countyoforange** **1-800-225-2273** P.O. Box 110 Fond du Lac, WI 54935

For Questions About…	Click or Call…
Medicare Advantage PPO Health Plans	
Anthem Blue Cross (Custom Plan & Standard PPO Plan)	**www.anthem.com/ca/countyoforange** **1-877-411-1640** P.O. Box 110 Fond du Lac, WI 54935
Wellwise PPO - Prescription Drugs	
OptumRx (for the Wellwise Retiree PPO Plan)	**OptumRx.com** **1-800-573-3583** 24 hours 7days P.O. Box 509075 San Diego, CA 92150-9075
Retirement Benefits	
Retired Employees Association of Orange County (REAOC)	**www.reaoc.org** **1-714-840-3995**
Social Security Administration (Medicare coverage)	**www.ssa.gov** **1-800-772-1213**

Network directories

To View Network Directories for…	Go to…
Kaiser Health Plan Kaiser Senior Advantage Plan	**http://my.kp.org/oc**
Wellwise Retiree Plan	**www.blueshieldca.com/oc**
Sharewell Retiree Plan	**www.blueshieldca.com/oc**
SCAN Medicare Advantage HMO Health Plan	**www.scanhealthplan.com/countyoforange**
Anthem Blue Cross Traditional HMO Anthem Blue Cross Select HMO Anthem Blue Cross Senior Secure HMO Anthem Blue Cross Custom PPO Anthem Blue Cross Standard PPO	**www.anthem.com/ca/countyoforange**

If you have questions regarding deductions or your monthly retirement allowance, please call the Orange County Employees Retirement System at **1-888-570-6277**.

Legal Notices

Women's Health and Cancer Rights Act of 1998

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

- Received benefits for a mastectomy; and
- Elected breast reconstruction in connection with a mastectomy.

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

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

Benefits for breast reconstruction are subject to the annual deductible and co-insurance provisions that are consistent with those established for other benefits under the plan.

Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

Health plan descriptions contained in this Benefits Enrollment Guide

This Benefits Enrollment Guide only serves to provide a summary of the health plans offered to retired individuals and their eligible dependents and does not fully represent all of the terms of each of the benefit plans. Please refer to each plan's evidence of coverage documents/plan documents for the specific terms and conditions of coverage. If there are any discrepancies between this summary Benefits Enrollment Guide and the evidence of coverage or the plan document, the evidence of coverage or the plan documents will govern in all cases.