A GUIDE TO RETIREMENT

2019 ORANGE COUNTY WELLNESS FOR LIFE PLAN

BENEFITS & WELLNESS

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Revised 01/17/2019

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 on page 9.

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 or 30 years of Service Special Risk- Age 55 or 25 years of Service	**Enrolled in FRS prior to July 1, 2011**: Regular Class- Age 62 or 30 years of Service Special Risk- Age 55 or 25 years of Service
Enrolled in FRS after July 1, 2011: Regular Class- Age 65 or 33 years of Service Special Risk- Age 60 or 30 years of Service	**Enrolled in FRS after July 1, 2011:** Regular Class- Age 65 or 33 years of Service Special Risk- Age 60 or 30 years of Service
Meet the requirements for FRS early retirement	**Have reached the age of 59½ and have six years of FRS creditable service, 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 on page 35
- Eligible dependents may be added to your retiree benefits only in certain situations, as described in the "Coverage Changes" section on page 10

Which family members are eligible?

Spouses:

- Common Law marriage partners are not recognized by the State of Florida and are not eligible.
- Former spouses are not eligible under the plan, regardless of any legal settlement. However, separated spouses are eligible as there is no defined "legal separation" in the State of Florida.

Children:
From birth until the end of the month in which they turn age 26

- Natural children
- Legally adopted children
- Children who have been placed for adoption
- Stepchildren
- Other children for whom the employee is the legal guardian or has legal responsibility for providing medical coverage as defined by a court order

Children age 26 to 30:
Refer to page 7 for details

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

Disabled Children:

- Children considered to be disabled through Social Security Administration (SSA) regardless of whether the child receives Social Security Income (SSI) or not.
- Single and incapable of self-care, dependent on retiree for support due to physical and/or mental disability
- Disability must occur before child eligibility ceases due to age

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.**

Required Documentation for Spouse

Spouse
- If married within 12 months of the eligibility/coverage begin date, only **Legal Marriage License** (issued by a government/regulatory agency) is required; - If married for greater than 12 months, a **Tax Return Transcript** of your most recently filed federal income tax return showing you filed as married, either jointly or separately. The tax return transcript is the only official record of the tax return that you filed with the IRS. A copy of your tax return (Form 1040) will not be sufficient. The Form 1040 can be falsified and is not an official record of what was filed with the IRS. You can request a copy of your transcript from the IRS at www.irs.gov/individuals/get-transcript or by calling the IRS at 800-908-9946.
If married outside of the United States, marriage license must be officially translated by a translation organization before being submitted to your HR Service Center* ***Note: In addition to the dependent documentation listed above, your marriage date, spouse's date of birth, and spouse's social security number are required on the enrollment form.*

Required Documentation for Dependent Children

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* (spouse's name must be listed), and • Copy of employee's legal marriage license to stepchild's parent, and • Verification of current marital status *(see above requirements for joint financial documentation)*	• 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**(Hospital certificate will not be accepted, parents must be listed),* and • Social Security Administration award letter or a recent Social Security Income statement, and • Verification of unmarried dependent child status

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

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

[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 Chard-Snyder 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 on page 35.

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 Humana Vision.

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 2019, that amount is $659.09 per month for the OrangePrime Plus Plan (HDHP) or $725.12 per month for the OrangePrime Plan (LDHP). Premiums for these dependents 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 (e.g., BCC, Comptroller, Property Appraiser, Tax Collector, Supervisor of Elections, Clerk of Courts, and/or County paid positions in Court Administration, etc.), 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 on page 10, 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.

Switching plans at the time of retirement

You are not permitted to enroll in a different medical plan at the time of your retirement (except for a Medicare Supplement plan). For example, if you are currently covered on the High Plan as an active employee, you are eligible to elect the same plan at the time of your retirement. To change to the Low Plan (or vice versa), you would need to wait until the next open enrollment period.

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 on page 35 of this book.

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

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

What is an annual deductible?

An annual deductible is the amount of expenses that must be paid by you during the plan year before the insurance plan will start sharing costs. However, the HDHP will still cover preventive care at 100%, even prior to reaching the deductible. The in-network deductible for 2019 is $1500 for those with employee only medical coverage and $3,000 for those who cover dependents on the medical plan. When you are covering dependents on the plan, one member can meet the deductible for the entire family or it can be met by a combination of members.

What is coinsurance?

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

What is out-of-pocket maximum?

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

Is the deductible for medical separate from the pharmacy deductible?

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

Is there a pre-existing condition clause?

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

Do I need a referral to see a specialist?

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

Medical Coverage through Cigna

- Annual Deductible, 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, coinsurance, and out-of-pocket maximum amounts are listed on page 16 in the Medical Plan Design Summary chart.

Optional Health Savings Account (HSA)

Reduces your taxes three ways:

1. Money deposited is considered non-taxable
2. You pay no tax on the interest you earn
3. Withdrawals for eligible expenses are tax-free

- Helps you pay for your eligible medical and pharmacy expenses
- Carries over from year to year and goes with you when you retire

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 2019 maximum contribution amounts are as follows:

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

Note: The County will not make a contribution into 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

2019 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*	$1,500 / $3,000	$3,000/ $6,000	$750 / $1,500	$3,000 / $6,000
OUT-OF-POCKET MAX Individual/Family	$3,000 / $6,000	$6,000 / $12,000	$2,100 / $4,200	$6,000 / $12,000
Preventive Care	$0	***40% after Deductible	$0	***40% after Deductible
Primary Care	20% after Deductible	*40% after Deductible	**$20 co-pay	*40% after Deductible
Specialist	20% after Deductible	*40% after Deductible	**$35 co-pay	*40% after Deductible
Inpatient Hospital Admission	20% after Deductible	*40% after Deductible	20% after Deductible	*40% after Deductible
Outpatient Surgery (Non-Hospital)	20% after Deductible	*40% after Deductible	**$100 co-pay	*40% after Deductible
Outpatient Surgery	20% after Deductible	*40% after Deductible	20% after Deductible	*40% after Deductible
X-Rays, Lab, Diagnostics, CT, MRI, PET, Nuclear	20% after Deductible	*40% after Deductible	20% after Deductible	*40% after Deductible
Urgent Care	20% after Deductible	*20% after Deductible	**$40 co-pay	*$40 co-pay
Emergency Room	20% after Deductible	*20% after Deductible	20% after Deductible	*20% after Deductible
Ambulance	20% after Deductible	*40% after Deductible	20% after Deductible	*40% after Deductible
Home Healthcare	20% after Deductible	*40% after Deductible	20% after Deductible	*40% after Deductible
Durable Medical Equipment	20% after Deductible	*40% after Deductible	20% after Deductible	*40% after Deductible
Short-Term Rehabilitation/Therapy	20% after Deductible	*40% after Deductible	20% after Deductible	*40% after Deductible
Mental Health / Substance Abuse Inpatient Outpatient	20% after Deductible 20% after Deductible	*40% after Deductible *40% after Deductible	20% after Deductible **$35 co-pay	*40% after Deductible *40% after Deductible

*Out-of-network benefits are subject to reasonable and customary limitations. Any amount over reasonable charges will not be calculated toward your out-of-pocket maximum or deductible.
**OrangePrime plan copays do NOT apply to the deductible but are applied to the out-of-pocket maximum.
***Out-of-network deductible does not apply to preventive care for dependents under the age of 16.

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

Prescription Drug Coverage

What Prescription Drug Plan is available?

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

<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 3-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 3-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</td><td>Generic
Preferred
Non-Preferred</td><td>$10
10% + $30
10% + $50</td><td>Tier 1
Tier 2
Tier 3</td><td>Generic
Preferred
Non-Preferred</td><td>$10
10% + $30
10% + $50</td></tr>
<tr><td>Home Delivery –
90-day supply</td><td colspan="3">Preventive* Drugs: Before and after your deductible is met, you pay according to the 3-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 3-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</td><td>Generic
Preferred
Non-Preferred</td><td>$25
10% + $75
10% + $125</td><td>Tier 1
Tier 2
Tier 3</td><td>Generic
Preferred
Non-Preferred</td><td>$25
10% + $75
10% + $125</td></tr>
</table>

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

Is there a deductible for pharmacy?

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

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

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

What is Step Therapy?

It is a prior authorization program designed for you and your doctor to take one step at a time when choosing your medication. It works to help you find the most affordable medication appropriate for the treatment of a diagnosed condition, 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. Home delivery through the Cigna Pharmacy allows you to receive a 90-day supply of maintenance medications through the mail at a reduced co-pay, once the deductible has been met, if applicable.

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

Are smoking cessation drugs covered?

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

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 on page 17 in the Medical Plan Design Summary chart.

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 Supplement Plans

Medicare Part D Plan

Orange County offers our Medicare eligible retirees (and their covered spouses) the option of electing a cost-saving Medicare supplement plan with an additional Part D plan while still retaining affiliation with the Orange County group.

Eligibility

Medicare Supplement Plans are an option for retirees (and their covered spouses) age 65 and over who are on Medicare Part B. Medicare Supplement Plans are also available for under 65 retirees who are eligible for Medicare through disability.

Summary

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 the access to your choice of doctors and specialists if you need them, as long as they accept Medicare. There are various Medicare Supplement Plans to choose from (plans vary in MN, MA and WI). Orange County Government offers the Cigna Medicare Surround Supplement Plans F and N.

Comparison of Medicare Supplement Plans

Benefits	Plan F	Plan N
Part A Coinsurance plus 365 additional hospital days after Medicare benefits end 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%

***These are not Medicare Advantage plans*

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.

Part D Prescription Coverage

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

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

Highlights of the Cigna Medicare RX High Plan

- ✓ No deductible
- ✓ $3,000 Out-of-pocket Maximum
- ✓ Eliminates the Medicare Part D Coverage Gap, commonly referred to as the "donut hole" ($3,820-$5,100)
- ✓ Utilizes the Medicare National Preferred Drug Formulary

Highlights of the Cigna Medicare RX Low Plan

- ✓ No deductible
- ✓ Lower Generic Copay
- ✓ Generic copay during the Medicare Part D Coverage Gap, commonly referred to as the "donut hole" ($3,820-$5,100)
- ✓ 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	45%
Tier 3	$50	45%
Tier 4	$50	45%
Catastrophic Coverage*		
Generic	Greater of $3.35 or 5%	
Brand	Greater of $8.35 or 5%	

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 Supplement Plan with Part D 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 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 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 B. Therefore, if you fail to sign up for Medicare 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 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 and has a schedule of maximum reimbursements for other covered services. This plan pays the same amount for services whether you are using an in-network or out-of-network dentist, 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 on page 25.

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)	Paid according to Schedule of Benefits	Employee pays 30%, after deductible has been met	Employee pays 20%, after deductible has been met
Major Services (Periodontics, dentures, bridges, crowns, inlays, onlays)	Paid according to Schedule of Benefits	Employee pays 60%, after deductible has been met	Employee pay 50%, after deductible has been met
Orthodontia (Coverage for eligible children only up to age 19)	Not covered Select network orthodontists provide a 15% discount for adults. Contact your provider for more details.	Employee pays 60%, no deductible Lifetime limit of $1,000 Select network orthodontists provide a 15% discount for adults. Contact your provider for more details.	Employee pays 50%, no deductible. Lifetime limit of $1,000 Select network orthodontists provide a 15% discount for adults. Contact your provider for more details.

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

Vision

Orange County also offers vision insurance through Humana (in coordination with Eye Med), the plan covers routine eye examinations, corrective lenses, frames, and contact lenses.

What are the benefits?

Plan Frequencies:

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

Note: *You receive a $120 retail allowance yearly to be used toward frames* ***or*** *contacts. The entire amount must be used in one purchase. Failure to use the full amount will result in loss of the remaining balance.*

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

What are the network copayments?

In-Network copayments:

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

Are there any restrictions or limitations?

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

Could I have additional costs?

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

Is LASIK vision correction covered?

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

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

Each plan has a different level of benefit. Employees should compare the differences between the plans. The Vision Plan Comparison Chart on the next page offers some highlights, please contact your vision and medical providers for additional information (see contact information on the back page of this handbook).

Paying for Your Dental and Vision Insurance

If you enroll in one of the dental or vision plans, you will be billed monthly by Chard Snyder, 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 on page 33 of this book.

Vision Comparison Chart

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

***Note:** You receive a $120 retail allowance yearly to be used toward frames **or** contacts. The entire amount must be used in one purchase. Failure to use the full amount will result in loss of the remaining balance.*

[1]Vision benefits received from non-Humana In-Sight Network Providers are reimbursed by filing a claim. Reimbursable amounts are listed on this schedule.
Details regarding specific eligibility, coverage exclusions, definitions, and other information are included in the full Certificate of Benefits.

Section 2: Health Insurance Subsidies

Florida Retirement System Health Insurance Subsidy

The Florida Retirement System (FRS) provides eligible retirees 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 each month $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.

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 $3.00 per month for each **whole year of service**, including service time in DROP, up to $90.00 per month (30 years of service).

Retirees who are members of IAFF and IAFF Battalion Chiefs and are retired due to in-line-of duty disability, will receive $5.00 per month for each whole year of service, including service time in DROP, up to 30 years of service. The minimum subsidy shall be $75.00 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, separate due to medical disability, and then retire from the FRS within two years from 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 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.*

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

EFT Number
4380108

STATE OF FLORIDA

Payment Date
5/31/2016

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 : C ALLOWANCES : 0 STATED W/H TAX : ADDL W/H TAX : W/H TAX : Y

SUMMARY OF BENEFITS AND DEDUCTIONS

BENEFIT DESCRIPTION	THIS PAYMENT	CALENDAR YEAR-TO-DATE
Retirement Benefit	[redacted]	[redacted]
Health Insurance Subsidy (HIS)	$125.00	$125.00
Health Ins Sub Retro	$250.00	$250.00
DROP Paymt Rollover	[redacted]	[redacted]
GROSS BENEFITS	[redacted]	[redacted]
WITHHOLDING TAX	[redacted]	[redacted]
MISC DEDUCTIONS	[redacted]	[redacted]
NET BENEFITS	[redacted]	[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

A CHANGE IN YOUR MISC. DEDUCTIONS OR BENEFIT MAY HAVE RESULTED IN A CHANGE IN YOUR NET BENEFITS LISTED ABOVE. (PLEASE COMPARE WITH A PREVIOUS STATEMENT.)

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 or you can take care of it yourself if you prefer. 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 from 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 port your group life insurance into an individual term life policy 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 family 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 of 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 out 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

2019 Retiree Monthly Rates (Premiums)

Medical

Tier 1: Retiree and Spouse Under 65				
	Single	Retiree + Spouse	Retiree + Children	Retiree + Family
OrangePrime Plus (High Plan)	$646.17	$1,410.95	$1,302.15	$1,924.98
OrangePrime (Low Plan)	$710.90	$1,501.71	$1,397.25	$2,042.26
Tier 2: Retiree and/or Spouse Who Became Eligible for Medicare From 2002-2004*				
Retiree OR Spouse are Medicare Eligible	Single	Retiree + Spouse	Retiree + Children	Retiree + Family
OrangePrime Plus (High Plan)	$537.42	$1,302.20	$1,193.40	$1,816.23
OrangePrime (Low Plan)	$602.15	$1,392.96	$1,288.50	$1,933.51
BOTH Retiree AND Spouse are Medicare Eligible	Single	Retiree + Spouse	Retiree + Children	Retiree + Family
OrangePrime Plus (High Plan)	$537.42	$1,193.45	$1,193.40	$1,707.48
OrangePrime (Low Plan)	$602.15	$1,284.21	$1,288.50	$1,824.76
Tier 3: Retiree and/or Spouse Who Became Eligible for Medicare From 2005-Current*				
Retiree OR Spouse are Medicare Eligible	Single	Retiree + Spouse **	Retiree + Child(ren)	Retiree + Family **
OrangePrime Plus (High Plan)	$546.17	$1,310.95	$1,202.15	$1,824.98
OrangePrime (Low Plan)	$610.90	$1,401.71	$1,297.25	$1,942.26
Both Retiree AND Spouse are Medicare Eligible	Single	Retiree + Spouse **	Retiree + Child(ren)	Retiree + Family **
OrangePrime Plus (High Plan)	$546.17	$1,210.95	$1,202.15	$1,724.98
OrangePrime (Low Plan)	$610.90	$1,301.71	$1,297.25	$1,842.26

*Medicare eligibility begins either at age 65 or retirement - whichever occurs last (unless Medicare eligibility is due to disability, which occurs first).

** Only applicable in situations where a retiree or spouse is covered by Medicare due to disability, is under the age of 65 and retiree must be enrolled in one of the County medical plans.

Dental

	Retiree Only	Retiree + 1	Retiree + 2 or More
Low	$11.82	$24.08	$44.05
Middle	$20.58	$42.64	$80.18
High	$33.53	$68.28	$124.06

Vision

	Retiree Only	Retiree + 1	Retiree + 2 or More
Vision	$6.48	$12.94	$19.00

Medicare Supplement Plans

(Medicare Eligibility Only)

Plan F	Florida Residents Only	3 Digit Zip 330 – 334	Except 3 Digit Zip 330 - 334
Issue Age	<65	$605.38	$470.98
Issue Age	65 – 69	$266.68	$207.49
Issue Age	70 – 74	$311.79	$242.58
Issue Age	75 – 79	$350.67	$272.82
Issue Age	80+	$392.49	$305.36
Plan N	**Florida Residents Only**	**3 Digit Zip 330 – 334**	**Except 3 Digit Zip 330 - 334**
Issue Age	<65	$454.01	$353.22
Issue Age	65 – 69	$200.01	$155.60
Issue Age	70 – 74	$240.78	$187.33
Issue Age	75 – 79	$274.39	$213.48
Issue Age	80+	$311.46	$242.31
Non-Florida Residents			
	Retiree Only	**Retiree Plus 1**	**Retiree Plus Family**
Plan F	$235.32	$470.65	$705.97
Plan N	$180.19	$360.38	$540.56

Medicare Prescription Drug Part D

(Medicare Eligibility Only)

A Low Plan - $160.23	A High Plan - $264.80

Section 5: Important Notices

Notice of COBRA Continuation Coverage Rights

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Orange County Plan. 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). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becomes entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child loss of eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Human Resources.

How is COBRA Coverage Provided?

Once Human Resources receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Other Options

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

2019 COBRA Rates

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

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

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

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

Social Security Number Collection Disclosure 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.

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

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

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

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

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

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

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

Activities include but are not limited to:

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

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

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

The Plan Sponsor agrees to the following:

1. Plan Sponsor shall not use or disclose PHI other than as permitted or required by their Plan Document or as required by law.
2. Plan Sponsor shall ensure, through a written agreement that any agents, including a subcontractor ("Business Associate"), to whom it provides PHI received from Plan Administrator agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.
3. Plan Sponsor agrees not to use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual.

4. Plan Sponsor agrees to notify Plan Administrator in writing within a reasonable time after becoming aware of any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted under this subsection.
5. Upon receipt of a written request signed by Covered Person, Plan Sponsor may afford the Covered Person the right to access and obtain a copy of his or her PHI in accordance with HIPAA's access requirements.
6. Covered Persons may request that the Plan Sponsor amend the PHI maintained in a designated record set in accordance with HIPAA, so long as such requests are in writing and provide a reason to support the requested amendment.
7. Upon receipt of written request by Covered person, Plan Sponsor agrees to provide Covered Person a written accounting of disclosures of PHI made by Plan Sponsor in accordance with HIPAA.
8. Plan Sponsor agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan Administrator available to the Secretary and Health and Human Services or his designee for purposes of determining compliance by the Plan Administrator with the Standards for Privacy of Individually Identifiable Health Information.
9. If feasible, Plan Sponsor agrees to return or destroy all PHI received from the Plan Administrator that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
10. Plan Sponsor agrees to make reasonable actions to maintain adequate separation from Plan Administrator.
    a) Plan Sponsor shall grant only the Director of Insurance, Employee Benefits Manager and Employee Benefits Specialists access to Covered Person's PHI to be disclosed under this subsection IX.6.
    b) Plan Sponsor agrees to restrict the access to, and use of PHI by the employees referenced in subsection IX.6 (H) (1) to the "plan administration functions: that the Plan Sponsor performs for, or on behalf of, the Plan Administrator. "Plan administration functions" do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan or the Plan Sponsor.

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

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

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, 2018. Contact your State for more information on eligibility –

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

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

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

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

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

Contact Information

ComPsych Guidance Resources Program Company ID: ORANGECOUNTY Member Services: 1-855-221-8925 https://guidanceresources.com/groWeb/login/login.xhtml	**Medicare** Member Services: 800-MEDICARE (800-633-4227) medicare.gov
Deferred Compensation Vanguard Group: 078082 Member Services: 800-523-1188 Vanguard.com	**Medicare Supplement** Cigna Surround 800-cigna24 (800-244-6224) www.myCigna.com
Dental Cigna Group: 3337200 Member Services: 1-800-CIGNA24 www.myCigna.com	**Medicare Part D** Cigna Medicare Rx 800-558-9562 www.myCigna.com
Florida Retirement System (FRS Pension or Investment Plan) Member Services: 866-44-MYFRS (866-446-9377) myfrs.com	**Orange County Benefits** Benefits@ocfl.net
Health Savings Account HSA Bank 1-800-CIGNA24 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*
Life Insurance The Standard Group: 641718-F Member Services: 1-800-628-8600	**Vision** Humana Group: 1007800 (Eyemed) Plan: 7741123 Member Services: 1-877-398-2980 www.Humana.com
Medical and Prescription Drug Plan Cigna Group: 3337200 Member Services: 1-800-Cigna24 Ask a Nurse: 1-800-CIGNA24 Delivery Pharmacy: 1-800-285-4812 www.myCigna.com (*for help with mycigna.com, call* 1-800-284-8346)	

Human Resources Division

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ORLANDO, FLORIDA 32802-1393

Benefits@ocfl.net