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

▶ Pathways to Your Benefits

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

We know that your benefits are important to you and your whole family. We also know that you need tools and resources to help you take advantage of all your coverage has to offer. This Enrollment Guide is designed to help you take the first steps down the pathways to your benefits — understanding and choosing your benefits for the coming year. Inside you'll find details about your eligibility, enrollment instructions, and an outline of your medical and other benefits, as well as tips on where you can find additional information. Take some time to read through this guide carefully and share it with your family. Then you'll be ready to make the decisions that are right for you and your family.

Time to Enroll

The annual Open Enrollment period is generally during the month of November. This is your only opportunity to make changes to your benefits unless you have a qualified life event. You will receive information on specific Open Enrollment dates and deadlines when the time comes.

We encourage you to enroll well before the enrollment deadline so that you're not left "waiting in line" to speak with a Benefits Specialist at the last minute.

The benefits you elect during Open Enrollment are effective January 1 of the following year.

Remember, all you have to do to enroll is click or call — log on to the Benefits Center Web Site or call the Benefits Resource Line and speak to a Benefits Specialist.

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

If you have questions about enrollment, you can visit the Benefits Center Web Site at www.benefitsweb.com/countyoforange.html or call the Benefits Resource Line toll-free at 1-866-325-2345 and follow the instructions to speak with a Benefits Specialist. Benefits Specialists are available Monday through Friday, 7:30 a.m. to 5:30 p.m. Pacific Time, except for holidays. If you need assistance in another language or are hearing impaired, Benefits Specialists can connect you with a translation service or TDD at no cost to you.

What to Do Now

- Read this Enrollment Guide carefully to understand how your benefit package works.
- Review the materials in your enrollment package, including:

- **Benefits Enrollment Summary** — This summary contains information about the benefits available to you in the upcoming calendar year and a list of your contribution amounts. It also shows your automatic benefit coverage for the coming year.
- **Open Enrollment Meeting Schedule** — To help explain your Open Enrollment options, we set up a series of meetings. Find a date, time, and location that is convenient for you. Your attendance is strongly recommended.
- **Wallet Card** — This card includes Open Enrollment dates, important phone numbers and Web Sites, and basic instructions on how to use the Benefits Center Web Site and Benefits Resource Line to enroll.

- Enroll for your benefits before the Open Enrollment deadline.

If You're a Current Employee

If the automatic coverage and dependents shown in your Benefits Enrollment Summary are what you want for the coming year, and you don't want to participate in a reimbursement account, you do not need to enroll. However, **you must enroll if you want to:**

- Add or drop dependents
- Change your coverage
- Participate in a Health Care Reinbursement and/or Dependent Care Reimbursement account in the coming year.

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

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

Keep in mind that after the Open Enrollment period you can't change your benefit elections during the year unless you have a qualified life event. See Making Changes to Your Benefits later in this guide for more information.

If You're a New Employee

If you're a new employee of the County, **you have 30 days from your hire date or the date on your enrollment package** (whichever is later) to enroll in your benefits for the first time. After this period, you won't be allowed to make changes to your benefit elections until the next Open Enrollment unless you have a qualified life event. See Making Changes to Your Benefits later in this guide for more information.

Important: If you don't enroll in a County health plan within the 30-day enrollment period, a full-time employee will be enrolled in Premier Wellwise health plan with employee-only coverage. If you are a part-time employee you will be enrolled in the Premier Sharewell health plan with employee-only coverage.

If You Change Your Home Address

If you change your home address, you must contact your human resources and/or payroll department. It's important that the Benefits Center has your correct home address so that it can send you important information about your benefits.

If You Move Out of Area

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

Leave of Absence or Go Off Payroll

When you go off payroll, you must pay the full cost of your health insurance if you want to continue coverage. The full cost includes both the County and the employee portions of the premium. All leave of absence billing is done on a monthly basis. Before you begin your leave, you will be sent a leave of absence package detailing your options.

If you terminate your health plan while off payroll, you may re-enroll in the health plan of your choice when you return to work by calling the Benefits Resource Line. Your health insurance will be effective on the first day of the month following the date you return to work. For the PPO health plans, the pre-existing-condition clause and new deductibles will apply. If you terminate your coverage, do not return to work, and subsequently take active retirement, you cannot re-enroll in health insurance. This lapse in coverage also makes you ineligible for COBRA coverage.

You may choose to terminate coverage for your dependents while you are off payroll. Upon return to work you may enroll dependents only if approved by your health plan. CIGNA and Kaiser health plans do not allow enrollment of existing dependents except during the Open Enrollment period.

The 1% deduction for participation in the Retiree Medical Program is not taken while you are off payroll, and you do not accumulate service hours during this time.

The Federal Family and Medical Leave Act

If you've worked for the County for at least one year, you've worked at least 1,250 hours in the 12 months preceding your leave, and the reason for the leave is one of those listed below, you may be eligible for up to 12 weeks of benefits under the federal Family and Medical Leave Act (FMLA). During an FMLA leave, the County will continue to pay its share of health insurance premiums.

To be eligible for an FMLA leave, the leave must be due to:

- The birth or adoption of a child,
- The serious health condition of your spouse, child, or parent, or
- A serious health condition that makes you unable to perform the functions of your job.

You still pay your share of health insurance premiums, if any, for each pay period you are off payroll. Contact the Human Resources Specialist in your agency for specific requirements and more information.

The Last Step on Your Pathways to Benefits

After you enroll, you'll receive a Benefits Confirmation Statement in the mail. You can also print out a statement if you enroll online. Review the statement to make sure it correctly reflects your benefit elections. If any of the information in your statement is incomplete or incorrect, call the Benefits Resource Line right away and speak with a Benefits Specialist. You have 10 business days from the date of your Benefits Confirmation Statement to report errors in your elections. After the enrollment period, if you don't receive a Benefits Confirmation Statement shortly after making your elections, call the Benefits Resource Line right away to notify a Benefits Specialist.

Making Changes to Your Benefits

You may change your benefits between Open Enrollment periods if you experience certain qualified life events. Listed below are some of the situations in which a change is permitted:

- You marry, divorce, or become legally separated or your marriage is annulled
- You **file a declaration of domestic partnership**
- You gain a dependent through birth, adoption, placement for adoption, or domestic partnership
- Your dependent or domestic partner dies
- Your dependent no longer meets the eligibility requirements
- You, your 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 domestic partner moves to a location where your current coverage is not available.

Any change in your coverage must be made within 30 days of the qualified life event and must be consistent with that event. If your qualified life event allows you to add or drop dependents, log on to the Benefits Center Web Site or call the Benefits Resource Line and speak to a Benefits Specialist to make any necessary changes. You may be asked to submit documentation (e.g., birth certificate) to support your elections for eligible-dependent coverage. Failure to submit documentation may result in your dependent not being covered, with no benefits payable. Keep in mind that HMO contracts do not allow you to add newly eligible dependents after the 30-day period. Dependents added to a PPO plan outside Open Enrollment are subject to the plan's pre-existing-condition-exclusion provision.

If you have a qualified life event after the end of Open Enrollment but before the start of the new year and want to make changes to your benefits, you must call the Benefits Resource Line within 30 days of your qualified life event. You may need to confirm or make elections to ensure benefit coverage during the current and upcoming plan years. If you have any questions, please call the Benefits Resource Line and speak with a Benefits Specialist.

Pathways to Enrollment: Enrolling Step-by-Step

You Can Click or Call to Enroll

Enrollment is a paperless process. You can enroll through the County of Orange Benefits Center in two ways:

- On the Web — You can enroll online at the Benefits Center Web Site any time the enrollment period.
- By phone — You can call the toll-free Benefits Resource Line and speak to a Benefits Specialist. Benefits Specialists are available Monday through Friday, from 7:30 a.m. to 5:30 p.m. Pacific Time, except for holidays.

When to Click or Call

The Benefits Center makes it easy to enroll and get information about your benefits. You can enroll or find information about your benefits on the Benefits Center Web Site or through the Benefits Resource Line. If you need help and can't find the information you need, you may speak to a Benefits Specialist.

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

	Log on to the Benefits Center Web Site to…	Call the Toll-Free Benefits Resource Line to…	Speak to a Benefits Specialist to…
Review your automatic benefit coverage	✔	✔	✔
Find out the cost of your benefit elections	✔		✔
Confirm who is covered under your benefit plans	✔	✔	✔
Enroll for coverage during enrollment period	✔		✔
Use tools such as Select-a-Plan to help you make decisions about your benefits	✔		
View and print health plan Provider Directories	✔		
Report most qualified life event changes	✔		✔
Change dependent information	✔		✔
Request forms	✔	✔	✔
Find answers to your questions about benefits	✔		✔

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

What to Have with You When You Enroll

When you enroll, you should have the following handy:

- Your Social Security number
- Your Benefits Enrollment Summary

- Your personal identification number (PIN).

If you're electing a health plan that requires you to select a primary care physician (PCP) when you enroll, you can find a list of PCP identification numbers on the Benefits Center Web Site by clicking on the links to provider sites.

Benefits Enrollment Summary

Your personalized Benefits Enrollment Summary is a valuable tool to help you make your choices at Open Enrollment. You'll find your Benefits Enrollment Summary in your enrollment package. This summary shows:

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

You will be enrolled in the automatic benefit coverage shown in your Benefits Enrollment Summary if you do not make any changes before the deadline.

You can also access your Benefits Enrollment Summary on the Benefits Center Web Site. If you can't find your PIN, either use the Benefits Center Web Site's "Forgot Your PIN?" feature (if you registered for it) or call the Benefits Resource Line and press **0, and speak with a Benefits Specialist.

▶ **How to Change Your PIN**

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

• Online — Log on to the Benefits Center Web Site and follow the instructions to change your PIN.

• By phone — Call the Benefits Resource Line and follow the instructions to change your PIN.

Because your PIN provides access to your personal information, please keep it confidential at all times.

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

How to Read Your Benefits Enrollment Summary

Your personalized Benefits Enrollment Summary lists your name and address in the upper left corner. Below that, the summary shows your automatic benefits — the benefits you receive if you don't make any changes at Open Enrollment. For each benefit, the summary also shows your coverage level and your before- and after-tax cost (if applicable).

The next section lists all the benefits for which you're eligible, including option numbers and cost by coverage level.

Carefully review the benefits for which you're eligible before you enroll. You can even highlight your benefit selections on your summary so that you can quickly and easily reference them as you enroll.

How to Enroll Through the Benefits Center Web Site

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

1. Go to **www.benefitsweb.com/countyoforange.html**
2. When prompted, enter your Social Security number and personal identification number (PIN).
3. The first time you log on to the Web Site, change your PIN (you'll automatically be prompted).
4. Follow the instructions for Open Enrollment from there.

Steps to Enroll Online

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

- Get an overview of the benefits available to you in the coming year.
- Compare health plans and plan features that are important to you. You can also use the "Evaluate Health Plans" feature (available to most employees and retirees who are eligible for County health plan coverage) to help select a health plan based on the factors that are most important to you.
- Read PPO plan documents and HMO Group Service Agreements, which provide detailed information about your County of Orange benefit plans.
- Make changes to your benefit elections and/or dependent information for the upcoming plan year.
- Review your elections, including a list of all the benefits you are eligible for through the County of Orange. The benefits you see are the benefits you will receive in the upcoming calendar year unless you make changes during Open Enrollment.
- Use the "Model a Qualified life event" tool to help you plan for the future. Enter different scenarios and find out how each would affect you financially. For example, you can determine what your health plan cost would be if you added a dependent.

After you have made your benefit elections, you will see a Benefits Confirmation Statement. Print a copy of this statement for your records. You'll also receive a Benefits Confirmation Statement in the mail.

Web Tools

Good looks and speed are just the beginning of the improvements to your County Benefits Center Web Site. Here a some of the great tools that you'll have at your fingertips, anytime night or day.

Select-a-Plan

This tool compares features of and estimates your costs under the various County health plans available to you, so you can make enrollment decisions that best fit your needs. With the Select-a-Plan tool, you can perform preference modeling. By answering questions about what you want in a health plan, the tool determines which of the available options is best suited for you. Compare plans side-by-side. Use this overview of the benefit features that are important to you to see how your health plan options stack up against one another. Estimate your costs. Use the cost calculator to estimate costs based on benefit features and your estimate of the medical services that you and your family will use.

Healthcare Advisor

You can use the Healthcare Advisor tool on the Benefits Center Web Site to research medical conditions or procedures. Use the tool when you become aware of a health issue to learn about treatment options, risks, and the recovery process, and to find suggestions for questions you should ask your provider or insurance company. The tool even lists those hospitals rated the best in treating a given condition.

The Healthcare Advisor also has a medical encyclopedia with additional information on various medical terms, including diseases, symptoms, tests, surgical procedures, and more.

How to Use the Benefits Resource Line

With the Benefits Resource Line, you can:

- Enroll, change your dependents, or ask questions by speaking to a Benefits Specialist
- Review your elections, change your PIN, and request forms through the automated system.

To use the Benefits Resource Line:

1. Dial the toll-free phone number, **1-866-325-2345**.
2. Enter your Social Security number and PIN when prompted. If this is your first time calling the Benefits Resource Line, you'll be prompted to change your PIN.
3. Listen to the list of available options and select the one you need.

Your Benefits Confirmation Statement

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

How the Pathways to Benefits Program Works

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

Who Is Eligible?

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

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

Your eligible dependents for health care coverage include your:

- Legal spouse or domestic partner
- Unmarried children under age 19 (or under age 23 if full-time student), including stepchildren, foster children, children placed for adoption, legally adopted children, and children of domestic partners. Children who are full-time students must attend an accredited school, college, or university (12 units or more) and must be dependent on you for financial support to continue to be covered
- Unmarried incapacitated children of any age if they depend on you for financial support, are enrolled in your health plan when you retire, and were incapacitated prior to age 19.

Proof of adoption, domestic partnership, or legal guardianship may be requested at any time. Dependents over age 19 who are students may be required to provide proof of full-time-student status to the County's carriers and administrators at any time. You must notify the Benefits Center within 30 days if your covered dependent no longer meets eligibility requirements.

Most employees may also participate in a reimbursement account to help pay expenses with before-tax dollars. Your personalized Benefits Enrollment Summary lists all the benefits for which you're eligible.

Domestic Partner Coverage

The County of Orange offers many of the benefits described in this guide to the domestic partners of eligible employees. Benefits available to a spouse and eligible dependent children are also available to a domestic partner and his or her eligible dependent children. Coverage may include health care (including prescription drug), dental, dependent life insurance, and voluntary AD&D coverage.

What Is a Domestic Partnership?

In California, a domestic partnership is established when two people file a declaration of domestic partnership with the Secretary of State and meet a number of legal requirements. The partners must, among other things, have a common residence, be at least 18 years of age, not be blood-related in a way that would prevent them from being married to each other in

California, and be of the same sex (unless one of them is over age 62 and at least one of them is eligible for Social Security retirement benefits).

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

Enrolling a Domestic Partner

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

To enroll, you must call the Benefits Resource Line and affirm that you have a valid California declaration of domestic partnership or similar document from another state. You may be asked to provide a copy of the document to verify eligibility.

If you and your domestic partner are both benefit-eligible County employees or retirees, you must follow the same rules for dual coverage that apply to married couples working for or retired from the County. Also, the coverage and enrollment or disenrollment rules under the applicable EME, RME, or RMR Program pertain to you.

Effect on Taxes

If you are not allowed to claim your covered domestic partner and his or her children as dependents on your federal income tax return, you have to pay federal tax on both the County's contributions and any before-tax contributions you make toward the cost of their health care coverage. The value of these contributions is reported to the IRS as "imputed income." If you prefer, you may elect to make your own contributions on an after-tax basis. After-tax contributions are not taxable as imputed income. However, County contributions are still subject to treatment as imputed income.

County contributions toward domestic partner coverage are not taxable for California state income tax purposes. You will see imputed income for any before-tax contributions you make toward the cost of your domestic partner's health care coverage. Tax laws for other states vary.

You should consult your tax advisor in connection with the tax effect of domestic partner benefits offered by the County. The County cannot provide you with any tax advice.

For More Information

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

▶ **Employee Married to Employee (EME) Program**

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

▶ **EME Participants Must Enroll on the Benefits Resource Line**

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

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

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

If you have a qualified life event (e.g., divorce, change from full-time to part-time status) that changes your status as an EME, you must report your new status within 30 days of the event by calling the Benefits Resource Line and speaking to a Benefits Specialist.

Health Plan Options

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

- Health Maintenance Organization (HMO) or
- Preferred Provider Organization (PPO)

Cost of Coverage

The County pays 95% of full-time employee-only health plan premiums and a large percentage of dependent health plan premiums. For part-time employees, the County pays a portion of employee-only health plan premiums and a portion of dependent health plan premiums. Information on the cost of the various health plan options is available in your Benefits Enrollment Summary and through the Benefits Center Web Site.

How the HMO Plans Work

HMO plans provide a comprehensive array of services, including preventive care, at a minimal cost, but you must use providers in the HMO network. An HMO network includes doctors, hospitals, and other health care providers and facilities that have contracted with the

HMO to provide care at lower rates. HMOs do not generally pay benefits for care received outside the HMO network, except in certain emergency situations.

Important features of HMO plans include:

- Minimal copayments for certain services (e.g., doctor's office visits)
- No claim forms
- Coverage for preventive services such as annual physicals, well-baby and well-woman care, and immunizations
- No lifetime maximums
- No pre-existing-condition exclusions.

Your HMO Options

The County offers two HMO plans:

- CIGNA Health Plan HMO (CIGNA HealthCare of Southern California and San Diego)
- Kaiser Health Plan HMO.

An overview of HMO plan benefits can be found in the Health Plans At-A-Glance chart at the end of this section.

CIGNA Health Plan HMO

A few highlights of the CIGNA Health Plan HMO:

- You select a Primary Care Physician (PCP) from the CIGNA network to coordinate all of your health care. With the exception of emergency treatment and Well Woman exams and mental health services, your PCP must authorize, provide and/or arrange all of your care in order for you to receive benefits.
- You contact your PCP's office when you need care. At the time of your appointment, you present your ID card and pay a small copayment.
- Access to specialists is through the CIGNA Access Advantage Program. You can often get same-day referrals.
- Annual well woman exams may be scheduled with an OB/GYN in the same medical group without a PCP referral.
- When medication is prescribed, you must fill the prescription at a CIGNA-contracted retail pharmacy. You pay a small copayment for up to a 30-day supply of either a generic or a brand-name prescription drug. A list of CIGNA pharmacies is available on the CIGNA Web Site and through CIGNA Member Services.
- You may order up to a 90-day supply of maintenance drugs through CIGNA's mail order program. To place an order, use CIGNA's Web Tel-Drug Web Site or call the toll-free number 1-800-TEL-DRUG (1-800-835-3784).
- In an emergency, seek care at the nearest hospital. Call or have your doctor or family call your PCP or CIGNA Member Services within 48 hours to receive benefits.

- If you need vision care, call Vision Service Plan.
- Chiropractic care is covered. See details later in this section.

▶ How to Locate a CIGNA PCP

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

Kaiser Health Plan HMO

Highlights of the Kaiser Health Plan HMO:

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

▶ Chiropractic Care

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

How the PPO Plans Work

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

Important: The pre-existing-condition clause for all the PPO health plans applies if you enroll in a PPO plan outside the Open Enrollment period. See the PPO plan document on the Benefits Center Web Site for details.

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

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

Your PPO Options

You have two PPO plans to choose from:

- Premier Wellwise PPO
- Premier Sharewell PPO.

A few highlights of the PPO plans:

- When you need care, you can go to a provider in (PPO) or outside (non-PPO) the PacifiCare Signature Options℠ preferred provider network. Although the PPO plans have the same provider network, they have different deductibles and coinsurance amounts. See the Health Plans At-A-Glance comparison chart for details.
- When you see a PPO provider, present your ID card at the time of your appointment. Your provider files the paperwork for your claim and you receive a bill in the mail for your deductible and/or coinsurance amount — 10% of the discounted rate for most covered services.
- When you see a non-PPO provider, you generally pay 20% of the usual, reasonable and customary charge for most covered services and, in some instances, you may have to pay up front.
- Both PPO plans pay 100% of eligible health care expenses that exceed $10,000 per calendar year per participant.
- If you're scheduled for hospital admission or surgery, you must contact the claim administrator, PacifiCare, to obtain precertification for the hospital stay before admittance to receive the higher level of benefits.
- In an emergency, seek care at the nearest hospital and call or have your doctor or family call PacifiCare's Customer Service Center within 2 business days of admission to a hospital.

▶ **PacifiCare Signature Options℠ (PPO)**

Each of the County PPO plans uses the PacifiCare Signature Options℠ (PPO) as its preferred provider organization network. PacifiCare Signature Options℠ includes more than 3,000 hospitals and 600,000 physicians across the country. You can use the provider directory on PacifiCare's Web Site to find out which hospitals and doctors are in the network, or you can call PacifiCare's Customer Service Center for assistance.

Prescription Drug Benefits — Premier Wellwise PPO

If you enroll in the Premier Wellwise PPO, Walgreens will administer your prescription drug coverage. Walgreens offers discount prices on name brand and generic drugs with no annual deductible and no claim forms. Walgreens also has a large network of more than 54,000 pharmacies throughout the country, including most major pharmacies like Rite-Aid, Sav-on, and Costco and offers state-of-the-art mail order facilities.

You must fill your prescriptions through Walgreens' participating retail pharmacies or through their mail service program. Please note: you do not need to go to a Walgreens pharmacy but you can use any participating pharmacy in the Walgreens' pharmacy network. Prescriptions obtained as a result of an emergency must be filed with PacifiCare, the PPO claims administrator. When you purchase prescription drugs from a Walgreens participating retail pharmacy, you will always present your health plan ID card to the pharmacist. For mail service prescriptions drugs, if you have a new "maintenance" medication prescription, you may use Walgreens' Mail Order program. If you enroll or are enrolled in the Premier Wellwise health plan you will receive additional communications about the Walgreens Prescription drug card and mail order program in late Fall 2005.

Here's an overview of Walgreens prescription drug coverage:

Premier Wellwise Prescription Drug Benefits		
Retail Pharmacy (up to a 30-day supply)		
Walgreens participating Pharmacy Network		
Generic drugs	you pay 20%	plan pays 80%
Brand name drugs	you pay 20%	plan pays 80%
Mail-order Pharmacy (up to a 90-day supply		
Walgreens Mail-order Pharmacy		
Generic drugs	you pay 20%	plan pays 80%
Brand name drugs	you pay 20%	plan pays 80%

You always save money by using generic drugs (if available) instead of name brand drugs. Although you pay the same coinsurance for generic and name brand drugs, you pay less for generic drugs because they cost less. Additional discounts may be available for maintenance drugs through Walgreens' Mail Order Program, and with mail service you enjoy the additional convenience of being able to order refills online.

Prescription Drug Benefits — Premier Sharewell PPO

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

Things to Consider If Selecting a PPO Plan

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

- The Premier Wellwise PPO offers wellness incentives — up to a $200, $400, or $500 taxable incentive, depending on the level of coverage you elect — if you or your enrolled dependents don't file any claims or fill prescriptions using your PPO ID card during the year, as well as a $50 year-end taxable cash incentive for non-smoking subscribers.
- The Premier Sharewell PPO has a $5,000 annual deductible per family and is designed for employees who have Medicare coverage or other health insurance coverage but want to supplement their family's coverage.

Because of these differences, it's important to review the Health Plans At-A-Glance comparison chart if you're thinking about electing a PPO plan.

▶ **Health Plan Decision Guidelines**

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

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

Health Plan Identification Cards and Claim Forms

All participants enrolled in the Premier Wellwise will receive a new identification (ID) card for the new plan year. If you need a replacement card or the information on the card you receive is incorrect, contact your health plan's Member Services directly.

If you are switching health plans during Open Enrollment, you will receive a new ID card.

If you are a new employee, you will receive an ID card for the health plan you selected.

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

If You Have a Qualified Life Event Outside Your Enrollment Period

If you have a qualified life event after your enrollment period ends and you want to make changes to your benefits, you must call the Benefits Resource Line within 30 days of your qualified life event. If you have any questions, call the Benefits Resource Line and speak with a Benefits Specialist.

Health Plans At-a-Glance

	Preferred Provider Organization (PPO) Plans*				Health Maintenance Organization (HMO) Plans**	
	Premier Wellwise		Premier Sharewell		CIGNA Health Plan	Kaiser Health Plan
BENEFIT	PPO Provider	Non-PPO Provider	PPO Provider	Non-PPO Provider	HMO Provider	HMO Provider
	Covered Person Pays:		Covered Person Pays:		Covered Person Pays:	Covered Person Pays:
Maximum Lifetime Coverage	$1,000,000		$1,000,000		No dollar limit	No dollar limit
Calendar Year Deductible	$300 per individual $600 per family		$5,000 per family		No deductible	No deductible
Hospital Services						
• Inpatient	10%	20%	10%	20%	$100 per admission	$100 per admission
• Outpatient	10%	20%	10%	20%	$15 per visit	$15 per visit
• No Precertification Review	40%	40%	40%	40%	N/A	N/A
Physician Care						
• Office Visits	10%	20%	10%	20%	$15 per visit	$15 per visit
• Second Opinion	10%	20%	10%	20%	$15 per visit	$15 per visit
• W/o Second Opinion	40%	40%	40%	40%	N/A	N/A
• Well Baby Care	No charge	Not covered	No charge	Not covered	No charge	No charge to 23 months
• Diagnostic X-rays/Lab	10%	20%	10%	20%	No charge	No charge
• Immunizations	No charge (limited)	Not covered	No charge (limited)	Not covered	No charge	No charge
Routine Exams – Adults						
• Annual Physical	No charge, up to a maximum annual benefit of $250 in-network only ($250 annual limit does not apply to specific procedures listed under "Wellness Benefit" in the plan document)	Limited to specific procedures listed under "Wellness Benefit" in the plan Document	No charge, up to a maximum annual benefit amount of $250 In-network only ($250 annual limit does not apply to specific procedures listed under "Wellness Benefit" in the plan document)	Limited to specific procedures listed under "Wellness Benefit" in the plan document	$15 charge	$15 charge
• Prostate Screening					$15 charge	$15 charge
• Well Woman Exams					$15 charge Note: Well woman exams are for breast and pelvic only; not complete physicals. May self-refer within designated plan medical group	$15 charge Note: For well woman exam, may self-refer to a Kaiser provider
Prescription Drugs	20%	20%	20%	20%	$10 generic prescription $15 brand prescription 30-day supply	$10 generic prescription $15 brand prescription Up to 100-day supply Dental prescriptions included
	Drug card program					
Maternity Care	10%	20%	10%	20%	$100 per admission	$100 per admission
Emergency Services	10%	20%	10%	20%	$50 per visit Waived if admitted	$50 per visit Waived if admitted
Ambulance	20%	20%	20%	20%	No charge	No charge
Family Planning						
• Contraceptives	Not covered	Not covered	Not covered	Not covered	$10 generic prescription $15 brand prescription	$10 generic prescription $15 brand prescription
• Vasectomy	10%	20%	10%	20%	$15 charge	$15 charge
• Tubal Ligation	10%	20%	10%	20%	$15 charge	$15 charge
• Infertility Services	Not covered	Not covered	Not covered	Not covered	Limited, $15 per visit	Limited, $15 per visit

	Preferred Provider Organization (PPO) Plans*				Health Maintenance Organization (HMO) Plans**	
	Premier Wellwise		Premier Sharewell		CIGNA Health Plan	Kaiser Health Plan
BENEFIT	PPO Provider	Non-PPO Provider	PPO Provider	Non-PPO Provider	HMO Provider	HMO Provider
	Covered Person Pays:		Covered Person Pays:		Covered Person Pays:	Covered Person Pays:
Mental Health						
• Inpatient	10%	20%	10%	20%	$100 per admission, up to 30 days	$100 per admission, up to 45 days
• Outpatient	50%	50%	50%	50%	$20 per visit	$15 per visit
	up to $50 per visit		up to $50 per visit			
• Maximum Yearly Outpatient	50 visits		50 visits		N/A	20 visits
• Lifetime Maximum	$30,000, combined with Alcohol and Substance Abuse below. Note: The lifetime and visit maximums do not apply to certain conditions that are covered the same as any other illness in accordance with the California Mental Health Parity Act				N/A Note: Lifetime, visit, and day maximums do not apply to certain conditions that are covered the same as any other illness in accordance with the California Mental Health Parity Act	N/A Note: Lifetime, visit, and day maximums do not apply to certain conditions that are covered the same as any other illness in accordance with the California Mental Health Parity Act
Alcohol and Drug Abuse						
• Inpatient	10%	20%	10%	20%	$100 per admission	$100 per admission, detox only
• Outpatient	50%	50%	50%	50%	$15 per visit	$15 per visit
	Up to $50 per visit		Up to $50 per visit			
• Maximum Yearly Outpatient	50 visits		50 visits		Detox only	Unlimited
• Lifetime Maximum	$30,000 maximum benefit combined with Mental Health above					N/A
Home Health Care	10%	20%	10%	20%	No charge	No charge
Skilled Nursing Facility	Limited (Limited to 60 days)		Limited (Limited to 60 days)		No charge (Up to 60 days)	No charge (Up to 100 days)
Eye Refractions	Not covered		Not covered		$5 charge Glasses $10	$15 charge
Chiropractic	10%	20%	10%	20%	$15 per visit	$15 per visit
• Frequency Limitations	50 visits per year		50 visits per year		30 visits per year	30 visits per year
• Yearly Maximum	$1,000		$1,000			
Durable Medical Equipment	Covered	Covered	Covered	Covered	Covered at 100% when prescribed by your Primary Care Physician	Not covered
	Contact health plans for further details					

Health Care and Dependent Care Reimbursement Accounts

The Health Care Reimbursement Account (HCRA) and Dependent Care Reimbursement Account (DCRA) allow you to set aside before-tax dollars from each paycheck to help pay health care and dependent care expenses for you and your family.

How the Reimbursement Accounts Work

- When you enroll in a reimbursement account, you elect how much money you want to put into the account from each paycheck over the course of the year. Your before-tax contributions are automatically deducted each pay period. As a result, you have a lower net income and pay less in income tax.
- When you have an eligible expense, you pay the expense and then submit a claim form to FlexServ, the County's HCRA/DCRA administrator. The administrator uses the funds in your account to reimburse you for your expense.
- You may file claims for reimbursement account expenses incurred at any time during the calendar year, and claims must be filed before March 31 of the following year.
- HCRA expenses are reimbursed from your account as they are incurred. For example, if you decide to contribute $1,200 to your HCRA over the course of the year and you have $1,200 of eligible expenses in February, you may request reimbursement for $1,200 at that time even though you don't yet have the full amount in your account.
- DCRA expenses are reimbursed only if there are sufficient funds in your account. If your claim is for more than you have in your account, you'll be reimbursed for the amount in your account and may resubmit the unreimbursed expense later.
- An HCRA and a DCRA are separate accounts. Although you may enroll in both accounts, you can't use money from one account to reimburse yourself for expenses that are eligible under the other account.

Health Care Reimbursement Account

You may contribute up to $5,000 to your HCRA each year. The tax-free funds in your account can be used to reimburse you for eligible out-of-pocket health care expenses incurred by you and your family.

Eligible HCRA Expenses

Eligible health care expenses include:

- Deductibles, copayments, and other amounts you pay out of your own pocket to cover eligible health care expenses
- Medical, dental, vision, and prescription drug expenses that are not covered or are only partially covered by your health plans.

For a list of eligible and ineligible expenses, contact your tax advisor, call the IRS at 1-800-829-3676, or visit the IRS Web Site at www.irs.gov.

Dependent Care Reimbursement Account

You can use a DCRA to set aside tax-free money to pay eligible dependent care expenses, such as day care for your child or care for an older family member.

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

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

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

Eligible Dependents

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

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

Eligible DCRA Expenses

Eligible dependent care expenses include:

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

For a list of eligible and ineligible expenses, contact your tax advisor, call the IRS at 1-800-829-3676, or visit the IRS Web Site at www.irs.gov.

Important IRS Information about HCRAs and DCRAs

The "Use It or Lose It" Rule

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

DCRA vs. the Dependent Care Tax Credit

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

How to File HCRA and DCRA Reimbursement Claims

You can obtain reimbursement claim forms:

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

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

Things to Consider before Enrolling in an HCRA or a DCRA

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

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

Determining Your HCRA and DCRA Contributions

You can use the forms below to help estimate your and your dependents' expenses for the coming year. You may want to review your bills and checkbook register for the previous 12 months as you estimate your upcoming expenses. Remember to estimate conservatively – the IRS requires that you forfeit any amounts left in your accounts after the claim-filing deadline.

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

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

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

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

Employee Assistance Program

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

Before Tax Deductions

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

- Employee health care premiums
- Dependent health care premiums
- Part-time health care premiums
- 1% Retiree Medical Contribution Plan contributions.

If you do not want the tax advantage of before-tax deductions, call the Benefits Resource Line to elect after-tax deductions.

Retiree Medical Information

The County currently offers several benefits to help you prepare for retirement.

1% Medical Contribution

As an active employee, you automatically contribute 1% of your biweekly gross salary on a before-tax basis to help pay the cost of your and your dependents' health insurance coverage.

Retiree Medical Grant

When you retire, you may receive a retiree medical grant (Grant) to use toward the cost of your County health plan and/or your Medicare premiums. To be eligible for a Grant, you must:

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

Survivor Benefits

If you're a survivor of a deceased employee or retiree, you may be eligible for coverage under the County retiree health plan and for a Survivor Retiree Medical Grant.

Survivor Health Care Coverage

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

- Be covered under the deceased employee's or retiree's health plan at the time of his or her death
- Receive a monthly retirement allowance from the OCERS Exceptions to this rule include:
    - Dependent children under age 19 (or under age 23 if full-time students) who aged out of receiving a monthly retirement allowance from OCERS but are still eligible under the plans
    - Incapacitated children and surviving spouses who aren't eligible for a monthly retirement allowance but are eligible for health plan coverage.

Survivor Retiree Medical Grant Benefits

To be eligible for a Survivor Grant, you must:

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

If you are eligible for a Survivor Retiree Medical Grant, you will receive half of the Retiree Medical Grant that would have been available to the employee or retiree to use toward the cost of a County health plan and/or Medicare coverage.

Retiree Medical 1% Cash Lump Sum Benefit

If you terminate your employment with the County and you are not eligible to receive a Grant at the time of employment termination, you are eligible to receive a taxable cash lump sum benefit. This benefit is equal to 1% of your final hourly salary, averaged over your last three years of service, multiplied by your total number of eligible service hours.

Important Legal Information

Continuing Your Coverage Under COBRA

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

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

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

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

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

For more information, call COBRA Continuation Services at the number listed under Helpful Information at the end of this guide.

Health Insurance Portability and Accountability Act (HIPAA)

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

- Is limited in imposing pre-existing-condition exclusions
- Must offer employee and dependents the opportunity to enroll outside Open Enrollment in certain situations
- Can't discriminate on the basis of health status with respect to eligibility for plan participation and premium costs
- Can't impose discriminatory lifetime or annual benefit limits on participants with mental illness

- Must permit hospital admissions (if otherwise covered by the plan) of at least 48 hours in case of normal deliveries and 96 hours in the case of Cesarean sections.

Under HIPAA, the sponsor of a self-funded non-federal-governmental plan, such as the County's PPO plans, has the option to exempt the PPO plans from any or all of these requirements except for the certification requirement (see below). The County opted to exempt the PPO plans from HIPAA requirements. Our plans already provide for hospital admissions of at least 48 hours in the case of normal deliveries and 96 hours in the case of Cesarean sections and will not be changed as a result of the exemption. A summary of current health plan benefits, copayments, and deductibles is included in this guide and is not affected by this exemption option.

The County's HMO plans comply with HIPAA.

Certification of County Group Health Plan Coverage

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

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

Women's Health and Cancer Rights Act of 1998

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

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

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

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

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

Supplemental Employee Benefits

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

- Dental Plan
- Basic Life and Basic Accidental Death and Dismemberment (AD&D) insurance
- Voluntary life and AD&D insurance
- Short-Term and Long-Term Disability plans
- Optional Benefit Plan
- 457 Defined Contribution Program
- Retirement benefits
- Annual physical

Eligible Dependents

Some supplemental benefits cover your dependents.

For the Dental Plan, your eligible dependents include your:

- Legal spouse or domestic partner
- Unmarried children — including stepchildren, foster children, children placed for adoption, children of a domestic partner, or legally adopted children — under age 19 (or under age 25 if full-time students at an accredited school, college, or university) who are dependent on you for financial support
- Unmarried children of any age if they have a mental or physical disability that requires them to depend on you for financial support

For Dependent Life insurance, your eligible dependents include your:

- Legal spouse or domestic partner
- Unmarried children — including stepchildren, legally adopted children, and children of a domestic partner — under age 21 (or under age 25 if full-time students at an accredited school, college, or university) who are dependent on you for financial support
- Unmarried children of any age if they have a mental or physical disability that requires them to depend on you for financial support

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

- Legal spouse or domestic partner under age 70
- Unmarried children — including stepchildren, legally adopted children, and children of a domestic partner — under age 19 (or under age 23 if full-time students at an accredited school, college, or university) who are dependent on you for financial support
- Unmarried children of any age if they have a mental or physical disability that requires them to depend on you for financial support

Coverage Costs

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

Dental Plan

The County Dental Plan offers comprehensive dental benefits for you and your family. The coverage is provided at no cost to you (unless you are a part-time Management employee or Attorney, in which case you pay a portion of the cost).

When Dental Coverage Begins

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

If you wish to enroll your eligible dependents, you must elect the appropriate family coverage within 30 days after your coverage begins. If you don't enroll your dependents, you receive automatic dental coverage for yourself only.

If you're a part-time Management employee or Attorney and you want to enroll in the Dental Plan, you must do so through the Benefits Center Web Site or the Benefits Resource Line within your 30-day enrollment period. If you do not enroll within the enrollment period, you will not receive dental coverage.

How the Dental Plan Works

The Dental Plan is a "freedom of choice" plan administered by PacifiCare Dental & Vision Administrators (PDV), a subsidiary of PacifiCare Health Plan Administrators. You may see any licensed dentist for your care and no identification card is required. After you pay a lifetime deductible (for basic services) and an annual deductible (for major services), the plan pays a percentage of eligible expenses, based on usual, reasonable, and customary (URC) charges — the usual charges for dental services in your geographic area as determined by the plan. If your dentist charges more than URC charges, yo are responsible for paying the amounts above URC limits.

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

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

▶ Your Dental Plan At-A-Glance

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

Predetermination of Benefits

If a proposed dental treatment is expected to cost more than $1,200, the dentist must submit a treatment plan to the Dental Plan administrator, PacifiCare Dental & Vision Administrators for review before providing services. You and your dentist will be told what's covered and how much you'll have to pay.

How to File Claims

When you see your dentist, you pay up front for services then complete a claim form and send it to PacifiCare for reimbursement. You can get a claim form from the Benefits Center Web Site or by calling PacifiCare.

For More Information

More information on the Dental Plan is available on the Benefits Center Web Site.

Basic Life and Accidental Death and Dismemberment Insurance

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

When Basic Life and AD&D Coverage Begins

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

▶ **IRS Rules on Life or AD&D Insurance over $50,000**

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

Voluntary Life Insurance

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

Evidence of Insurability (EOI)

For voluntary life plans, evidence of insurability is a medical history stating that the person to be covered is currently in good health. You (or your dependents) need EOI to be approved for certain types of coverage, including:

- Additional Life, Extra Additional Life, or Dependent Life of any amount if elected more than 30 days after the latest of your hire date, promotion date, or the date on your enrollment package
- Additional Life of three times Basic Life
- Extra Additional Life of $150,000, $200,000, or $250,000

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

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

When Coverage Begins

You may elect voluntary life insurance at any time, subject to evidence of insurability. You may end coverage at any time.

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

Additional Life Insurance Benefits

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

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

- Three times (3x) Basic Life

Extra Additional Life Insurance Benefits

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

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

Dependent Life Insurance Benefits

You may buy Dependent Life insurance in these amounts:

- Spouse: $20,000
- Dependent child: $5,000

Life Insurance Portability Feature

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

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

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

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

Voluntary AD&D

You may buy Voluntary AD&D insurance for yourself only or for yourself and your family at any time with coverage levels from $20,000 to $250,000. Your voluntary coverage is effective the first of the month following the election date.

If you buy Voluntary AD&D for yourself only, your voluntary benefits are identical to your County-paid Basic AD&D benefits, effectively doubling your coverage. If you elect Voluntary AD&D for your family, the levels of coverage vary.

If You Cover Your…	Coverage Is…
Spouse only	50% of employee coverage for your spouse
Spouse and dependent child(ren)	40% of employee coverage for your spouse 5% of employee coverage for your dependent children
Dependent child(ren)* only	10% of employee coverage for your dependent children

*The coverage level of any one dependent child cannot exceed $15,000.

▶ **Beneficiary Designations**

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

If you're a new employee, you must complete the Beneficiary Designation form (included with your Confirmation Statement) and return it to the Benefits Center.

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

Short-Term Disability Coverage

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

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

STD coverage is effective on the 31st consecutive day after your hire, appointment, or promotion date.

When STD Benefits Begin and End

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

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

How to Apply for STD Benefits

You may receive STD benefits if:

- A licensed medical professional determines that you're totally disabled,
- You're unable to perform your normal job duties,
- Your disability is expected to last longer than seven working days after you exhaust your 192 hours of annual leave, and

- You're not on a catastrophic leave. You're considered to be on catastrophic leave when you're on an extended unpaid medical leave due to a catastrophic medical condition and you receive donated vacation and/or compensatory time from other employees.

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

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

Long-Term Disability Coverage

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

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

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

Continuing Your Benefits and Payments While on Disability Leave

Here's the cost breakdown to continue your other benefits while on disability leave.

If You're on STD Leave...	The County Pays...	You Pay...
Health Coverage	Its share of health premiums	Your share of the health premium for your dependents, if any
Dental Coverage	The full premium for you and your enrolled dependents	$0
Basic Life and Basic AD&D	The full premiums	$0
Additional Life, Dependent Life and voluntary AD&D	$0	The full premiums
If You're on LTD Leave...	**the County Pays...**	**You Pay...**
Health Dental, Basic Life*, Basic AD&D, Voluntary Life*, and Voluntary AD&D	$0	The full premiums

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

Optional Benefit Plan

The Optional Benefit Plan (OBP) is an additional benefit provided by the County to help eligible employees meet personal needs and goals. You may allocate up to $3,500 through the OBP each calendar year.

Who's Eligible?

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

If you're a current Executive Management employee or Elected Official, you must make a new OBP election each year at Open Enrollment. If you don't make an election, you receive the full OBP benefit in a taxable cash lump sum in the first pay period of the new year.

If you're newly hired or promoted after Open Enrollment, you must make an OBP election within 28 days of your hire or promotion. If you do not, you receive the full OBP benefit in a taxable cash lump sum in the first pay period following that 28-day period.

When Benefits Begin

If you're a current employee, your OBP benefits begin on January 1 each year. If you're a new employee, your OBP benefits begin on the first day of the month following 28 days from your hire or promotion date. Employees hired or promoted after the start of a plan year are eligible for a prorated benefit that starts on the first day of the month after 28 days from being hired or promoted.

Your OBP Options

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

Taxable Cash Lump Sum

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

Voluntary AD&D Payroll Credit

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

Voluntary AD&D Coverage Level	Maximum Annual Employee-Only	Maximum Annual Family
	Payroll Credit	Payroll Credit
$ 20,000	$ 11.96	$ 16.64
$ 40,000	$ 23.92	$ 33.28
$ 60,000	$ 35.88	$ 49.92
$ 80,000	$ 47.84	$ 66.56
$100,000	$ 60.06	$ 83.20
$150,000	$ 89.96	$124.80
$200,000	$119.86	$166.40
$250,000	$150.02	$208.00

Health Care Reimbursement Account (HCRA)

You may allocate OBP dollars to fund your HCRA. Once you allocate OBP dollars to your HCRA, you can use your HCRA to reimburse yourself for eligible medical, dental, or vision expenses.

Important Limitations

- You cannot change your OBP HCRA amount during the year.
- The total OBP benefit amount you allocate plus any regular HCRA contributions cannot exceed the $5,000 annual HCRA limit.
- Any OBP amount in your HCRA that is not used for eligible health care expenses during the year is forfeited.

Professional Reimbursement

You may allocate OBP dollars to pay for professional job-related conferences, memberships, licenses, certificates, journals, and periodicals that are not reimbursed or payable through the County. Current employees cannot change their Professional Reimbursement allocation outside Open Enrollment for any reason. If you're a new employee, you cannot change your allocation after your effective date for the OBP plan.

When you have an eligible expense, you pay the expense and then submit a claim form to FlexServ, the OBP administrator. Claim forms are available on the Benefits Center Web Site and through the Benefits Resource Line.

Any amount in your Professional Reimbursement Account that is not used for eligible OBP expenses during the year is forfeited.

457 Defined Contribution Plan Lump Sum

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

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

You can't change your OBP 457 Defined Contribution Plan allocation after Open Enrollment for any reason. Because choosing this option is an irrevocable election and it affects your

total annual plan contributions, you may want to speak with a Great West Retirement Services representative and your tax adviser before allocating OBP dollars.

OBP Claim Filing Deadlines

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

401(a) Defined Contribution Program

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

457 Defined Contribution Program

The 457 Defined Contribution Program allows you to defer some of your salary through before-tax payroll deductions on a regular basis. You can defer up to the annual IRS limit. Taxes on the money and earnings are deferred until they are withdrawn. You can make a withdrawal when you no longer work for the County.

You can enroll in the program at any time. To enroll, contact the plan administrator, Great West Retirement Services.

Retirement Benefits

The Orange County Employees Retirement System (OCERS) provides retirement benefits for Executive Managers and Elected Officials of the County that belong to OCERS. Elected Officials have the option of participating in OCERS or the County's 401(a) Plan as a retirement plan. If you elect not to participate in OCERS then you elect to participate in the 401(a) Plan and the County will contribute 1.5% of your base salary into the 401(a) Plan. Elected Officials must notify OCERS in writing of their election to participate or not to participate in the Orange County Employees Retirement System. If you require additional information about OCERS, call 1-888-570-6277 or visit the web site at www.OCERS.org.

Defined Contribution Program

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

Annual Physical

You're eligible for one County-paid physical examination every 12 months. For more information or to schedule your exam, call Employee Health Services at 1-714-834-5974 Monday through Friday from 7:30 a.m. to 11:00 a.m.

For More Information

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

Helpful Information

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

For Questions About…	Click or Call…
Benefits or Enrolling	
• Benefits Center Web Site	**www.benefitsweb.com/countyoforange.htm**
• Benefits Resource Line	1-866-325-2345 Benefits Specialists are available Monday through Friday between 7:30 a.m. and 5:30 p.m. Pacific Time, except holidays TDD: 1-800-TDD-TDD4 (833-8334)
• Employee Benefits Web Site	**www.oc.ca.gov/hr/employeebenefits**
Your Health Plans	
• American Specialty Health Plans (HMO chiropractic care)	**www.ashcompanies.com** 1-800-678-9133 P.O. Box 509002 San Diego, CA 92150-9002
• CIGNA Health Plan HMO	**www.cigna.com/countyoforange** 1-800-244-6224 400 North Brand Blvd. Glendale, CA 91209
• PacifiCare Health Plan Administrators (claim administrator for the PPO plans and provider network)	**www.pacificare.com/ocppo** 1-800-908-9185 P.O. Box 6076 Cypress, CA 90630-0076
• Kaiser Health Plan HMO	**www.kp.org** 1-800-464-4000 P.O. Box 1840 Corona, CA 91718-1840
Prescription Drugs	
• Walgreens (for the Premier Wellwise PPO plans)	**Information forthcoming**
• Tel-Drug (for the CIGNA Health Plan HMO)	**www.teldrug.com** 1-800-TEL-DRUG (1-800-835-3784)
Vision Plan	
• Vision Service Plan (CIGNA HMO)	**www.vsp.com** 1-800-877-7195 P.O. Box 997105 Sacramento, CA 95899-7105
HCRA or DCRA	
• FlexServ	**www.ceridianfsa.com** 1-866-300-2303 FSA Claims Administration P.O. Box 534134 St. Petersburg, FL 33747-4134 Fax 1-888-342-5333

COBRA	
• COBRA continuation services	**www.ceridian.com** 1-888-877-7994 3201 34th Street South St. Petersburg, FL 33711
Billing	
• Benefit billing services	**www.ceridian.com** 1-877-588-0946 3201 34th Street South St. Petersburg, FL 33711
Employee Assistance Program	
• Employee Assistance Program	**www.esscocorp.com** 1-800-221-0945 309 N. Rampart Ave., Suite A Orange, CA 92868
Dental Plans	
• PacifiCare dental and vision	**www.pacificare.com/ocppo** 1-800-591-5915 P.O. Box 25191 Santa Ana, CA 92799-5191
Short-Term Disability, Long-Term Disability, Basic Life, Additional Life, Extra Additional Life, and Dependent Life	
• The Standard Insurance Company	**www.standard.com** 1-800-368-2859 P.O. Box 2800 Portland, OR 97208-2800
Basic AD&D and Voluntary AD&D	
• The Standard Insurance Company	**www.standard.com** 1-800-628-8600 P.O. Box 2800 Portland, OR 97208-2800
Retirement Benefits	
• 457 and 401(a) Defined Contribution Program (executive policy unit and attorneys)	**countyoforangedcplan.com** 1-866-457-2254, press 2 Great West Retirement Services 18111 Von Karman Ave., Suite 560 Irvine, CA 92612
• Orange County Employees Retirement System (OCERS)	**www.ocers.org** 1-888-570-6277 2223 Wellington Ave. Santa Ana, CA 92701

Network Directories Online

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

To view network directories for…	Go to…
CIGNA Health HMO Plan	**www.cigna.com/countyoforange**
Kaiser Health HMO Plan	**www.kp.org**
Premier Wellwise Plan	**www.pacificare.com/ocppo**
Premier Sharewell Plan	**www.pacificare.com/ocppo**

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