ORANGE COUNTY GOVERNMENT FLORIDA

Orange County Wellness for Life Plan

2024 Retiree Benefits Handbook

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Section 1: Retiree Health Benefits

Orange County employees meeting certain requirements and their eligible covered dependents, as explained below in the "Health Benefits Eligibility" section, may choose to continue their group medical, dental and/or vision coverage at the time of their retirement. As a retiree, you will be charged the full premium for any coverage you elect. At the time of your retirement appointment with a Benefits Team member, you will make your health benefit elections. Retirees also have an annual open enrollment window in which certain changes are allowed as explained in the "Coverage Changes" section below.

Flexible Spending Accounts (FSAs) are not included in Orange County's retiree health benefits; however, the Medical FSA and Limited Purpose FSA can be continued through COBRA until the end of the plan year. Important information on when FSA coverage ends is included in this handbook.

Health Benefits Eligibility for Retirees and Dependents

In order to qualify for Orange County retiree health benefits (medical, dental, and/or vision insurance), you must be an active employee with the County at the time of retirement and you must be "Retired" as defined by the Florida Retirement System (FRS). You are considered "Retired" under the FRS if you:

Pension *Must meet one of the following*	Investment *Must meet one of the following*
Enrolled in FRS prior to July 1, 2011: **Regular Class**- Age 62 with 6 year of service or 30 years of Service, regardless of age	Enrolled in FRS prior to July 1, 2011: **Regular Class**- Age 62 or 30 years of Service
Enrolled in FRS after July 1, 2011: **Regular Class**- Age 65 with 8 years of service or 33 years of Service, regardless of age	Enrolled in FRS after July 1, 2011: **Regular Class**- Age 65 or 33 years of Service
Enrolled in FRS prior to July 1, 2011: **Special Risk Class** - Age 55 with 6 years of Service or 25 years of Special Risk Service regardless of age or age 52 with 25 years of Special Risk service and military service.	Enrolled in FRS prior to July 1, 2011: **Special Risk Class** - Age 55 or 25 years of service or Age 52 with 25 or more years of Special Risk and military service
Enrolled in FRS after to July 1, 2011: **Special Risk Class** – Age 55 with at least 8 years of Special Risk service, or 25 years of Special Risk service, regardless of age or age 52 with 25 years of Special Risk service and military service.	Enrolled in FRS after July 1, 2011: **Special Risk Class** - Age 60 or 30 years of Service or Age 57 with 30 or more years of Special Risk and military service
Meet the requirements for FRS early retirement	Have reached the age of 59½ and have six years of FRS creditable service (if enrolled in FRS prior to July 1, 2011) or eight years of credible service (if enrolled after July 1, 2011), and have taken a distribution from your Investment Plan account
Have been approved for FRS disability retirement	

Who is Eligible?

- At the time of your retirement, you must be already covering yourself in order to continue your coverage.
- You must be already covering your spouse and/or other eligible dependents in order to continue their coverage.
- You cannot continue coverage for a spouse or dependents without covering yourself. The County does not permit "dependent only" coverage. However, if you choose to waive coverage for yourself, your dependents may be eligible to continue coverage under COBRA for up to 36 months. For more information about COBRA, refer to the Notice of COBRA Continuation Coverage Rights in this handbook.
- Eligible dependents may be added to your retiree benefits only in certain situations, as described in the "Coverage Changes" section in this handbook.

Am I required to provide proof of dependent eligibility?

Retirees who add dependents due to a qualified event (family status change) or during Open Enrollment must provide proof of dependent eligibility in order for the dependent to be added. **Documentation must be submitted to Chard-Snyder no later than 60 days from the date of the qualified event.**

Which family members are eligible?

- Spouses:
  - Employee's legally married spouse. Common Law marriage partners are <u>not</u> recognized by the state of Florida and are <u>not eligible</u>
  - Former spouses are <u>not eligible</u> under the plan, regardless of any legal settlement (However, separated spouses are eligible as there is no defined "legal separation" in the state of Florida)

- Children (birth to the beginning of the pay period following the end of the month they turn 26):
  - Natural or step children
  - Legally adopted or children who have been placed for adoption
  - Other children for whom the employee is the legal guardian or has legal responsibility for providing medical coverage as defined by a court order

- Children (age 26 to 30):
  - Additional details can be found in this handbook, starting of page. 7

- Children of covered dependent children (grandchildren):
  - Can be covered through the end of the month the child turns 18 months of age if the parent is covered under the plan

- Disabled Children:
  Age 26 or older, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of <u>mental or physical disability which arose while the child was covered</u>

as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

- Children considered to be disabled by a physician for any of the following permanent conditions: Legally blind, legally deaf, suffering from paralysis, mentally disabled, or requires assistance with basic daily activities such as eating and bathing.
- Children considered to be disabled through Social Security Administration regardless of whether the child receives Social Security Income or not.
- Single and incapable of self-care, dependent on employee for support due to physical or mental disability
- Disability must occur before child eligibility ceases due to age

Am I required to provide proof of dependent eligibility?

Employees who add dependents within 60 days of a qualified life event, or during open enrollment, must provide proof of dependent eligibility in order for the dependent to be added. Applicable dependent documentation must be provided with enrollment requests.

Required Documentation for Spouse

Please provide clear copies of the original documents. Illegible photocopies of your dependent documentation will not be accepted.

- The legal Marriage License/Certificate from a government or regulatory agency shall be used to enroll a spouse into the benefits offered*, and

- Employees will be subject to periodic audits by the County, or its designee. A full dependent audit shall be conducted at the Comptroller's discretion. Acceptable supporting documents shall be determined by the auditor in accordance with Generally Accepted Auditing Standards (GAAS).

**Marriage licenses written in a foreign language must be officially translated by a translation organization before being submitted to the county's third-party billing provider.*

Note: *In addition to the dependent documentation listed above, your marriage date, spouse's date of birth, and spouse's social security number are required for enrollment. Please contact HR Benefits for assistance if your spouse is working through the immigration process but has not yet obtained a SSN. Utilizing an ITIN may be a temporary option.*

Required Documentation for Dependent Children

Birth Child Under Age 26	Stepchild Under Age 26	Adopted Child or Child Placed for Adoption Under Age 26
❑ Official Birth Certificate* *(Hospital certificate will not be accepted, parents must be listed)*	❑ Copy of birth certificate* or proof of other dependent relationship, and ❑ Copy of employee's legal marriage license to stepchild's parent, and ❑ Verification of current marital status (see above requirements verification of current relationship status)	❑ Adoption Certificate, or ❑ Placement Letter (document establishing placement preceding a formal adoption)
Child under Age 26 for Whom You Are the Legal Guardian	**Child of a Covered Dependent (Grandchild) Under 18 months**	**Disabled Child**
❑ Proof of legal guardianship[1]	❑ Official Birth Certificate* or birth record *(covered dependent's name must be listed as parent)*, and ❑ Verification that parent of child is eligible and covered as dependent child noted above	❑ Official Birth Certificate*, and ❑ Proof of continuous coverage (no break in coverage), and ❑ Social Security Administration award letter, or ❑ A recent Social Security Income statement, or ❑ A signed physician's statement.

**Birth certificates written in a foreign language must be officially translated by a translation organization before being submitted to the county's third-party billing provider.*

Note: *In addition to the dependent documentation listed above, your dependent's name, date of birth, and social security number are required for enrollment. Please contact HR Benefits for assistance if your dependent is working through the immigration process but has not yet obtained a SSN. Utilizing an ITIN may be a temporary option.*

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

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

Dependent Eligibility Changes

It is the **responsibility of the retiree** to notify the county's third-party billing provider within **60 days** of a change in dependent eligibility, especially if eligibility is lost. Failure to remove ineligible dependents from the plan within 60 days is considered fraud against the plan and may result in disciplinary action, including fines for premiums and/or claims.

Any retiree failing to provide the required information and documentation, or falsifying information and documentation, or listing ineligible individuals as eligible dependents, shall cause his or her dependents to be removed from the County's retiree benefit plans. Additionally, the retiree may be excluded from coverage altogether under the County's benefit plans.

When does coverage end?

If	Coverage Ends
You stop working for Orange County, retire or pass away	The end of the pay period in which your employment or eligibility ends
You are already retired, and you pass away, or you no longer meet eligibility requirements	The end of the month in which your eligibility ends
You choose to stop coverage for yourself and/or your dependents because of a qualified event	Upon approval, but no earlier than the beginning of the month following the receipt of the completed new election form by Chard Snyder
Your dependents no longer meet the eligibility requirements (divorce, death, age, etc.)	Upon approval, but no earlier than the beginning of the month following the receipt of the completed new election form by Chard Snyder
You choose to stop coverage for yourself and/or your dependents during the open enrollment period	The last day of the current calendar year

When will your FSA end?

If you stop working for Orange County due to termination or retirement, your Medical or Limited Purpose FSA will be discontinued on the date you cease to be an employee, but you may be reimbursed for qualifying expenses that were incurred on or before that date. *You must submit claims for reimbursement within 90 calendar days after your termination.* This is called the "run-out period."

You may continue to use your FSA funds after you terminate employment or retire only if you continue the plan and pay premiums through COBRA. For more information about COBRA, see the Notice of COBRA Continuation Coverage Rights in this handbook.

Optional Coverage for Dependents Age 26-30

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

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

Age 26-30 dependent eligibility

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

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

Cost of age 26-30 dependent coverage

For these dependents, the full cost of the plan premium is required plus a 2% administrative fee. For 2024, that amount is $1,009.67 per month for the OrangePrime Plus Plan (HDHP) or $1,099.82 per month for the OrangePrime Plan (LDHP). Premiums for these dependents will be billed directly by Chard Snyder, our third-party administrator.

Enrolling age 26-30 dependent(s)

Contact Chard-Snyder to enroll. After signing up, Chard-Snyder will send payment coupons with the monthly payment amount for the elected plan(s).

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

Waiver of Coverage Provision

You and your dependents must be enrolled in insurance at the time of retirement in order to continue the insurance at retirement. For example, if you only have medical coverage at the time of retirement, you are only eligible for medical as a retiree and cannot add dental or vision coverage. Furthermore, once you terminate participation in the County's group health insurance plans, you and your eligible dependents are excluded from future participation in the terminated plan(s). For example, if you waive dental, you are no longer eligible for any of the County's group dental plans in the future.

The only exception to the waiver of coverage provision is if your spouse is covered as an employee under the County's group health insurance plans, and you are a covered dependent of your spouse. You can then elect like coverage when you are no longer covered as a dependent of your spouse.

Coverage Changes

Certain changes to your coverage are permitted as qualified events during the year or during annual open enrollment, as explained in the chart below.

Benefit	Change Desired	Open Enrollment	Qualified Event
Medical	Dependent may be added	No	✓
	Dependent may be dropped	✓	✓
	Plan may be changed (HDHP to LDHP, etc.)	✓	No
	Plan may be waived*	✓	✓
Dental	Dependent may be added	✓	✓
	Dependent may be dropped	✓	✓
	Plan may be changed (High to Middle, etc.)	✓	✓
	Plan may be waived*	✓	✓
Vision	Dependent may be added	✓	✓
	Dependent may be dropped	✓	✓
	Plan may be waived*	✓	✓

**Once you waive coverage, you are permanently excluded from returning to that plan.*

Exception regarding changing medical plans midyear

As demonstrated in the chart above, you cannot change medical plans midyear, with one exception. Once you turn age 65, you are eligible to join the County's Medicare Supplement Plan. Your covered spouse, if not yet Medicare eligible, will be allowed to remain on the regular medical plan that s/he was previously covered on until s/he turns age 65, as long as you are enrolled in one of the County's Medicare Supplement or Advantage plans.

Switching plans at the time of retirement

Yes. Upon retirement, you can enroll in a different medical and/or dental plan. For example, if you are currently covered on the High Plan as an active employee, you can either keep this plan or you can choose to switch to the Low Plan.

Qualified Event (family status change)

As outlined in the "Coverage Changes" chart, you can make certain changes to your benefits during the retiree annual open enrollment period. In addition, if you experience a Qualified Event, you may be permitted to make additional changes. **You must contact Chard-Snyder to process any Qualified Event changes within 60 days of the event date**. Proof of the event will need to be sent to Chard Snyder.

Qualified events allowing a family status change are as follows (not an all-inclusive list):

- Marriage
- Divorce
- Death of a spouse or child
- Birth or adoption of a child
- Termination of dependent's employment
- Significant change in dependent's coverage
- Change in dependent's employment (part-time to full-time or vice versa)
- Enrollment in Medicare or Medicaid
- Loss or gain of dependent eligibility
- Loss of coverage elsewhere

Keep your address updated!

In the fall of each year, you will receive an open enrollment informational packet to the address on file. If you wish to make changes during open enrollment, you must follow the instructions contained in the informational packet. Because of this and other important mailings you may receive concerning your retirement benefits, it is important to always keep your address updated with the Orange County Benefits, Florida Retirement System (FRS), and with Chard-Snyder, the retiree billing administrator (see contact information in the back of this book).

Paying for Your Benefits after Retirement

Retirees enrolled in any of the County's retiree group plans will be billed monthly by Chard Snyder, our retiree billing administrator. Premiums may be paid by check, automatic bank draft or as a deduction from the FRS pension check. Upon retirement, Chard-Snyder will send you a welcome letter and coupon book. If you want to have FRS deductions, contact Chard-Snyder for the FRS authorization form, and return it to Chard-Snyder for processing.

Note: The monthly premiums for retiree medical coverage vary based on your Medicare eligibility. Monthly premiums are listed separately in the rates section of this handbook.

Retiree Medical Plan Options

Orange County currently offers the following medical plan options for retirees:

- OrangePrime Plus Plan (HDHP)
- OrangePrime Plan (LDHP)
- Medicare Supplement Plans
- Medicare Advantage Plan

What is an annual deductible?

An annual deductible is the amount of expenses that must be paid by you during the plan year before the insurance plan will start sharing costs. However, preventive care is covered at 100%, even prior to reaching the deductible. When you are covering dependents on the plan, one member can meet the deductible for the entire family, or it can be met by a combination of members. The in-network deductible for both plans are detailed in the *Medical Plan Comparison Chart* in this booklet. Remember, with the OrangePrime Plan, none of the funds you spend on co-pays will count toward your annual deductible.

Is the deductible for medical separate from the pharmacy deductible?

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

What is coinsurance?

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

What are the copays?

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

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

No. Co-pays will count toward your out-of-pocket maximum.

What is an out-of-pocket maximum?

The out-of-pocket maximum is the most that you will have to pay in a year for deductible, coinsurance, and copayments for covered medical and pharmacy benefits. It does not include premiums. It's like a safety net, to protect you from high costs in case you have a bad year. The in-network out-of-pocket maximums are detailed in the Medical Plan Comparison Chart in this booklet. When you are covering dependents on the plan, one family member can reach the out-of-pocket maximum for the entire family, or it can be met by a combination of family members.

Is there a pre-existing condition clause?

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

Do I need a referral to see a specialist?

No. Both the HDHP and the LDHP are open access plans, which means you have the freedom to access medical care at any time through any participating network physicians, including specialists, without a referral.

What does medical coverage cost?

Please refer to the premium section of this handbook.

OrangePrime Plus Plan (HDHP)

The HDHP is a consumer driven health plan called the Choice Fund Open Access Plus HSA Plan and is offered through Cigna with an optional Health Savings Account (HSA). Pharmacy coverage is included and managed by Cigna. This is the same plan that is currently offered to our active employees.

The HDHP is made up of three parts:

- Medical Plan
- Pharmacy Plan
- *Optional* Health Savings Account

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

The HDHP is made up of two parts – the medical plan and the optional HSA contributions:

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

  The Cigna Plan has a national network, but also allows you to access care out-of-network. However, you will have a separate deductible and out-of-pocket maximum for out-of-network services, and it will not be combined with the expenses you have incurred in-network. The deductible, coinsurance, and out-of-pocket maximum amounts are listed in the *Medical Plan Comparison Chart* in this handbook.

- Optional Health Savings Account (HSA):
  - Helps you pay for your eligible medical and pharmacy expenses
  - Carries over from year to year and goes with you when you retire
  - Reduces your taxes three ways:
    - Money deposited is considered non-taxable
    - You pay no tax on the interest you earn
    - Withdrawals for eligible expenses are tax-free

HSA Eligibility

According to the IRS, to be an eligible individual allowed to contribute to an HSA, you must meet the following requirements:

- You must be covered under a high deductible health plan (HDHP)
- You may not have other health coverage that is not HDHP including TRICARE, TRICARE for Life, Medical Flexible Spending Account (yours or your spouse's)
- You are not enrolled in Medicare (A, B, C or D)
- You cannot receive VA medical benefits within the three months prior to making a contribution
- You cannot be claimed as a dependent on someone else's tax return
- Note: once you join Medicare, you can no longer fund your HSA, but you can still spend the remaining HSA dollars on eligible health related expenses

<u>You can use your existing bank through Cigna or your own bank</u>

You have the option of opening an HSA with any financial institution you choose, and you can contribute directly to your HSA. The contributions are tax deductible so you can claim them on your taxes each year, thus reducing your taxable income. As a retiree on the County's medical plan, you also have the option of opening or continuing your HSA through Cigna.

HSA Contributions

The IRS sets the maximum contributions amounts on an annual basis. However, amounts that roll over from year to year are not included and can accumulate as high as you like. If you accidentally contribute more than the annual maximum to your HSA, you should contact your HSA bank to correct this situation so that you don't have to pay income tax or IRS penalties on the additional contribution.

The 2024 maximum contribution amounts are as follows:

- Retiree only (single coverage): $4,150
- Retiree with dependents (family coverage): $8,300
- Catch-Up Contribution: $1,000*

The maximum amount is based on the medical coverage you have, not how you file your taxes. Even if you file married/jointly, if you are only covering yourself on the medical plan (single coverage) your maximum is $4,150.

Note: The County will not make a contribution to the HSA on behalf of a retiree.

**If you are 55 or older, there is an additional "catch-up" contribution amount of $1,000 per year. If you and your spouse are both over age 55 (and both are covered on the medical plan), then your spouse can also open up their own HSA through a bank of their choosing and put in an additional $1,000 in catch-up contributions. For more information regarding HSA regulations, you should contact your HSA bank or view the regulations at: www.IRS.gov*

OrangePrime Plan (LDHP)

The LDHP is a hybrid plan called the Open Access Plus. It combines elements of a deductible plan with a traditional co-pay plan. There is an included pharmacy plan administered through Cigna. This is the same plan currently offered to our active employees and is not an HSA eligible plan.

The OrangePrime Plan is made up of two parts:
- Medical Plan
- Pharmacy Plan

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

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

- You pay copays year-round for the following services:
  - Doctor's office visits
  - Specialist office visits
  - Urgent Care
  - Prescriptions
  - Outpatient Mental Health/Substance Abuse

- The remaining medical services are subject to the following plan design:
  - You pay the Co-insurance of 20% after you meet the calendar year deductible for all other medical services
  - Co-pays and co-insurance amounts that you pay contribute to the out-of-pocket maximum
  - Preventive care coverage of 100%, even before you reach your deductible

Medical Coverage through Cigna

- Annual Deductible, Copayments, Coinsurance, and Out-of-Pocket Maximum
- Preventive care coverage of 100%, even before you reach your deductible

The Cigna Plan has a national network, but also allows you to access care out-of-network. However, you will have a separate deductible and out-of-pocket maximum for out-of-network services, and it will not be combined with the expenses you have incurred in-network. The deductible, copayments, coinsurance, and out-of-pocket maximum amounts are listed in the Medical Plan Design Summary chart in this handbook.

Medical Plan Design Summary and Comparison

Benefit	OrangePrime Plus Plan (HDHP)		OrangePrime Plan (LDHP)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
DEDUCTIBLE *Individual/Family*	$1,600 / $3,200	$3,000/ $6,000	$1,250 / $2,500	$3,000 / $6,000
OUT-OF-POCKET MAX *Individual/Family*	$3,000 / $6,000	$6,000 / $12,000	$3,000 / $6,000	$6,000 / $12,000
Preventive Care	$0	***50% after Deductible	$0	***50% after Deductible
Telehealth	$10 after Deductible	*50% after Deductible	**$10 co-pay	*50% after Deductible
Primary Care	$30 after Deductible	*50% after Deductible	**$30 co-pay	*50% after Deductible
Specialist	$50 after Deductible	*50% after Deductible	**$50 co-pay	*50% after Deductible
Inpatient Hospital Admission	20% after Deductible	*50% after Deductible	20% after Deductible	*50% after Deductible
Outpatient Surgery (Non-Hospital)	20% after Deductible	*50% after Deductible	**$150 co-pay	*50% after Deductible
Outpatient Surgery (Hospital Based)	20% after Deductible	*50% after Deductible	20% after Deductible	*50% after Deductible
Advanced Imaging (Hospital Based)	20% after Deductible	*50% after Deductible	20% after Deductible	*50% after Deductible
Advanced Imaging (Freestanding Facility)	20% after Deductible	*50% after Deductible	**$150 co-pay	*50% after Deductible
Urgent Care	20% after Deductible	*20% after Deductible	**$50 co-pay	*20% after Deductible
Emergency Room	20% after Deductible	*20% after Deductible	20% after Deductible	*20% after Deductible
Ambulance	20% after Deductible	*50% after Deductible	20% after Deductible	*50% after Deductible
Home Healthcare	20% after Deductible	*50% after Deductible	20% after Deductible	*50% after Deductible
Durable Medical Equipment	20% after Deductible	*50% after Deductible	20% after Deductible	*50% after Deductible
Short-Term Rehabilitation/Therapy	20% after Deductible	*50% after Deductible	20% after Deductible	*50% after Deductible
Mental Health/Substance Abuse (inpatient)	20% after Deductible	*50% after Deductible	20% after Deductible	*50% after Deductible

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

**OrangePrime plan copays do NOT apply to the deductible but are applied to the out-of-pocket maximum.
**$150 copay per type of scan per day, and plan pays 100%

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

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

Prescription Drug Coverage

What Prescription Drug Plan is available?

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

<table>
<tr><th></th><th colspan="3">OrangePrime Plus Plan</th><th colspan="3">OrangePrime Plan</th></tr>
<tr><td>Retail –
30-day supply</td><td colspan="3">Preventive* Drugs: Before and after your deductible is met, you pay according to the 4-tier schedule below (does not count toward your deductible but does count toward your out-of-pocket max).

Treatment Drugs: You pay full price until your deductible is met. AFTER your deductible is met, you pay according to the 3-tier schedule below.</td><td colspan="3">Preventive* and Treatment Drugs: Before and after your deductible is met, you pay according to the 4-tier schedule below.

(Note: Prescription copays do not count toward your deductible but do count toward your out-of-pocket max on this plan.)</td></tr>
<tr><td></td><td>Tier 1
Tier 2
Tier 3
Tier 4</td><td>Generic
Preferred
Non-Preferred
Specialty</td><td>$10
10% + $30
10% + $50
10% +$100</td><td>Tier 1
Tier 2
Tier 3
Tier 4</td><td>Generic
Preferred
Non-Preferred
Specialty</td><td>$10
10% + $30
10% + $50
10% +$100</td></tr>
<tr><td>Express Scripts Home Delivery – 90-day supply</td><td colspan="3">Preventive* Drugs: Before and after your deductible is met, you pay according to the 4-tier schedule below (does not count toward your deductible but does count toward your out-of-pocket max).

Treatment Drugs: You pay full price until your deductible is met. AFTER your deductible is met, you pay according to the 4-tier schedule below.</td><td colspan="3">Preventive* and Treatment Drugs: Before and after your deductible is met, you pay according to the 4-tier schedule below.

(Note: Prescription copays do not count toward your deductible but do count toward your out-of-pocket max on this plan.)</td></tr>
<tr><td></td><td>Tier 1
Tier 2
Tier 3
Tier 4</td><td>Generic
Preferred
Non-Preferred
Specialty</td><td>$25
10% + $75
10% + $125
10% + $200</td><td>Tier 1
Tier 2
Tier 3
Tier 4</td><td>Generic
Preferred
Non-Preferred
Specialty</td><td>$25
10% + $75
10% + $125
10% + $200</td></tr>
</table>

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

Is there a deductible for pharmacy?

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

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

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

What is Step Therapy?

It is a prior authorization program designed for you and your doctor to take one step at a time when choosing your medication. It works to help you find the most affordable medication appropriate for the treatment of a diagnosed condition, for example, high cholesterol.
Often, you and your doctor have a choice of several different safe and effective prescription drugs to treat the same condition. Cost is often the biggest difference. Brand-name medications usually are the most expensive, while generic medications are the least expensive.

Several common ongoing medical conditions are subject to Step Therapy:

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

How Does Step Therapy Work?

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

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

Does Our Pharmacy Plan Have Home Delivery?

Yes. With Cigna you receive home delivered prescriptions through Express Scripts Pharmacy. This benefit allows you to receive a 90-day supply of maintenance medications through the mail at a reduced co-pay, once the deductible has been met, if applicable.

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

Are smoking cessation drugs covered?

Yes, there are smoking cessation drug options in all three tiers. Generic prescription smoking cessation medications are included at a $0 co-pay and are excluded from the deductible.

Pharmacy Coverage through Cigna

All members enrolled in the OrangePrime Plan (LDHP) will have Medical and Prescription Drug coverage through Cigna. Remember, on this plan all expenses incurred for prescription drugs are not counted toward your deductible, but they are counted toward your out-of-pocket max. The co-pay/coinsurance schedule is included in the Medical Plan Design Summary chart in this handbook.

All members enrolled in the OrangePrime Plus (HDHP) will also have Medical and Prescription drug coverage through Cigna. Please note, however, treatment medications are subject to your deductible and are counted toward your out-of-pocket max.

Cigna has partnered with Orange County to offer programs to better educate members on prescription drug options and lower cost alternatives. These programs are the same as previously explained in the section above.

Medicare Advantage and Medicare Supplement Plans

Orange County offers our Medicare eligible retirees (and their covered spouses) the option of electing a cost-saving Cigna Medicare Advantage or Medicare Supplement Plan. Options are available for retirees (and their covered spouses) age 65 or older who are enrolled in Medicare Part A and Part B. Likewise, these plans are also available for retirees under age 65 (and their covered dependents) who are eligible for Medicare through disability.

Cigna Medicare Advantage and Medicare Supplement Plans provide help covering the out-of-pocket medical costs not paid by traditional Medicare. This helps to protect participants from having to pay high out-of-pocket expenses like co-insurance, co-payments, and deductibles. With no network restrictions, these plans offer access to your choice of doctors and specialists if you need them, as long as they accept Medicare.

Enrollment in one of the Cigna Medicare Advantage and Medicare Supplement Plans enables retirees to retain affiliation with the Orange County group. There are various plans to choose from (plans vary in MN, MA, and WI).

Cigna Surround Medicare Plan (Part A and B)

Orange County Government offers the Cigna Medicare Surround Supplement Plans G, F and N. If you enroll in one of the Supplement plans you must also enroll in one of the Cigna RX Medicare (Part D) Prescription Drug Plans (Low or High).

Due to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Plan F cannot be sold to "newly eligible" Medicare beneficiaries on or after January 1, 2020. This applies to the Florida Medicare Surround plan only. Our non-Florida Medicare Surround Plans are filed as indemnity plans so MACRA does not apply.

- Plan F can continue to be offered to retirees who are currently enrolled in that plan and/or became Medicare eligible prior to 01/01/2020.
- Plan G will be offered to retirees who became Medicare eligible on or after 01/01/2020. Medicare deductible applies.
- The difference between Plan F and G is that Plan G does not cover the Part B deductible.
- Like Plan G, Plan N does not cover the Part B deductible and also has copays for provider and emergency room visits.

Cigna Surround Medicare Plans (Part B) Comparison Chart

Benefits	Plan G	Plan F	Plan N
Part A Coinsurance plus 365 additional hospital days after Medicare benefits and Hospital Costs	✓	✓	✓
Part B (Medical) Coinsurance or Copayment	✓	✓	Copay[1]
Blood (First Three Pints)	✓	✓	✓
Hospice/Respite Care Coinsurance or Copayment	✓	✓	✓
Skilled Nursing Facility Care Coinsurance	✓	✓	✓
Part A Deductible	✓	✓	✓
Part B Annual Deductible		✓	
Part B Excess Charges	✓	✓	
Foreign Travel Emergency Care[2]	80%	80%	80%

1 - Plan pays Part B coinsurance or copayment except for an insured copay of up to $20 for each doctor's office visit and up to $50 for each emergency room visit (emergency room copay waived if admitted as inpatient).

2 - Beneficiaries must pay a separate deductible for a foreign travel emergency ($250 per year) and a lifetime maximum benefit of $50,000 applies.

Cigna RX Medicare (PDP) (Part D)

Orange County retirees who enroll in one of the Medicare Supplement Plans (Plan G, F, or N) must also enroll in one of the two Medicare Part D Prescription Drug Plans (Low or High). While it appears to have two separate charges, Chard Snyder, the County's retiree billing administrator, will combine the billing with a single bill for your convenience.

Basic components of the Orange County Retiree Part D plan – Cigna Medicare Rx

Highlights of the Cigna Medicare RX High Plan	Highlights of the Cigna Medicare RX Low Plan
❑ No deductible ❑ $3,000 Out-of-pocket Maximum ❑ Generic copay during the Medicare Part D Coverage Gap, commonly referred to as the "donut hole" ($5,030-$8,000) ❑ Utilizes the Medicare National Preferred Drug Formulary	❑ No deductible ❑ Lower Generic Copay ❑ Generic copay during the Medicare Part D Coverage Gap, commonly referred to as the "donut hole" ($5,030-$8,000) ❑ Utilizes the Medicare National Preferred Drug Formulary

Part D prescription co-pays are as follows:

Rx Benefits	High Plan	Low Plan
Deductible	$0	$0
Maximum Out-Of-Pocket	$3,000	N/A
Initial Coverage Period		
Tier 1	$10	$5
Tier 2	$30	$45
Tier 3	$50	$75
Tier 4	$50	33%
Coverage Gap		
Tier 1	$10	$5
Tier 2	$30	25%
Tier 3	$50	25%
Tier 4	$50	25%
Catastrophic Coverage True Out of Pocket	$8,000	
Generic	$0	
Brand	$0	

Cigna Medicare Advantage True Choice (Part B and Part D)

The Medicare Advantage PPO includes both Medical (Part A and Part B) and Prescription (Part D) coverage in one combined plan. The Medicare Advantage plan offers the freedom to use any provider or facility of choice and does not require you to select a primary care physician or obtain referrals. You pay the same cost-share whether you see an in-network or out-of-network provider.

Cigna True Choice Medicare (PPO)

Cigna True Choice Medicare (PPO) is a national Medicare Advantage plan available to retirees in Florida and across the country. Retirees have nationwide access, including when traveling. The plan provides the freedom to see any provider who participates in Medicare and accepts the Cigna plan, in-network, or out-of-network, at the same cost share with no referrals required.

This new enhanced plan has no member cost share for all covered medical benefits and adds new programs and services to support your health, well-being, and peace of mind.

- **Lower monthly premiums** for you compared to the Medicare Supplement and Medicare Rx Part D options
- **One combined rate** for your medical and pharmacy coverage

- Integrated Medicare Part D prescription drug coverage with one ID card and dedicated customer service

- Caregiver support services is available to you and your family to help ease the impact of caregiving.

- In-home support provides a helping hand with everyday tasks and companionship through our partner Papa Pals.

- Home life resources and referral services are available online or over the phone for a range of topics, including aging, healthy eating, home repair and improvements, pet care, and more.

- Yearly Health Check-ups review every aspect of your overall health and well-being, going beyond a normal yearly Medicare wellness exam at no added cost to you.

- Cigna Medicare Advantage Incentives program allows you to earn up to $200 in incentives for completing your Yearly Health Check-up and other healthy activities.

- Retiree-focused care coordination and disease management programs support the specific needs of Medicare beneficiaries.

- Routine Hearing and Vision exams with hearing aid and eyewear allowances.

- Quarterly over the counter allowance for retail and home delivery products through our partner, Convey.

- Non-Emergent Medical Transportation through our partner, Access2Care Transportation

- Silver & Fit healthy aging and exercise program includes a network of more 16,000 fitness centers, home-based fitness programs, coaching, and much more, at no cost to you.

- The Home Delivered Meals program can help make your transition home more comfortable and safer after an inpatient hospital stay.

- 24/7 virtual care allows you to connect with doctors by phone or video for non-emergency care from anywhere.

- Health-related education and guidance, support available 24 hours a day with Cigna's Health Information Line.

- Online access to personalized tools and resources with myCigna.com and the myCigna app.

- Healthy Rewards offers savings on a variety of health and wellness products and programs.

Selecting Your Health Plan

To sign up to continue coverage under the High Deductible or Low Deductible Health Plans, you will simply make that designation at the time of your retirement appointment with an Orange County Benefits Team member.

To sign up for the Medicare Advantage or the Medicare Surround Plan with PDP plan:

- Notify the Benefits Team at least two month prior to your retirement appointment, so they can have you added to the eligibility roster and generate an informational kit. You will receive the kit by mail from Chard Snyder, our retiree billing administrator

- Turn in your application to Chard-Snyder who will complete your enrollment to the plan of your choice.

Tip: Sign up for the Medicare Advantage or Medicare Supplement plan initially to avoid complications! By signing up for the plan when you first become eligible (either by turning age 65 or newly retiring at or over age 65), you will be guaranteed acceptance without having to complete medical underwriting (evidence of insurability). Save yourself the headache!

Important Notice about Medicare

After retirement, you and/or your covered dependents must enroll in Medicare Part A and Part B when you are first eligible (by age or disability). The County's medical plan will ALWAYS be the secondary payer for all Medicare-eligible retirees and covered dependents. Cigna will pay all medical claims for retiree plan members eligible for Medicare, due to age or disability, as secondary to Medicare – even for those who fail to enroll in Medicare Part A and Part B. Therefore, if you fail to sign up for Medicare Part A and Part B when you are first eligible, you could end up with very high out-of-pocket costs for all services you receive. Further, if you delay signing up for Medicare Part A and Part B, you may face a penalty from Medicare for late enrollment.

As a retiree, aged 65 or older, you **MUST** sign up for Medicare!

Note for active employees: As an active employee, you can defer your Medicare enrollment until the time of your retirement. However, if you defer it beyond retirement, you will face a late entrant penalty from Medicare.

Dental Insurance

Orange County offers three dental plans for retirees, currently offered by Cigna. The level of benefit will vary depending on the plan selected. Information regarding the benefits available under the dental plans is recorded in the applicable certificates of coverage.

- The Low Plan pays 100% of preventive and diagnostic care services with no deductible, 60% of basic services and 30% of major services for in-network or out-of-network coverage, after deductible.
- The Middle Plan pays 100% of preventive and diagnostic care services with no deductible, 70% of basic services and 40% of major services for in-network or out-of-network coverage, after deductible.
- The High Plan pays 100% of preventive and diagnostic care services with no deductible, 80% of basic services and 50% of major services for in-network or out-of-network coverage, after deductible.

What about the network?

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

What is a progressive plan maximum?

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

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

Is there a late entrant penalty?

No. The County's dental plans do not have a late entrant penalty.

Dental Plan Comparison Chart

Benefits	Low Plan	Middle Plan	High Plan
Annual Maximum paid by insurance	$1,000 per person per calendar year	$1,000 per person per calendar year	$1,500 per person per calendar year
Progressive Maximum	$250 per year up to $1,750	$250 per year up to $1,750	$250 per year up to $2,250
Calendar Year Deductible	$50 per individual $150 per family	$50 per individual $150 per family	$50 per individual $150 per family
Preventive Services (Oral exams, cleanings, routine x-rays, fluoride)	100% - No Deductible	100% - No Deductible	100% - No Deductible
Basic Services (Sealants; fillings; oral surgery; root canals; repairs to dentures, bridges, and crowns)	Employee pays 40%, after deductible has been met	Employee pays 30%, after deductible has been met	Employee pays 20%, after deductible has been met
Major Services (Periodontics, dentures, bridges, crowns, inlays, onlays)	Employee pays 70%, after deductible has been met	Employee pays 60%, after deductible has been met	Employee pay 50%, after deductible has been met
Orthodontia (Coverage for eligible children only up to age 19)	Not covered Select network orthodontists provide a 15% discount for adults. Contact your provider for more details.	Employee pays 60%, no deductible Lifetime limit of $1,000 Select network orthodontists provide a 15% discount for adults. Contact your provider for more details.	Employee pays 50%, no deductible. Lifetime limit of $1,000 Select network orthodontists provide a 15% discount for adults. Contact your provider for more details.

Details regarding specific eligibility, coverage exclusions, definitions, and other information are included in the full Certificate of Coverage.

Vision Insurance

Vision coverage is available for Orange County employees and their dependents. Provided by MetLife, the plan covers routine eye examinations, corrective lenses, frames, and contact lenses.

What are the benefits?

Plan Frequencies:

- Exams every 12 months
- Lenses every 12 months
- Frames every 24 months
- Contacts every 12 months

What are the In-Network copayments?

- Vision Examination: $5
- Materials: $15
- Standard Progressive Lenses: $15
- Tiers 1-3 Progressive Lenses: $110-$225
- Frames $175-$200 allowance *
- Contacts $175 allowance

Can I order my glasses and/or contacts online?

Yes, Glasses.com, 1-800 Contacts, and ContactsDirect.

Are there any restrictions or limitations?

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

Could I have additional costs?

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

Is LASIK vision correction covered?

National LASIK Network of laser vision correction providers, featuring QualSight, offers Superior Vision members a discount on services. These discounts should be verified prior to service.

What's the difference between this plan & vision under our medical plans?

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

Vision Comparison Chart

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

Vision Services	In-Network	Out-of-Network[1]
Exam Copay	$5	$45 allowance[1]
Materials Copay	$15	N/A
Frames	$175-$200 (after copay) *	Up to $70 (after copay)[1]
Standard Plastic Lenses Per Pair	$15	Up to $30
Conventional Contact lenses (materials) when *Elective*	$30	Up to $105
Disposable Contact lenses (materials) when *Elective*	$175 allowance	Up to $105
Contact Lenses (materials) when *Medically Necessary*	Covered in full *With prior authorization*	Up to $210
Contact lens Fitting & Follow-up. *(Standard Fit)*	Covered in full after $30 Co-Payment	Applied to the allowance for contact lenses
Contact lens Fitting & Follow-up. *(Premium Fit)*	Covered in full after $30 Co-Payment	Applied to the allowance for contact lenses
Laser Vision Correction	Discounts available through Qualsight	N/A

*Depending on the provider, retail allowance will either be $200 or $175 with 20% off balance over $175. Contact MetLife for more information.

[1] Vision benefits received from Out-Of-Network providers are reimbursed by filing a claim.

Details regarding specific eligibility, coverage exclusions, definitions, and other information are included in the full Certificate of Benefits.

Paying for Your Dental and Vision Insurance

If you enroll in one of the dental or vision plans, you will be billed monthly by our retiree billing administrator. You may pay your premiums by check, automatic bank draft, or as a deduction from your FRS pension check. The monthly premiums for retiree dental and vision are listed in the rates section of this book.

Section 2: Health Insurance Subsidies

Florida Retirement System Health Insurance Subsidy

The Florida Retirement System (FRS) provides eligible retirees with a health insurance subsidy (HIS) to help offset the cost of medical insurance premiums. Proof of insurance will be requested by the FRS when you apply for the subsidy. Once satisfied, the Division of Retirement will pay $5.00 for each FRS year of service, excluding time in DROP, not to exceed $150.00. The subsidy amount will be added to the retiree's FRS benefit payment each month.

Eligibility for Pension Plan Retirees

You must meet the FRS normal or early retirement requirements to be eligible for the FRS health insurance subsidy.

Eligibility for Investment Plan Retirees

- You must have at least six years of FRS service (or 8 years if hired on or after 7/1/2011); and
- You must meet the normal FRS pension plan age or service retirement requirements; and
- Must have taken a distribution from your investment account

Note: If you leave FRS employment and take a distribution prior to the normal retirement age or date, you must wait until the normal retirement age to begin receiving your HIS benefit.

Enrollment

- Shortly before your first pension check, retirees under the Pension Plan or terminating from DROP will receive a packet in the mail from FRS. The packet will contain:
  - FRS Health Insurance Subsidy Application
  - Direct Deposit Form and
  - Withholding Preference Certificate
- Investment Plan retirees are responsible for requesting the FRS Health Insurance Subsidy Application from FRS (if eligible). **FRS will not automatically send the application to you.** You may request the form when requesting your first distribution.

Income Taxes on Your Health Insurance Subsidy (HIS)

Your HIS benefit is taxable income, but you may not have to pay income taxes on all or part of your HIS if your health insurance premiums are deducted each month from your retirement FRS benefit payments.

The amount of your HIS payments excludable from taxable income is based on the total of your HIS payments and your total health insurance premium amount paid during the calendar year. If your health insurance premium is more than your HIS payment, your entire annual HIS amount will be excluded from your taxable income. However, if your health insurance premium is less than your HIS payment, only the portion of the HIS payment equal to the health insurance premium deducted will be excluded from your taxable income. The remaining portion of your HIS payment is treated as taxable income. *One exception applies: Although Medicare coverage qualifies you to receive the HIS, the IRS does not allow you to treat your Medicare premium payments as tax-exempt income. The FRS determines your eligibility for the HIS tax exclusion before preparing your Form 1099-R and adjusts your taxable income amount accordingly. 1099-R Forms are issued by FRS in January, for additional questions please contact FRS directly.*

Orange County Health Insurance Subsidy

The Orange County Health Insurance Subsidy (HIS) is available to eligible retirees to help offset the cost of medical insurance premiums. The subsidy is available for the **retiree only** and does not include dependent coverage. Retired employees of Orange County will receive $5.00 per month for each **whole year of service**, including service time in DROP, up to $150.00 per month (30 years of service). The minimum subsidy shall be $30.00 per month.

Eligibility

In order to receive the County HIS, retirees must meet **all** of the following criteria:

- Must be retired. An employee is considered retired if he or she qualifies for and begins to receive the FRS Health Insurance Subsidy.
- Must be an active employee with the County at the time of retirement with a minimum of ten years of service **OR** have a minimum of twenty years of service **AND** be terminated from the County.
  - The only exception to this rule is separation due to medical disability. In these special cases, an employee must have at least ten years of service, separated due to medical disability, and then retire from the FRS within two years of the date of separation.
- Must not have been terminated due to misconduct.

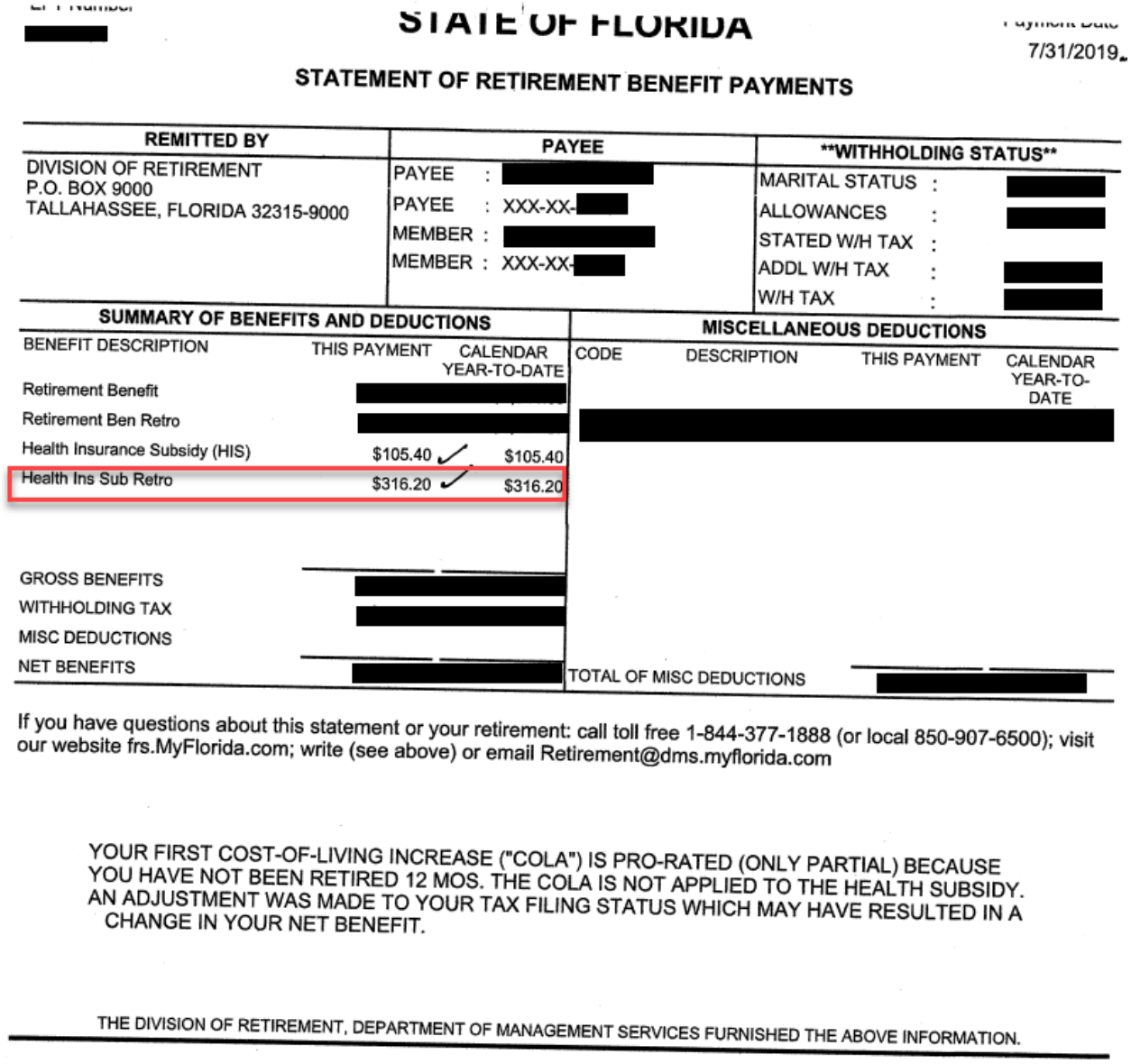
Only full years count toward years of service for the Orange County HIS. The subsidy may stop at any point the County mandates. Please do not plan your retirement based on receiving this subsidy.

Enrollment

- At the time of your retirement appointment, your Benefits Team member will determine if you are eligible for the subsidy and explain the process to receive your subsidy. (Contact the Benefits Team at benefits@ocfl.net for more information)
- Once you begin receiving the FRS HIS, you can apply for the Orange County subsidy, if you meet the above-mentioned eligibility.

Note: *Retroactive Orange County HIS payments are only processed if you receive a retroactive FRS HIS payment AND you provide us with proof of this retroactive payment. It is your responsibility to provide us with proof of your FRS retro payment if you would like an Orange County HIS retro payment. Maximum 6 months of retro.*

Below is an example of what the FRS Statement of Benefits looks like:



STATE OF FLORIDA

7/31/2019

STATEMENT OF RETIREMENT BENEFIT PAYMENTS

REMITTED BY	PAYEE	**WITHHOLDING STATUS**
DIVISION OF RETIREMENT P.O. BOX 9000 TALLAHASSEE, FLORIDA 32315-9000	PAYEE : [redacted] PAYEE : XXX-XX-[redacted] MEMBER : [redacted] MEMBER : XXX-XX-[redacted]	MARITAL STATUS : [redacted] ALLOWANCES : [redacted] STATED W/H TAX : ADDL W/H TAX : [redacted] W/H TAX : [redacted]

SUMMARY OF BENEFITS AND DEDUCTIONS

BENEFIT DESCRIPTION	THIS PAYMENT	CALENDAR YEAR-TO-DATE
Retirement Benefit	[redacted]	
Retirement Ben Retro	[redacted]	
Health Insurance Subsidy (HIS)	$105.40	$105.40
Health Ins Sub Retro	$316.20	$316.20
GROSS BENEFITS	[redacted]	
WITHHOLDING TAX	[redacted]	
MISC DEDUCTIONS		
NET BENEFITS	[redacted]	

MISCELLANEOUS DEDUCTIONS

CODE	DESCRIPTION	THIS PAYMENT	CALENDAR YEAR-TO-DATE
[redacted]			
TOTAL OF MISC DEDUCTIONS		[redacted]	

If you have questions about this statement or your retirement: call toll free 1-844-377-1888 (or local 850-907-6500); visit our website frs.MyFlorida.com; write (see above) or email Retirement@dms.myflorida.com

YOUR FIRST COST-OF-LIVING INCREASE ("COLA") IS PRO-RATED (ONLY PARTIAL) BECAUSE YOU HAVE NOT BEEN RETIRED 12 MOS. THE COLA IS NOT APPLIED TO THE HEALTH SUBSIDY. AN ADJUSTMENT WAS MADE TO YOUR TAX FILING STATUS WHICH MAY HAVE RESULTED IN A CHANGE IN YOUR NET BENEFIT.

THE DIVISION OF RETIREMENT, DEPARTMENT OF MANAGEMENT SERVICES FURNISHED THE ABOVE INFORMATION.

Income Taxes on Your Health Insurance Subsidy (HIS)

All or a portion of your County HIS benefit may be considered taxable income. Orange County Finance will prepare and mail your Form 1099-MISC in January each year and questions regarding taxation should be directed to that office. Please note, Form 1099-MISC is only issued if you've received more than $600 from the County (OC HIS). For additional information, please reach out to the Orange County Comptroller, Accounts Payable department at (407) 836-4548.

Section 3: Miscellaneous- Continuation of Other Benefits & Leave Payouts

Deferred Compensation

Orange County automatically notifies Vanguard, our current 457(b) record keeper of your retirement 2-3 weeks after your Leave Pay from Payroll. Once your "termination date" is submitted to the Vanguard, you will be able to contact them regarding payment options. Vanguard will not be able to provide any information until you have been officially "terminated" from Orange County Government's payroll system.

Tip: Deferred Compensation participants are encouraged to consider adjusting (increasing, decreasing, starting, or stopping) their bi-weekly deferred compensation payroll deduction deferral rate to ensure that only the amount desired is placed into the 457(b) account when your leave payout is processed (see section below). There are strict deadlines regarding changing your deferral rate and the pay period that they take effect.

Your HR representative can provide you with a copy of the Vanguard Payroll Deduction Calendar and you should review the deadlines carefully. In order to adjust your deferral percentage rate, you must log into your account at Vanguard.com by the deadline on the calendar.

Note: *If you retire from the Deferred Option Retirement Plan (DROP), you have the option of rolling your DROP funds directly into your Vanguard account. During your retirement appointment, the Benefits Team can assist you through this process. The only caveat is that you must be a plan participant before your termination date, and you must still have an open account with Vanguard at the time of the rollover.*

Life Insurance

To continue your life insurance policy, you will need to send The Standard your Portability Application or Conversion Request and make your first payment within 60 days of your last day worked. Choosing to continue your life insurance allows you to continue your current policy for Basic and Supplemental policies, without medical underwriting.

If you are under the age of 65, you can buy portable group life insurance coverage or you can convert your group life insurance into an individual whole life policy. If you are 65 or older, you can convert your group life insurance into an individual whole life policy.

If you choose to continue your policy, you will be billed directly from The Standard. For payment options and any additional information please contact The Standard directly.

Employee Assistance Program

Upon retirement, you and your household members will have continued access to employee assistance services through ComPsych, for up to 90 days after your last day of work.

Leave Payouts

The remaining balances of your personal and term leave will be paid in a lump sum in the pay period following your final paycheck for hours worked. If you'd like to roll your final payout of personal and/or term time into your County Deferred Compensation plan, you have the option of increasing your Vanguard deduction up to 100%. Remember to look at the Vanguard calendar to ensure that you change your deductions within the appropriate time frame to ensure the lump sum payout is paid appropriately. Consult your tax professional about the benefits of rolling your lump sum payments into Vanguard.

Types of Leave Payouts:

- Personal Leave
- Term Leave
- Old Sick Leave

Personal Leave Payouts

Employees are eligible to receive a payout of 100% of accrued personal leave time. Employees who enroll in DROP will have the amount of their personal leave payout determined at their DROP Enrollment appointment. The difference between the leave hours sold, and the employee's eligible Personal/Vacation accrual amount is the maximum hours that can be paid out at the end of DROP.

Term Leave/Old Sick Leave Payouts

Employees with 10 or more years of continuous service will be paid 25% of all accrued term leave and/or old sick leave.

Note: If you are contributing to an HSA (Health Savings Account) through payroll deduction at the time of your retirement, the deduction will NOT be taken on your leave payout (final paycheck) and sent to HSA Bank. However, any Vanguard deferred compensation deductions you have scheduled WILL take place (see TIP above for details regarding changing the deferral percentage).

Section 4: Rates

Retiree Monthly Rates (Premiums)

Medical

Plan Option	Single*	Retiree + Spouse	Retiree or Spouse + Child(ren)**	Retiree + Family
OrangePrime Plus (HDHP)	$989.87	$2,079.37	$1,878.90	$2,751.25
OrangePrime (LDHP)	$1,078.25	$2,218.44	$2,020.39	$2,940.29

* **Single** rate will apply to either Retiree, spouse, or one child.
** **Retiree or Spouse + Child(ren)** rate will also apply to coverage for two or more children only.

Dental

Plan Option	Retiree Only	Retiree + 1	Retiree + 2 or More
Low	$15.08	$30.76	$56.24
Middle	$23.10	$47.86	$89.98
High	$37.62	$76.62	$139.22

Vision

Plan	Retiree Only	Retiree + 1	Retiree + 2 or More
Vision	$4.77	$9.53	$13.99

Medicare Reminder:
Members, aged 65 or older, must sign up for Medicare and will no longer be eligible to participate in County medical plans. Once enrolled in Medicare, the County does offer medical and prescription supplemental plan options. Keep in mind, as a retiree, you must continue enrollment in either a County medical or supplemental plan in order to continue coverage for your dependent(s).

Disability:
Members who become disabled and enroll in Medicare prior to age 65, have the option of continuing the County medical plan or enrolling in supplement options.

Cigna Medicare Advantage PPO (Part A, B and Part D) *(Medicare Eligibility Only)*

Cigna Medicare Advantage True Choice (Medical and pharmacy combine)

Plan	Individual
Cigna True Choice Medicare Advantage (PPO)	$357.38

Cigna Surround Medicare Supplement Plans (Part A and B) *(Medicare Eligibility Only)*

For Florida residents living **outside** the 330XX-334XX zip codes

Age Bracket*	Plan G	Plan F	Plan N
Issue Age <65	$449.52	$499.78	$374.81
Issue Age 65-69	$198.03	$220.17	$165.12
Issue Age 70-74	$234.04	$257.40	$198.78
Issue Age 75-79	$265.62	$289.50	$226.53
Issue Age 80+	$300.08	$324.02	$257.13

** You will retain the age bracket you first enrolled with Cigna Surround, unless you change plans.*

For Florida residents living **inside** the 330XX-334XX zip codes
(*Miami-Dade, Broward, Monroe, & Palm Beach Area*)

Age Bracket*	Plan G	Plan F	Plan N
Issue Age <65	577.79	642.38	481.77
Issue Age 65-69	254.53	282.99	212.23
Issue Age 70-74	300.82	330.86	255.50
Issue Age 75-79	341.42	372.11	291.17
Issue Age 80+	385.71	416.49	330.51

** You will retain the age bracket you first enrolled with Cigna Surround, unless you change plans.*

For those living outside Florida

Plan Option	Retiree Only	Retiree Plus 1	Retiree Plus Family
Plan F	$194.00	$388.00	$582.00
Plan G	$157.62	$315.24	$472.86
Plan N	$138.51	$277.02	$415.53

Cigna RX Medicare (PDP) (Part D) *(Medicare Eligibility Only)*

If you elect a Cigna Surround Medicare Supplement Plan (Plan F, G, or N), you must also elect a Cigna RX Medicare (PDP) Plan (High or low).

Plan	
High Plan	$345.88
Low Plan	$179.21

Section 5: Important Notices

Notice of COBRA Continuation Coverage Rights

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

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

Qualifying Events for Covered Employee

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

Qualifying Events for Covered Spouse and Dependent Children

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

- A termination of OCBCC employee's employment, or reduction in hours of employment with OCBCC
- The death of OCBCC employee
- Divorce
- OCBCC employee becomes entitled to Medicare
- Dependent Child ceases to be a "dependent child" under the terms of the plan

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

Election Period and Coverage

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

Length of Continuation Coverage

18 Months:

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

24 Months:

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

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

- Death
- Divorce
- Medicare entitlement
- Dependent child ceasing to be a dependent under the plan terms

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

Other Options

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/ready-to-sign-up-for-part-a-part-b

Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.
If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

COBRA Rates

Medical Plans	EE Only	EE + Spouse	EE + Child(ren)	EE + Family
HDHP	$1,009.67	$2,120.96	$1,916.47	$2,806.27
LDHP	$1,099.82	$2,262.81	$2,060.80	$2,999.09

Dental Plans	EE Only	EE + 1	EE + 2 or more
Low	$15.38	$31.38	$57.36
Middle	$23.56	$48.82	$91.78
High	$38.37	$78.15	$142.00

Vison Plan	EE Only	EE + 1	EE + 2 or more
Coverage	$4.87	$9.72	$14.27

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

Social Security Number Collection Disclosure Statement

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

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

Use and Disclosure of Protected Health Information (PHI)

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

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

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

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

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

B. Use and Disclosure of PHI. The Plan is permitted to use or disclose an individual's PHI without an authorization for:

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

   Activities include but are not limited to:

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

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

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

The Plan Sponsor agrees to the following:

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

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

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

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

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

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

The Orange County Government plan provides comprehensive prescription drug coverage through retail and mail providers. Below is a list of copayments and coinsurances for the OrangePrime Plus Plan (HDHP) and Orange Prime Plan (LDHP). The deductible does apply to non-preventive medications on the OrangePrime Plus Plan.

	Tier 1 Generic	Tier 2 Preferred Brand	Tier 3 Non-Preferred Brand	Tier 4 Specialty
30 Day Supply *(Retail or Mail Order)*	$10	$30 + 10% Coinsurance	$50 + 10% Coinsurance	$50 + 10% Coinsurance
90 Day Supply *(Mail Order)*	$25	$75 + 10% Coinsurance	$125 + 10% Coinsurance	n/a

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

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

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

Note: *Once you retire, if you decide to join a Medicare drug plan and drop your current Orange County Government health plan, be aware that you and your dependents will not be eligible to re-enroll in the Orange County Government health plan.*

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

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

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

For More Information about This Notice or Your Current Prescription Drug Coverage:

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

For More Information about Your Options under Medicare Prescription Drug Coverage:

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: October 1, 2023
Name of Entity/Sender: Orange County Government
Contact: Human Resources
Address: P.O. Box 1393 Orlando, FL 32802
Phone Number: 407-836-5661
Email: benefits@ocfl.net

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**

The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/Medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**

Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

Contact Information

Medical and Prescription Drug Plan **Cigna** Group: 3337200 Member Services: 1-800-244-6224 Delivery Pharmacy: 1-800-285-4812 Onsite Rep: OCRep@cigna.com or 407-403-8108 www.mycigna.com	**Vision** **MetLife** Group: 0236252 (Superior Network) Member Services: 1-833-393-5433 www.metlife.com/ocbocc
Dental **Cigna** Group: 3337200 Member Services: 1-800-244-6224 Onsite Rep: OCRep@cigna.com www.mycigna.com	**Deferred Compensation 457(b) Plan** **Vanguard** Group: 078082 Participant Services: 1-800-523-1188 http://ocf.vanguard-education.com/ekit
Health Savings Account **HSA Bank** Member Services: 1-800-244-6224 Onsite Rep: OCRep@cigna.com or 407-403-8108 www.mycigna.com	**Employee Assistance Program (EAP)** ComPsych Company ID: ORANGECOUNTY Member Services: 1-855-221-8925 https://guidanceresources.com/groWeb/login/login.xhtml
Cigna Surround Medicare Supplement (Part B) Member Services: 1-800-244-6224 www.mycigna.com	**Medicare** Member Services: 800-MEDICARE (800-633-4227) Medicare.gov
Cigna RX Medicare PDP (Part D) 800-558-9562 www.mycigna.com	**Life Insurance and AD&D** Standard Insurance Group: 641718-F Member Services: 844-870-8634 Onsite Rep: OCLifeAndDisability@standard.com
Cigna Medicare Advantage True Choice (MAPD-PPO) 888-281-7867 www.mycigna.com	**Retiree Billing** Chard Snyder Member Services: 888-993-4646 Fax: 1-513-459-9947 www.chard-snyder.com Payment mailing address: *6867 Cintas Boulevard* *Mason, OH 45040*
Florida Retirement System (FRS) Member Services: 866-446-9377 myFRS.com	

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