

► Legal Notices

Retiree Medical Insurance Program and Grant

The County of Orange Retiree Medical Insurance Program, including the grant allowance (if applicable), is not a vested nor an entitled benefit and is not guaranteed. The RMIP permits the Trust to use excess earnings to pay supplemental benefits such as a post-retirement health insurance grant. However, the Retirement Law does not mandate or require the RMIP to provide any post-retirement medical insurance program or payments. Pursuant to the authority granted under retirement Law, the Board of Supervisors have approved payment of a non-vested, post-retirement medical insurance grant, which may be cancelled, reduced or amended at any time and/or for any reason. The Board of Supervisors annually determines whether to continue the RMIP and Grant. The RMIP pays the authorized grant allowance on a nontaxable basis from an Internal Revenue Code Section 401(h) Trust maintained as part of the RMIP.

Women's Health and Cancer Rights Act of 1998

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

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

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

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

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

Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

Time to Enroll

The annual Open Enrollment period is generally during the month of November each year. This is your only opportunity to make changes to your benefits unless you have a Qualified Life Event, (QLE). You will receive information on specific Open Enrollment dates and deadlines when the time comes.

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

The benefits you elect during Open Enrollment will be effective January 1st of the following year.

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

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

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

What to Do Now

- Please read this Enrollment Guide carefully to understand how your benefits package works and review the materials in your enrollment package, including:
 - **Benefits Enrollment Summary** — This summary contains personalized information, specific to you about the benefits available to you and a list of your contribution amounts. The contribution amount represents the grant amount available towards your health plan coverage; the remainder of the premium amount (if any) would be your responsibility to pay. The summary also shows your current benefit coverage, which will be defaulted as your coverage for next year if you do not make an election during the Open Enrollment period.
 - **Open Enrollment Meeting Schedule** — To better inform and assist you with your health plan decisions, the County will be providing Open Enrollment Presentations in November at convenient locations throughout the County. The presentation schedule will be included as part of your Open Enrollment information. These presentations are a valuable source of information; therefore, we strongly encourage your attendance to ensure you make the most informed and appropriate choice possible regarding your health plan coverage.
 - **Wallet Card** — This card includes important phone numbers, Web Sites and basic information on how to use the Benefits Center Web Site and Benefits Resource Line.
- Remember: enroll for your benefits as early as possible before the enrollment deadline.

If You're a Current Retiree

If you're currently retired and wish to retain the same retiree health plan coverage, with the same dependents as shown on your Benefits Enrollment Summary, you do not need to enroll or take any action during Open Enrollment.

However, **you must enroll if you want to:**

- Add or drop dependents
- Change your retiree health plan.

You will automatically be enrolled in the coverage shown on your Benefits Enrollment Summary if you do not make any election changes before the open enrollment deadline.

Review the summary, including the dependent coverage section, within the required timeframe as no changes can be made or accommodated after the deadline.

Once you receive your Benefits Confirmation Statement, you must correct any errors to the elections you made and/or report any incorrect information that appears on the statement within 10 business days from the date on the statement.

Keep in mind that after the Open Enrollment period, you can not change your benefit elections during the year unless you have a Qualified Life Event. See the sub-section "Making Changes to Your Benefits" under the "Medical Plans for members Eligible for Medicare" section in this guide for more information.

New Retirees

If you're a new retiree of the County, **you have 30 days from the date on your enrollment package to enroll** in your benefits through the Benefits Center to change and/or continue your health plan coverage with the County. If you do not enroll within this period, you will be automatically defaulted to benefits coverage under the retiree health plan equivalent to your current employee health plan, with the exception of the amount of your monthly premium. If you are Medicare eligible and enrolled in Kaiser HMO you must elect Kaiser Senior Advantage when you retire or you will be defaulted to the Premier Wellwise PPO plan. You will have the opportunity to report errors to the elections within 10 business days from the date on your Benefits Confirmation Statement.

Your retiree health insurance coverage becomes effective on the first day of the month following your separation from County employment due to retirement. Since there will be no lapse in your health coverage, the Premier Sharewell PPO health plan pre-existing condition exclusions will be waived, even if you change health plans and/or add dependents during this one-time retiree enrollment period. If you elect to disenroll from your retiree health coverage, you will be electing to permanently disenroll from coverage under any plan through the County of Orange, without the opportunity to reenroll in Retiree Health Plan coverage again in the future through the County of Orange.

Deferred Retiree

You must activate your retiree medical insurance, if eligible, within 30 days of activating your OCERS pension check. If you select the Premier Sharewell PPO health plan, pre-existing conditions will apply. When calling the Benefits Center, you must self identify as a County of Orange deferred retiree.

► Pathways to Enrollment: Enrolling Step-by-Step

You Can Click or Call to Enroll

Open Enrollment is a paperless process. This means that you can enroll through the County of Orange Benefits Center in two ways:

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

When to Click or Call

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

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

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

What to Have with You When You Enroll

When you enroll, you should have the following items handy:

- Your Social Security number
- Your Benefits Enrollment Summary
- Your Personal Identification Number (PIN)

If you're electing the CIGNA, Blue Cross Traditional or Blue Cross Select Health Plan, you must select a Primary Care Physician (PCP) for each covered person and enter that PCP's identification (ID) number when you enroll. You can find a list of PCP ID numbers on the

Benefits Center Web Site by following the links to provider sites or by going directly to the CIGNA and/or the Blue Cross Web Site.

Benefits Enrollment Summary

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

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

You will be automatically be enrolled in the benefits coverage shown on your Benefits Enrollment Summary if you do not make any changes to your elections during enrollment period.

You can also access your Benefits Enrollment Summary on the Benefits Center Web Site. If you can't find your PIN, call the Benefits Resource Line, press **0, and speak with a Benefits Specialist.

► How to Change Your PIN

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

- Online — Log on to the Benefits Center Web Site and follow the instructions to change your PIN.
- By phone — Call the Benefits Resource Line and follow the instructions to change your PIN.

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

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

How to Read Your Benefits Enrollment Summary

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

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

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

How to Enroll through the Benefits Center Web Site

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

1. Go to **www.benefitsweb.com/countyoforange.html**
2. When prompted, enter your Social Security Number and Personal Identification Number (PIN).
3. The first time you log on to the Web Site, you'll automatically be prompted to change your PIN.
4. Follow the instructions for enrollment.

Steps to Enroll Online

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

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

After you have made your benefit elections, you will see a Benefits Confirmation Statement. Your Confirmation Statement from the Web Site should have a number assigned to it. This will show you that you have properly saved your elections. Print a copy of this statement for your records. You'll also receive a Benefits Confirmation Statement in the mail shortly after making your elections.

Web Tools

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

Select-a-Plan

This tool compares features and estimates your costs under the various County health plans available to you so you can make enrollment decisions that best meet your needs.

- **Preference Modeling:** Answer questions about what you want in a health plan, the tool determines which of the available options is best suited for you.
- **Comparison Module:** this provides an overview of the benefit features that are important to you and allows you to compare health plan options against one another.
- **Cost Calculator:** Estimates costs based on benefit features and your estimate of the medical services that you and your family will utilize.

Select a Plan Tool is not available to RME/RMR's/Medicare-eligible retirees.

Healthcare Advisor

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

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

How to Use the Benefits Resource Line

With the Benefits Resource Line, you can:

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

To use the Benefits Resource Line:

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

Your Benefits Confirmation Statement

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

▶ How the Pathways to Benefits Program Works

The County currently provides a Retiree Medical Insurance Program to assist you and your family with health plan coverage. If you are eligible, the County's Retiree Medical Insurance Program benefits include retiree health plan coverage and the Retiree Medical Plan to help you pay for your County health plan coverage and/or Medicare Part B premiums.

Your age and Medicare eligibility affect the benefits for which you're eligible. Be sure to read this section of this guide carefully so you'll have the information you need to make the right choices for you and your family.

Who Is Eligible?

Retiree Health Care Coverage

As a retiree of the County, you are eligible for County retiree health care coverage if you:

- Were enrolled in a County health plan at the time you separated and
- Had a minimum of 10 years of continuous eligible County service and
- Receive a monthly retirement allowance from the Orange County Employees Retirement System (OCERS).

Your eligible dependents for retiree health coverage include your:

- Legal spouse or Domestic Partner
- Unmarried children under age 19 (or under age 23 if full-time student), including step children, foster children, children placed for adoption, and legally adopted children. Children who are full-time students must attend an accredited school, college or university (enrolled in 12 units or more) and must be dependent on you for financial support to continue to be covered. Proof of enrollment may be requested at any time.
- Unmarried incapacitated children of any age who are dependent upon the participant for support and were incapacitated prior to their 19th birthday. The child did not have to be covered by the County of Orange at the point they became incapacitated if the event was prior to their 19th birthday.

Proof of adoption, domestic partnership, or legal guardianship may be requested at any time. Dependents over age 19 who are students may be required to provide proof of full-time student status to the County Benefits Center at any time.

Retirees must notify the Benefits Center within 30 days of dependent no longer meeting eligibility requirements. The retiree must use the Benefits Center Web Site or Benefits Resource Line to disenroll an ineligible dependent.

By enrolling or continuing enrollment in any County benefit programs, you are certifying to the County that the information supplied by you, your spouse/Domestic Partner and any of your dependents is true and correct. You are responsible for notifying the County of all changes in status which may affect benefits eligibility, including, but not limited to marriage, marriage dissolution, legal separation, addition or loss of dependent status. If true and



correct, notification to the Benefits Center is not provided within 30 days of status change, you or your dependent may not be covered, with benefits not payable. You may also be responsible for premiums retroactive to the month in which you or your dependent became ineligible.

Domestic Partner Coverage

The County of Orange offers many of the benefits described in this guide to domestic partners of eligible employees and retirees. Benefits available to a spouse and eligible dependent children are also available to a domestic partner and his or her eligible dependent children. Coverage may include health care including prescription drug. (Imputed Income may apply).

What Is a Domestic Partnership?

In California, a domestic partnership is established when two people file a “Declaration of Domestic Partnership” with the Secretary of State and meet a number of legal requirements. The partners must share a common residence, be at least 18 years of age, not be blood-related in a way that would prevent them from being married to each other in California, and be of the same sex (unless one of them is over age 62 and at least one of them is eligible for Social Security retirement benefits).

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

Enrolling a Domestic Partner

You may elect coverage for a domestic partner and his or her eligible children when you first enroll for benefits, during any Open Enrollment period, as a result of a Qualified Life Event, or within 30 days of establishing your domestic partnership.

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

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

Effect on Taxes

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

County contributions towards domestic partner coverage are not taxable for California State income tax purposes. You will see imputed income for any before-tax contributions you make

towards the cost of your domestic partner's health coverage. Please be aware that tax laws may vary from state to state.

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

For More Information

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

Making Changes to Your Benefits

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

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

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

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

► I'm Medicare-eligible, but my spouse/dependent/domestic partner is not. May I enroll in one of the County's Medicare-eligible plans?

The County does offer retirees an option for Mixed Family enrollment. If you are currently Medicare-eligible with Part A and B and your spouse/dependent/domestic partner is not, Blue Cross offers retirees a mixed enrollment option. Your eligible spouse/dependent/domestic partner may elect either the Blue Cross Traditional HMO health plan or the Blue Cross Select HMO health plan. You as a Medicare A & B eligible retiree will be enrolled in the Blue Cross SmartValue Custom plan.

If you are currently Medicare-eligible with Part B only and your spouse/dependent/domestic partner is not, you and your spouse/dependent/domestic partner may elect either the Blue Cross Traditional HMO plan or the Blue Cross Select HMO plan. Both you and dependent must elect the same Blue Cross HMO plan. You may also enroll in Cigna HMO, Kaiser HMO or any of the PPO plans. If you elect the Kaiser HMO plan, the Non-Medicare participant will be enrolled in the Kaiser HMO plan and the Medicare eligible participant will be enrolled in the Kaiser Senior Advantage Medicare plan.

► Health Plans for Members Not Eligible for Medicare

Who is Eligible?

If you are a retired participant (or an eligible dependent) not eligible for Medicare (usually under age 65), you may enroll in the health plans shown on the Health Plans at a Glance chart. The HMO plans require you to live within the plan's California service area. Before you enroll, contact the plan to confirm that you live within the plan's service area. Contact information for each plan is shown in the back of this guide in the Helpful Information section. If you elect one of the PPO plans, Premier Wellwise, Premier Sharewell, or Exclusive Care Select Plan you are not limited to a specific service area as these plans provide coverage worldwide.

Eligible dependents include your spouse or domestic partner and your unmarried children under age 19 (under age 23 depending on if you have verified as being a full-time student in an accredited school or university). If you choose to cover a dependent on a County health plan, your premium for your coverage will be deducted from your monthly pension check from OCERS. If your monthly pension check does not fully cover the cost of the plan you select, the Benefits Center will bill you monthly from Benefits Billing Services.

Domestic partners who enroll in any of these plans must contact the Benefits Center and speak with a Benefits Specialist who will provide information regarding the Affidavit of Domestic Partnership or a Declaration of Domestic Partnership Certificate from the State of California.

Enrollment

You may enroll or make changes to your current plan selection during the annual Open Enrollment period in November of each year. You may also enroll or make changes if you experience a Qualified Life Event, QLE, an event in your life that causes you to lose coverage you currently have, such as retirement, marriage, death, divorce or relocating out of area. If you enroll outside of Open Enrollment it must be within 30 days of the event that caused you to lose coverage.

When you become eligible for Medicare (generally when you reach age 65) the Benefits Center will send correspondence to you regarding your health plan choices. At that time, you may enroll in a County health plan for Medicare-eligible members as explained in the section, "Medical Plans for participants eligible for Medicare".

Non-Medicare Plans

County Health plans	Available in 2008
PPO Plans	Premier Wellwise, Premier Sharewell, Exclusive Care Select
HMO	CIGNA, Kaiser, Blue Cross Traditional and Blue Cross Select

How the HMO Plans Work

HMO plans provide a comprehensive array of services, including preventive care, at a minimal cost, but you must use providers in the HMO network. An HMO network includes doctors, hospitals, and other health care providers and facilities that have contracted with the HMO to provide care at lower rates. HMOs do not generally pay benefits for care received outside the HMO network, except in emergency situations.

Important features of HMO plans include:

- Minimal copayments for most services (e.g., doctor’s office visits)
- No claim forms
- Coverage for preventive services such as annual physicals, Well-Baby and Well-Woman care, and Immunizations
- No lifetime maximums
- No pre-existing condition exclusions

HMO Options

The County offers four HMO plans:

- CIGNA Health Plan HMO (CIGNA HealthCare of Southern California and San Diego)
- Kaiser Health Plan HMO
- Blue Cross Traditional HMO
- Blue Cross Select HMO

An overview of HMO plan benefits can be found in the Health Plans at a Glance chart at the end of this section. Additional information, member service and web site addresses can be found in the Helpful Information section at the end of this guide.

CIGNA, Blue Cross Traditional & Blue Cross Select HMO Health Plans

A few highlights of the HMO Health Plans:

- You select a Primary Care Physician (PCP) from the network to coordinate all of your health care. With the exception of emergency treatment, Well-Woman exams and mental health services, your PCP must authorize, provide and/or arrange all of your care in order for you to receive benefits.
- You contact your PCP’s office when you need care. At the time of your appointment, you present your ID card and pay a small co payment. Upon selection of a HMO plan for the first time or add a dependent, you must select a PCP at the time you enroll.
- Schedule an appointment with an OB/GYN in the same medical group as your PCP without referral.
- You can obtain additional information including provider directories (PCPs) for the Cigna and Blue Cross HMO plans through the Benefits Center Web Site, Cigna and Blue Cross Web Site Member Services. See the Helpful Information section in the back of your guide.

- When medication is prescribed, you must fill the prescription at a contracted retail pharmacy or you may order up to a 90-day supply of maintenance drugs through the HMO’s mail order program.
- In an emergency, seek care at the nearest hospital. Call or have the doctor or family call your PCP or Member Services within 48 hours to receive benefits.

Kaiser Health Plan HMO

Highlights of the Kaiser Health Plan HMO:

- Health services must be provided by Kaiser providers, but is not necessary to select Primary Care Physician upon enrollment.
- When you need care, contact either your Kaiser primary care physician or the Kaiser appointment center in your area. At the time of your appointment, present your ID card and pay a small co-payment. You can access any Kaiser office for care.
- You can self-refer to a number of specialists, including OB/GYN, internal medicine, optometry, and mental health (varies by location). You must fill prescriptions at any Kaiser pharmacy, located at each medical office. You pay a small co-payment for up to a 100-day supply of a prescription drug. Dental prescriptions are included in your coverage.
- In an emergency, seek care at the nearest hospital. Call or have the doctor or a family member call Kaiser as soon as possible to receive benefits.

You can obtain additional information through the Benefits Center Web Site, and Kaiser Web Site/Member Services. See the Helpful Information section in the back of your guide.

How the PPO Plans Work

Preferred provider organizations (PPOs) give you the freedom to choose any doctor, whether or not he or she is a member of the PPO network, but you receive a higher level of benefits from in-network providers. You do not need to select a PCP to coordinate your care and you can see a specialist any time you wish. An overview of the PPO plan benefits can be found in the Health Plans at a Glance chart at the end of this section. Additional information member service and web site addresses can be found in the Helpful Information section at the end of this guide.

PPO Options

You have three PPO plans to choose from:

- Exclusive Care Select PPO
- Premier Wellwise PPO
- Premier Sharewell PPO

Exclusive Care Select PPO

A few highlights of the Exclusive Care Select PPO plan:

- This plan is administered by the County of Riverside for Retirees and provides affordable, comprehensive coverage no matter where you need care — locally, regionally or nationally. As a plan participant, you have the flexibility to seek care from any provider,

but the plan pays more — and your co payments are lower — if you stay within the Tier 1 or Tier 2 networks. With Exclusive Care’s provider network and the Blue Shield regional and national networks, you have thousands of doctors, hospitals and facilities to choose from.

- **Tier 1 — The Exclusive Care Select Network**
A focused network of hospitals, medical groups and physicians specifically developed for Exclusive Care with the lowest level of copayments and coinsurance.
- **Tier 2 — The Blue Shield of California Network**
Provides excellent network coverage throughout the state, as well as coverage anywhere in the country through the nationwide BlueCross BlueShield network. The copayment and coinsurance for this tier is higher than Tier 1, but lower than Tier 3 out-of-network.
- **Tier 3 — Out-of-network providers**
Benefits are covered by the plan as long as they are licensed providers. Keep in mind your out-of-pocket costs will be higher, as these providers do not offer network discounted rates.

Some benefits are covered only at Centers of Excellence or specific facilities and require pre-authorization. You should review Exclusive Care’s coverage for further details.

An overview of plan benefits can be found in the Health Plans at a Glance chart at the end of this section. Additional information, member service and web site addresses can be found in the Helpful Information section at the end of this guide.

Premier Wellwise

A few highlights on the Premier Wellwise PPO plan:

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

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

- This plan provides affordable, comprehensive coverage no matter where you need care — locally, regionally, or nationally. The Blue Shield of California network includes more than 9,400 hospitals and 744,000 physicians across the country. You can use the provider directory on Blue Shield of California’s Web Site to find out which hospitals and doctors are in the network, or you can call Blue Shield of California’s Customer Service Center for assistance.
- When you need care, you can go to a provider in (PPO) or outside (non-PPO) the Blue Shield of California network. Although the PPO plans have the same provider network, they have different deductibles and coinsurance amounts. See the Health Plans at a Glance comparison chart for details.

Here’s an overview of WHI’s prescription drug coverage:

Type of Medication	30-Day Retail Coinsurance	90-Day (Advantage90) Retail Coinsurance	90-Day Mail Service Coinsurance
Generic Formulary	20%	20%	20%
Brand Formulary	25%	25%	25%
Non-formulary	30%	30%	30%

The Premier Wellwise Plan has a prescription formulary through Walgreens Health Initiatives which is a list of prescription drugs that includes all Generic Drugs and certain Brand-Name Drugs. The Formulary includes only those Brand-Name Drugs that do not have a generic equivalent or may be a less-expensive but equally effective alternative to other Brand-Name Drugs. The County’s Pharmacy Benefit Manager, Walgreens Health Initiatives determines which Brand-Name drugs are included on the Formulary.

Premier Sharewell (HSA Compliant Health Plan)

A few highlights on the Premier Sharewell PPO plan:

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

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

- This plan provides affordable, comprehensive coverage no matter where you need care — locally, regionally, or nationally. The Blue Shield of California network includes more than 9,400 hospitals and 744,000 physicians across the country. You can use the provider directory on Blue Shield of California’s Web Site to find out which hospitals and doctors are in the network, or you can call Blue Shield of California’s Customer Service Center for assistance.
- When you need care, you can go to a provider in (PPO) or outside (non-PPO) the Blue Shield of California network. Although the PPO plans have the same provider network, they have different deductibles and coinsurance amounts. See the Health Plans at a Glance comparison chart for details.
- When you see a PPO provider, present your ID card at the time of your appointment. Your provider files the paperwork for your claim and you receive a bill in the mail for your deductible and/or coinsurance amount — 10% of the discounted rate for most covered services.
- For Premier Sharewell, when you see a non-PPO provider, you generally pay 20% of the Usual, Reasonable and Customary (URC) charge for most covered services you

have a higher deductible and, in some instances, you may have to pay up front. You are responsible for all expenses above URC.

- Premier Sharewell pays 100% of eligible health care expenses that exceed \$10,000 per calendar year per participant. You are responsible for any additional expenses above URC.
- You are responsible for 100% of expenses that are not eligible under the plan.
- If you're scheduled for hospital admission or surgery, you must contact the claim administrator, Blue Shield of California, to obtain pre-certification for the hospital stay before admittance to receive the higher level of benefits.
- In an emergency, seek care at the nearest hospital and call or have the doctor or a family member call Blue Shield of California's Customer Service Center within 2 business days of admission to a hospital.
- Sharewell is a Health Savings Account (HSA) compliant health plan. The Plan design complies with a HSA, high deductible plan but without the Health Savings Account contribution. Retirees may establish their own HSA to which they may contribute and pay Sharewell co-payments, deductibles and qualified health care expenses on a non-taxable basis. Individuals can set-up a Health Savings Account through financial institutions. Please consult your financial advisors for details regarding HSAs and the tax implications before establishing an account.

An overview of plan benefits can be found in the Health Plans at a Glance chart at the end of this section. Additional information, member service and web site addresses can be found in the Helpful Information section at the end of this guide.

Prescription Drug Benefits — Premier Sharewell PPO

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

Making Your Decision

When making your decision about which plan will provide the best coverage, it is important to consider the differences among the types of plans. To recap: The County of Orange offers several types of insurance plans.

1. **A Preferred Provider, PPO plan: Premier Wellwise, Premier Sharewell and Exclusive Care Select.** When you choose a PPO plan, you have the flexibility to receive all covered services provided by the physician or facility of your choice, as long as your insurance is accepted. However, you will pay less if you select a physician or facility within the plan's Preferred Provider network. This is because: (1) the network physicians charge pre-negotiated discounted rates to patients for services and (2) the plan reimburses network physicians a higher percentage of those costs.
2. **HMO Plans — CIGNA, Kaiser, and Blue Cross Traditional and Blue Cross Select Plans.** When you select an HMO, the plan contracts with its own network of hospitals, pharmacies and physician group. All of your care is coordinated by your Primary Medical

Group or your Primary Care Physician that you choose from a list of doctors that the plan has contracted with to provide services. For these services, you are responsible for any co-payments or deductibles. This type of plan also offers prescription drug coverage.

After you have made your decision, either enroll via the Benefits Center Web Site simply by logging onto www.benefitsweb.com/countyoforange.html or contacting the Resources Line by dialing the toll-free phone number at 1-866-325-2345. A Benefits Specialist will be available from Monday through Friday 7:30 am to 5:30 pm Pacific Time, except on holidays, to take your elections.

► **I'm turning 65 in 2008 and will become eligible for Medicare. What do I do?**

The Benefits Center will send correspondence to your home mailing address approximately 90 days prior to your 65th birthday. The package will outline necessary steps to enroll in Medicare and give you information about enrolling in a Medicare plan with the County of Orange. At that time, you need to either enroll via the Benefits Center Web Site or speak to a Benefits Specialist by contacting the Benefits Center Resources Line without submitting new forms.

Enrollment in most County of Orange health plans will provides prescription drug coverage. Therefore, if you enroll in a County of Orange health plan, your drug coverage will be provided through the health plan you select and it is not necessary for you to enroll separately in an additional Medicare drug plan.

If you are enrolled in the Premier Sharewell PPO plan since the Plan has a \$5,000 annual family deductible, we encourage you to enroll in Medicare Part D. In addition, if you do not enroll in Medicare Part D and elect to enroll in another health plan in year after 2008, you may be subject to Medicare Part D late enrollment penalties.

► Health Plans at a Glance for Members **Not Eligible** for Medicare

There are many important considerations to make when choosing health care for you and your dependents. The County of Orange encourages you to review the following to help you make the best decisions.

Think about how you access your regular care and whether or not it's important that your physician's office or medical facilities are near your home. Contact your plan's customer service center to find out if you live within the plan's service area and how far you'll need to travel if you need emergency care.

Consider how often you travel. You should find out what services will be available to you when you are out of the area.

Many plans offer health education programs and research materials.

It's a good idea to find out what is available from the plan you are considering.

Keep in mind that you or your family may have special medical needs — now, or in the future.

If you are making a change or choosing a provider for the first time, contact the physician’s office you selected to confirm that the office accepts new patients. Ask how referrals to specialist are handled and find out what specialists are available. Also confirm with which hospitals the office is affiliated.

		Maximum Lifetime Benefit	Calendar year Deductible	Member Coinsurance	Prescription Drug Benefits	
					Retail Pharmacy	Mail order
HMO PLANS						
CIGNA Plan		Unlimited	No Deductible	N/A	\$10 Generic; \$20 Brand; \$40 Non-Formulary (up to 30 day supply)	\$10 Generic; \$20 Brand; \$40 Non-Formulary (up to 90 day supply)
Kaiser Plan		Unlimited	No Deductible	N/A	\$10 Generic \$20 Brand (up to 100 day supply)	
Blue Cross Traditional HMO Plan		Unlimited	No Deductible	N/A	\$10 Generic; \$20 Brand; \$40 Non-Formulary (up to 30 day supply)	\$20 Generic; \$40 Brand; \$80 Non-Formulary (up to 90 day supply)
Blue Cross Select HMO Plan		Unlimited	No Deductible	N/A	\$100 deductible (waived for generic) \$10 Generic \$25 Brand \$40 Non-formulary (up to 30 day supply)	\$100 deductible (waived for generic) \$20 Generic \$50 Brand \$80 Non-formulary (up to 90 day supply)
PPO PLANS						
Premier Wellwise	In Network	\$3,000,000	\$300 per ind/ \$600 per family	10%	20% / 25% / 30% ; Drug Card Program	20% / 25% / 30% ; Drug Card Program
	Out of Network	\$3,000,000	\$500 per ind./ \$1,000 per family	30%		
Premier Sharewell	In Network	\$1,000,000	\$5,000 per family	10%	20%	20%
	Out of Network	\$1,000,000	\$5,000 per family	20%	20%	20%
Exclusive Care	Tier 1 Exclusive Care Network	\$1,000,000	\$250 / \$750	10%	\$15 generic, \$25 brand, \$40 non-formulary (30 day supply) deductible does not apply, Medco pharmacies only	\$30 generic, \$50 brand, \$80 non-formulary (90 day supply) Medco pharmacies only
	Tier 2 Blue Shield Network		\$500/\$1,500	20%		
	Tier 3 Out-of-Network		\$1,000 / \$3,000	40%		

Hospital / Facility Benefits						
		Inpatient	Outpatient	Pre-certification review	Emergency Services	Ambulance
HMO PLANS						
CIGNA Plan		\$100 per admission	\$15 copay	N/A	\$50 copay, waived if admitted	\$0 copay
Kaiser Plan		\$100 per admission	\$15 copay	N/A	\$50 copay, waived if admitted	\$0 copay
Blue Cross Traditional HMO Plan		\$100 per admission	\$0 copay, excludes ER	N/A	\$50 copay, waived if admitted	\$0 copay
Blue Cross Select HMO Plan		\$0 copay	\$0 copay, excludes ER	N/A	\$100 copay, waived if admitted	\$0 copay
PPO PLANS						
Premier Wellwise	In Network	10%	10%	Pre-authorization required	10%	20%
	Out of Network	30%	30%	Pre-authorization required, w/out prior authorization coverage reduced to 50%	30%	30%
Premier Sharewell	In Network	10%	10%	Pre-authorization required	10%	20%
	Out of Network	20%	20%	Pre-authorization required, w/out prior authorization coverage reduced to 60%	20%	20%
Exclusive Care	Tier 1 Exclusive Care Network	10%	10%	Without review, 50% reduction in benefits for inpatient, outpatient and outpatient diagnostic testing	\$50 copay plus 10%	10%, life threatening only
	Tier 2 Blue Shield Network	20%	20%		\$100 copay plus 20%	20%, life threatening only
	Tier 3 Out-of-Network	40%	40%		\$100 copay plus 20%	20%, life threatening only

Physical & Professional Services					
		Physician Office Visits (Primary Care)	Physician Second Opinion	Physician Office Visits (Specialty Care)	Diagnostic X-ray / Lab
HMO PLANS					
CIGNA Plan		\$15 copay	\$15 copay	\$15 copay	\$0 copay
Kaiser Plan		\$15 copay	\$15 copay	\$15 copay	\$0 copay
Blue Cross Traditional HMO Plan		\$15 copay	\$15 copay	\$15 copay	\$0 copay
Blue Cross Select HMO Plan		\$15 copay	\$15 copay	\$30 copay	\$0 copay
PPO PLANS					
Premier Wellwise	In Network	10%	10%	10%	10%
	Out of Network	30%	30%	30%	30%
Premier Sharewell	In Network	10%	10%	10%	10%
	Out of Network	20%	20%	20%	20%
Exclusive Care	Tier 1 Exclusive Care Network	\$10 copay	\$10 PCP \$20 Speciality	\$20 copay	10%; Without review, 50% reduction in benefits for inpatient, outpatient and outpatient diagnostic testing
	Tier 2 Blue Shield Network	\$25 copay	\$25 PCP \$50 Speciality	\$50 copay	20%; Without review, 50% reduction in benefits for inpatient, outpatient and outpatient diagnostic testing
	Tier 3 Out-of-Network	40%	40%	40%	40%; Without review, 50% reduction in benefits for inpatient, outpatient and outpatient diagnostic testing

Mental Health					
		Inpatient Facility	Outpatient Facility	Maximum Yearly Outpatient	Lifetime maximum
HMO PLANS					
CIGNA Plan		\$100 Per Admission up to 30 Days p/calendar yr.	\$20 copay	N/A	N/A
Kaiser Plan		\$100 Per Admission up to 45 Days p/calendar yr.	\$15 copay	20 visits	N/A
Blue Cross Traditional HMO Plan		\$100 Per Admission up to 30 Days per Calendar year	\$20 copay	20 visits	N/A
Blue Cross Select HMO Plan		\$100 Per day up to 30 Days	\$30 copay	20 visits	N/A
PPO PLANS					
Premier Wellwise	In Network	10%, Pre-Admission required		Up to \$50 per visit & 50 visits per year	\$30,000 maximum benefit combined with Alcohol & Substance Abuse below
	Out of Network	30%, Pre-Admission required, out-of-network coverage reduced to 50%			
Premier Sharewell	In Network	10%, Pre-Admission required		Up to \$50 per visit & 50 visits per year	\$30,000 maximum benefit combined with Alcohol & Substance Abuse
	Out of Network	20%, Pre-Admission required, out-of-network coverage reduced to 60%			
Exclusive Care	Tier 1 Exclusive Care Network	Not covered unless a severe mental illness; then covered like any other benefit	\$20 copay up to 30 visits per year; unless a severe mental illness then covered like any other benefit	N/A	N/A
	Tier 2 Blue Shield Network			N/A	N/A
	Tier 3 Out-of-Network	Not covered	Not covered	N/A	N/A

Alcohol & Drug Abuse					
		Inpatient Facility	Outpatient Facility	Maximum Yearly Outpatient	Lifetime maximum
HMO PLANS					
CIGNA Plan		\$100 Per Admission Detox Only	\$15 copay	Detox only	N/A
Kaiser Plan		\$100 Per Admission	No charge	Unlimited	N/A
Blue Cross Traditional HMO Plan		\$100 Per Admission Detox Only	No charge	N/A	N/A
Blue Cross Select HMO Plan		\$100 Per day/detox only	No charge	N/A	N/A
PPO PLANS					
Premier Wellwise	In Network	10%	50%	Up to \$50 per visit & 50 visits per year	\$30,000 maximum benefit combined with Mental Health
	Out of Network	30% 50 visits			
Premier Sharewell	In Network	10%	50%	Up to \$50 per visit & 50 visits per year	\$30,000 maximum benefit combined with Mental Health
	Out of Network	20% 50 visits			
Exclusive Care	Tier 1 Exclusive Care Network	Not covered unless a severe mental illness; then covered like any other benefit	\$20 copay up to 30 visits per year; unless a severe mental illness then covered like any other benefit	N/A	N/A
	Tier 2 Blue Shield Network			N/A	N/A
	Tier 3 Out-of-Network	Not covered	Not covered	N/A	N/A

These benefit charts serve only as a summary of plan benefits. These charts contain the major features of the plan and are not intended to replace the legal documents containing the complete provisions.

► Health Plans for Members Eligible for Medicare

Who is eligible?

If you are a retired member or an eligible dependent eligible for Medicare, you may enroll in the health plans shown on the Health Plans at a Glance chart. The HMO plans and the Kaiser Medicare Advantage plans require you to live within the plan's California service area. Before you enroll, contact the plan to confirm that you live within the plan's service area. Contact information for each plan is shown in the Helpful Information section at the back of this guide. The County of Orange does offer plans that provide coverage to members outside the United States, worldwide.

Generally, when you reach age 65 you are eligible for Medicare through your work history, or the work history of a spouse. You may become eligible at an earlier age if you qualify for Social Security disability benefits and have been receiving those benefits for at least two years.

All eligible retirees and their dependents who are age 65 or older must be enrolled in Medicare Part A & B (Part A if eligible, at no cost) or Part B only to be eligible to receive a Retiree Medical Plan Grant, if applicable, (enrollment in Medicare may also apply to some disability retirements). If you and your spouse are already Medicare eligible, you should enroll in Medicare 90 days prior to your retirement date or from your or your spouse's 65th birthday to enroll in Medicare. Retirees who gain health coverage elsewhere following retirement will be required to enroll in Medicare once eligible. If either the subscriber or the dependent is eligible for Medicare each must enroll (Part A, if at no cost), even if they are actively working with coverage elsewhere.

You may be asked to submit documentation of your Medicare enrollment. Failure to be enrolled in Medicare or submit proof of Medicare coverage (e.g., a copy of your Medicare card) will result in suspension of your Retiree Medical Plan Grant and automatic enrollment in an applicable health plan.

Eligible dependents include your spouse or domestic partner and your unmarried children under age 19 (under age 23 depending upon the plan you choose if verified as being enrolled as a full-time student in an accredited school or university). If you choose to cover a dependent in a County of Orange health plan, premium(s) for all coverage will be deducted from your monthly pension check you receive from OCERS. If your monthly benefit does not fully cover the cost of the plan(s), the Benefits Center will set up direct monthly billing through Benefits Billing Services.

Domestic partners who enroll in any of these plans must contact the Benefits Center for more information regarding the completion of an Affidavit of Domestic Partnership or a Declaration of Domestic Partnership certificate from the State of California.

Medicare Information

Medicare coverage has historically been available in two parts: (1) Part A, which covers many major medical expenses including the costs of hospitalization and (2) Part B, which

covers physician’s office visits and most outpatient hospital services. Generally, you will not be charged when you enroll in Medicare Part A however, you will be charged a monthly premium for Medicare Part B.

Insurance companies and other private companies work with Medicare to offer prescription drug coverage through Medicare Part D. There are costs associated with enrolling directly in Part D and the County of Orange encourages you to contact Medicare for additional information.

The County of Orange health plans include comprehensive medical coverage as well as the Medicare prescription drug coverage; therefore, if you enroll in a County of Orange health plan, your drug coverage will be provided through the County of Orange health plan you select. Except for Premier Sharewell, it is not necessary for you to enroll separately in an additional Medicare drug Plan. Furthermore, as long as you are covered by a County of Orange health plan except for Premier Sharewell you will always have the option of joining a Medicare drug plan in the future without a penalty. The Benefits Center will provide you with the documentation you need to prove that you have had creditable coverage through a County of Orange health plan, which protects you from penalty if you decide to enroll in a separate Medicare drug plan in the future.

Premier Sharewell members should consider enrolling in a Medicare prescription drug plan because Medicare Part D provides additional prescription drug benefits. If you elect Premier Sharewell and do not enroll in Medicare Part D, you may be subject to a late enrollment penalty.

Enrollment

When you are eligible, any delay in enrolling in Medicare will result in higher plan rates for you and a suspension of your Retiree Medical Plan Grant. Usually, if you continue working after turning age 65, you should enroll in Medicare Part A, if at no cost to you but it is not necessary to enroll in Medicare Part B until three months before you terminate your employment. Contact the Benefits Center for details if you are still working at age 65. You should contact the Social Security Administration at 1-800-772-1213 or visit www.Medicare.gov 90 days prior to the month you will turn age 65 to obtain information about enrolling in Medicare.

You may enroll or make changes to your current health plan selection during the annual Open Enrollment period generally in November each year. You may also enroll or make changes if you have an event in your life, Qualified Life Event, that causes you to lose or change coverage you currently have, such as retirement, marriage, death, divorce or relocating out of area. If you enroll outside of Open Enrollment it must be within 30 days of the event that caused you to lose coverage.

If you are eligible for Medicare, but your dependent is not (or you are not and your dependent is), yet you both want to enroll in a County of Orange health plan, you may enroll in separate plans with the same provider. For example, if you want to enroll in a County of Orange Blue Cross Plan, your dependent may elect to enroll in the County of Orange Blue Cross Traditional or Select HMO health plan and you must enroll in the Blue Cross SmartValue Custom health plan, Read more about the County of Orange health plans for

The County of Orange Benefits Center will send you a letter of Credible Coverage to your home address. This letter is your proof that you have County prescription drug coverage that, on average, is as good as Medicare coverage. You will want to retain this letter for your personal records. And, **should** you join a Medicare prescription drug plan at a later date, you may do so without paying a penalty. If you ever enroll in one of the new prescription drug plans approved by Medicare after the May 15, 2006 date or when you dis-enroll from a County health plan, you may need to present a copy of this notice when you join to show that you are not required to pay a higher premium.

Medicare Plans

County Medicare plans	Available in 2008
PPO Plans	Premier Wellwise, Premier Sharewell, Exclusive Care Select
Medicare HMO	CIGNA HMO
Medicare Advantage	Kaiser Senior Advantage
Private Fee-for-Service (PFFS) Medicare Advantage	Blue Cross SmartValue Custom and Blue Cross SmartValue Standard

How the HMO Plans Work

HMO plans provide a comprehensive array of services, including preventive care, at a minimal cost, but you must use providers in the HMO network. An HMO network includes doctors, hospitals, and other health care providers and facilities that have contracted with the HMO to provide care at lower rates. HMOs do not generally pay benefits for care received outside the HMO network, except in emergency situations.

Important features of HMO plans include:

- Minimal co payments for most services (e.g., doctor’s office visits)
- No claim forms
- Coverage for preventive services such as annual physicals, Well-Baby and Well-Woman care, and Immunizations
- No lifetime maximums
- No pre-existing condition exclusions

HMO Option

The County offers one HMO plan:

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

An overview of HMO plan benefits can be found in the Health Plans at a Glance chart at the end of this section. Additional information member service and web site addresses can be found in the Helpful Information section at the end of this guide.

CIGNA HMO Health Plan

A few highlights of the HMO Health Plan

- You select a Primary Care Physician (PCP) from the network to coordinate all of your health care. With the exception of emergency treatment, Well-Woman exams and mental

health services, your PCP must authorize, provide and/or arrange all of your care in order for you to receive benefits.

- You contact your PCP's office when you need care. At the time of your appointment, you present your ID card and pay a small co payment. Upon selection of a HMO plan for the first time or add a dependent, you must select a PCP at the time you enroll.
- Schedule an appointment with an OB/GYN in the same medical group as your PCP without referral.
- You can obtain additional information including provider directories (PCPs) for the Cigna plan through the Benefits Center Web Site, Cigna Web Site Member Services. See Helpful Information in the back of your guide.
- When medication is prescribed, you must fill the prescription at a contracted retail pharmacy or you may order up to a 90-day supply of maintenance drugs through the HMO's mail order program.
- In an emergency, seek care at the nearest hospital. Call or have the doctor or family call your PCP or Member Services within 48 hours to receive benefits.

Medicare Advantage HMO Option

The County offers one Medicare HMO Advantage Option.

- Kaiser Senior Advantage

An overview of Medicare Advantage HMO plan benefits can be found in the Health Plans at a Glance chart at the end of this section. Additional information, member service and web site addresses can be found in the Helpful Information section at the end of this guide.

Kaiser Senior Advantage

A few highlights of the Senior Advantage Health Plan

Kaiser Health Plan offers a health plan specifically designed for retirees who are covered under Medicare Parts A and B (or Part B only) and live in the approved Southern California service area. When you elect to enroll in Kaiser Senior Advantage, you may not enroll in an individual plan or group plan offered by another carrier. You are making a Medicare assignment which requires that your Medicare Parts A & B or Part B only and Medicare Part D be assigned to the health plan.

If a retiree is not enrolled in Kaiser and elects KPSA during Open Enrollment they send in their completed KPSA enrollment form by December 31, 2007 or they will remain in their current coverage. If a retiree submits their enrollment form and it is accepted by Kaiser, they will be enrolled in KPSA.

Enrollment in KPSA requires CMS approval; therefore, if the retirees enrollment is not approved by CMS or they have lost their Medicare coverage, the retiree and their eligible dependents will be defaulted into the Premier Wellwise PPO plan effective the 1st of the month following the notification of the denial.

Likewise, any eligible dependents determined ineligible by CMS for KPSA will result in the retiree and all eligible dependents defaulted into the Premier Wellwise PPO plan effective the 1st of the month following the notification of the denial.

If a retiree is aging in, the above mentioned processes apply, except the retiree will have a 90-day time frame to submit their application and receive CMS approval.

This health plan is especially designed with enhanced benefits for seniors. In addition to basic coverage, the plan may offer limited:

- Dental care
- Hearing exams
- Hospice care
- Podiatry

Medicare Private-Fee-For-Service (PFFS) Options

The County offers two plans to choose from:

- Blue Cross SmartValue Custom
- Blue Cross SmartValue Standard

A few highlights of the Private Fee-For-Service Health Plans

- In order to enroll in either of these plans you must be Medicare A&B eligible. If you enroll in this type of plan you may not enroll in an individual or group plan offered by another carrier. When you elect to enroll in a PFFS, you are making a Medicare assignment, which requires that your Medicare Parts A & B and D be assigned to the health plan.
- With either the BlueCross SmartValue Custom plan or the BlueCross Smart Value Standard plan coverage, you have the freedom to receive health care services from any doctor you choose and with no referrals required. As long as your doctor participates in Original Medicare and is willing to accept the terms and conditions of BlueCross SmartValue, the choice is yours.
- It is important for you to know that care or services you get from providers who are not willing to accept the terms and conditions of the BlueCross SmartValue plans will not be covered, with few exceptions, such as emergencies. In most cases, you will be responsible for charges billed by these non-plan providers.
- Member Services can assist with confirming that a Medicare Provider will accept the SmartValue plans.
- Since your Medicare benefits are assigned to either BlueCross SmartValue plan you elect, you should not additionally sign up for any other individual or group-sponsored health care plan including Medicare Part D. Enrollment requires that Blue Cross verifies your coverage under Medicare Parts A & B & D. It is important if requested that you provide the Blue Cross or Benefits Center a copy of your signed Medicare card or a letter from Social Security stating the effective of your enrollment in Medicare. Providing this information as soon as possible will help to eliminate delays in processing your enrollment.
- If you elect to enroll in the Blue Cross SmartValue Custom or Standard plan and your enrollment is not approved by Centers for Medicare and Medicaid (CMS), you will be defaulted into the Blue Cross Traditional HMO plan. If you have dependents not eligible for Medicare are enrolled in a Blue Cross Select rather than the Traditional HMO, you will be default into the same plan that they are enrolled.

- If you dependent elects to enroll in the Blue Cross SmartValue Custom or Standard plan and their enrollment is not approved by Centers for Medicare and Medicaid (CMS), they will be defaulted into the Blue Cross Traditional HMO plan. If you are not eligible for Medicare and are enrolled in a Blue Cross Select rather than the Traditional HMO, your dependent will be default into the same plan that you are enrolled.
- An overview of plan benefits can be found in the Health Plans at a Glance chart at the end of this section. Additional information, member service and web site addresses can be found in the Helpful Information section at the end of this guide.

How the PPO Plans Work

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

Your PPO Options

You have three PPO plans to choose from:

- County of Riverside, Exclusive Care Select
- Premier Wellwise PPO
- Premier Sharewell PPO

Exclusive Care Select PPO

A few highlights of the Exclusive Care Select PPO plan:

- This plan is administer by the County of Riverside for Retirees and works in coordination with your Medicare benefits to provide comprehensive medical services with lower out-of-pocket costs.
- You must be enrolled in Medicare Part A and/or Part B to sign up for the Exclusive Care Select Plan.
- As a plan participant, you have the flexibility to seek care from any provider who accepts Medicare assignment. Medicare will pay benefits first, with the Exclusive Care Select Plan providing secondary coverage up to the plan limits.
- The plan will pay Tier 1 benefits for Exclusive Care providers.
- The plan will pay Tier 2 benefits for other providers up to the plan limits. You may still seek care from providers who do not accept Medicare; however, you will be responsible for 100% of expenses that are not paid under the plan.
- Some benefits are covered only at Centers of Excellence or specific facilities and require pre-authorization. You should review Exclusive Care’s coverage for further details.
- An overview of plan benefits can be found in the Health Plans at a Glance chart at the end of this section. Additional information, member service and web site addresses can be found in the Helpful Information section at the end of this guide.

A few highlights of the Premier Wellwise PPO plan:

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

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

- This plan provides affordable, comprehensive coverage no matter where you need care — locally, regionally or nationally. The Blue Shield of California network includes more than 9,400 hospitals and 744,000 physicians across the country. You can use the provider directory on Blue Shield of California’s Web Site to find out which hospitals and doctors are in the network, or you can call Blue Shield of California’s Customer Service Center for assistance.
- When you need care, you can go to a provider in (PPO) or outside (non-PPO) the Blue Shield of California preferred provider network. Although the PPO plans have the same network, they have different deductibles and coinsurance amounts. See the Health Plans at a Glance chart for details.
- When you see a PPO provider, present your ID card at the time of your appointment. Your provider files the paperwork for your claim and you receive a bill in the mail for your deductible and/or coinsurance amount — 10% of the discounted rate for most covered services.
- For Premier Wellwise, when you see a non-PPO provider, you generally pay 30% of the Usual, Reasonable and Customary charge for most covered services you have a higher deductible and, in some instances, you may have to pay up front. You are responsible for all expenses about URC.
- Premier Wellwise pays 100% of eligible in-network health care expenses that exceed \$10,000 per calendar year per participant and 100% of eligible out-of-network health care expenses that exceed \$15,000 per calendar year per participant. You may also be responsible for any additional expenses above URC.
- You are responsible for 100% of expenses that are not eligible under the plan.
- If you’re scheduled for hospital admission or surgery, you must contact the claim administrator, Blue Shield of California, to obtain pre-certification for the hospital stay before admittance to receive the higher level of benefits.
- In an emergency, seek care at the nearest hospital and call or have the doctor or a family member call Blue Shield of California’s Customer Service Center within 2 business days of admission to a hospital.

An overview of plan benefits can be found in the Health Plans at a Glance chart at the end of this section. Additional information, member service and web site addresses can be found in the Helpful Information section at the end of this guide.

Prescription Drug Benefits — Premier Wellwise PPO

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

You must fill your prescriptions through WHI’s participating retail pharmacies or through their mail service program. Please note: you do not need to go to a WHI’s pharmacy but you can use any participating pharmacy in the WHI’s pharmacy network. Claims for prescriptions obtained out of the network as a result of an emergency must be paid in full then filed with Blue Shield of California, the PPO claims administrator. When you purchase prescription drugs from a Walgreens participating retail pharmacy, you will always present your health plan ID card to the pharmacist. The Advantage90 Program is a convenient way to get a 90-day supply of your medications at select retail locations. (Your doctor must authorize a 90-day supply of medication(s). Some medications may not be available in 90-day supplies under applicable law.) This is a great way to save time and money and for more information please visit WHI’s web site at www.mywhi.com or call toll free **1-800-573-3583** with any questions you might have. For mail service prescription drugs, or if you have a new “maintenance” medication prescription, you may use WHI’s Mail Order program.

Here’s an overview of WHI’s prescription drug coverage:

Type of Medication	30-Day Retail Coinsurance	90-Day (Advantage90) Retail Coinsurance	90-Day Mail Service Coinsurance
Generic	20%	20%	20%
Brand Formulary	25%	25%	25%
Non-formulary	30%	30%	30%

The Premier Wellwise Plan has a prescription formulary through Walgreens Health Initiatives which is a list of prescription drugs that includes all Generic Drugs and certain Brand-Name Drugs. The Formulary includes only those Brand-Name Drugs that do not have a generic equivalent or may be a less-expensive but equally effective alternative to other Brand-Name Drugs. The County’s Pharmacy Benefit Manager, Walgreens Health Initiatives determines which Brand-Name drugs are included on the Formulary.

Premier Sharewell (HSA Compliant Health Plan)

A few highlights on the Premier Sharewell PPO plan:

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

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

- This plan provides affordable, comprehensive coverage no matter where you need care — locally, regionally or nationally. The Blue Shield of California includes more than 9,400 hospitals and 744,000 physicians across the country. You can use the provider directory on Blue Shield of California’s Web Site to find out which hospitals and doctors are in the network, or you can call Blue Shield of California’s Customer Service Center for assistance.
- When you need care, you can go to a provider in (PPO) or outside (non-PPO) the Blue Shield of California preferred provider network. Although the PPO plans have the same provider network, they have different deductibles and coinsurance amounts. See the Health Plans at a Glance chart for details.
- When you see a PPO provider, present your ID card at the time of your appointment. Your provider files the paperwork for your claim and you receive a bill in the mail for your deductible and/or coinsurance amount — 10% of the discounted rate for most covered services.
- For Premier Sharewell, when you see a non-PPO provider, you generally pay 20% of the Usual, Reasonable and Customary charge for most covered services you have a higher deductible and, in some instances, you may have to pay up front.
- Premier Sharewell pays 100% of eligible health care expenses that exceed \$10,000 per calendar year per participant.
- You are responsible for 100% of expenses that are not eligible under the plan.
- If you’re scheduled for hospital admission or surgery, you must contact the claim administrator, Blue Shield of California, to obtain pre-certification for the hospital stay before admittance to receive the higher level of benefits.
- In an emergency, seek care at the nearest hospital and call or have the doctor or a family member call Blue Shield of California’s Customer Service Center within 2 business days of admission to a hospital.
- Sharewell is a Health Savings Account (HSA) compliant health plan. The Plan design complies with a HSA, high deductible plan but without the Health Savings Account contribution. Retirees may establish their own HSA to which they may contribute and pay

Sharewell co-payments, deductibles and qualified health care expenses on a non-taxable basis. Individuals can set-up Health Savings Account through financial institutions. Please consult your financial advisors for details regarding HSAs and the tax implications before establishing an account.

An overview of plan benefits can be found in the Health Plans at a Glance chart at the end of this section. Additional information, member service and web site addresses can be found in the Helpful Information section at the end of this guide.

Prescription Drug Benefits — Premier Sharewell PPO

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

Medicare Part B Only Enrollees

If you are (or your dependent is) covered by Medicare Part B only, different rates may apply. Please refer to your Personalized Benefits Enrollment Summary that is contained in your annual Open Enrollment package or your intent to retire package. You may also contact the Benefits Center by dialing toll-free 1-866-325-2345 to confirm your monthly rate if this situation affects you.

Retirees with Part B only are also eligible for the Blue Cross Traditional or Blue Cross Select HMO Plans. An overview of HMO plan benefits can be found in the Health Plans For Participants Not Eligible for Medicare and in the Health Plans at a Glance chart at the end of the Participants Not Eligible for Medicare section. Additional information, member service and web site addresses can be found in the Helpful Information section at the end of this guide.

Mixed Family Enrollees

If you are not eligible for Medicare, but your dependent is (or if you are, and your dependent is not), yet you both want to enroll in County health plans, you may enroll in separate plans with the same provider. For example: The Non-Medicare participant may select the Blue Cross Traditional or Blue Cross Select HMO plan while the Medicare Eligible participant selection option would be to enroll in the Blue Cross SmartValue Custom plan.

An overview of Blue Cross HMO plan benefits can be found in the Health Plans For Participants Not Eligible for Medicare and Health Plans for Participants Eligible for Medicare. Additional information can be found in the Health Plans at a Glance chart at the end of the Participants Not Eligible for Medicare section. Member service and web site addresses can be found in the Helpful Information section at the end of this guide.

Please refer to your Personalized Benefits Enrollment Summary that is contained in your annual Open Enrollment package or your intent to retire package. You may also contact the Benefits Center by dialing toll-free 1-866-325-2345 to confirm the plans available for enrollment and the monthly rate if this situation affects you.

Health Plan Identification Cards and Claim Forms

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

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

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

RMEs and RMRs

Retiree Married to an Employee (RME)

If you're a retiree married to a County employee, both the County retiree and the active County employee must let the County know your status by calling the Benefits Resource Line and speaking with a Benefits Specialist. If you are eligible to be enrolled as a dependent on your spouse's County health plan, you may elect either to be enrolled individually in a retiree health plan with your Retiree Medical Plan Grant or be enrolled as a dependent under your spouse's employee health plan. Active employees pay normal bi-weekly deductions.

If you elect coverage as a dependent on your spouse's County health plan, your Retiree Medical Plan Grant will be suspended. If you later enroll in the retiree health plan (during annual Open Enrollment or within 30 days after a Qualified Life Event), your Retiree Medical Plan Grant will be reinstated at the start of the new plan year or on the first of the month following the Qualified Life Event.

Retiree Married to a Retiree (RMR)

If you are a County retiree married to another County retiree, both County retirees must notify the County of your status by calling the Benefits Resource Line and speaking with a Benefits Specialist. If you and your spouse enroll in the same County retiree health plan, one of you must be enrolled as a subscriber and the other must be enrolled as a dependent. You may choose to combine your Retiree Medical Plan Grants or enroll in different County health plans, utilizing your Retiree Medical Plan Grants separately.

RME and RMR Participants Must Enroll on the Benefits Resource Line

If you're a retiree married to an employee (RME) or a retiree married to a retiree (RMR) from the County, you will not be able to enroll in your health plan online — you must call the Benefits Resource Line and speak to a Benefits Specialist.

If you are participating in the RME or RMR program for the first time, you both must call the Benefits Resource Line to make your election prior to sending in your RME or RMR form, available on the Benefits Center Web Site. If you're a current retiree, you'll need to return your completed form to the Benefits Center by the Open Enrollment deadline. If you're a

new retiree, you'll need to return your completed form to the Benefits Center within your 30-day enrollment period.

Making your Decision

When making your decision about which plan will provide the best coverage, it is important to consider the differences among the types of plans that coordinate with Medicare. To recap: The County of Orange offers several types of insurance plans for members covered by Medicare Parts A & B or Part B only:

1. **A Preferred Provider, PPO plan: Premier Wellwise, Premier Sharewell and Exclusive Care Select.** When you choose a PPO plan, you have the flexibility to receive all covered services provided by the physician or facility of your choice, as long as your insurance is accepted. However, you will pay less if you select a physician or facility within the plan's Preferred Provider network. This is because: (1) the network physicians charge pre-negotiated discounted rates to patients for services and (2) the plan reimburses network physicians a higher percentage of those costs.
2. **A Medicare HMO Plan: CIGNA** accepts Medicare Parts A & B or Part B only and coordinates its coverage with Medicare. When you select an HMO, the plan contracts with its own network of hospitals, pharmacies and physician group. All of your care is coordinated by your Primary Medical Group or your Primary Care Physician that you choose from a list of doctors that the plan has contracted with to provide services. You may also use your Medicare card to obtain services outside your health plan. For these services, you are responsible for any co-payments or deductibles that Medicare does not cover. This type of plan also offers prescription drug coverage.
3. **A Medicare Advantage Plan; Kaiser Permanente Senior Advantage Plan** accepts Medicare Parts A & B or Part B only. This type of plan requires that your Medicare Parts A & B and D be assigned to the health plan. If you enroll in this type of plan you may not enroll in an individual or group plan offered by another carrier. In this type of plan, you must use the plan's network of hospitals, skilled nursing facilities, pharmacies and physician groups at all time except for emergencies or urgent care out of the plan's service area. All of your care is coordinated by your Primary Care Physician, which you select from a list of doctors provided by the plan. This type of plan also offers prescription drug coverage.

If a retiree is not enrolled in Kaiser and elects KPSA during Open Enrollment they send in their completed KPSA enrollment form by December 31, 2007 or they will remain in their current coverage. If a retiree submits their enrollment form and it is accepted by Kaiser, they will be enrolled in KPSA.

Enrollment in KPSA requires CMS approval; therefore, if the retirees enrollment is not approved by CMS or they have lost their Medicare coverage, the retiree and their eligible dependents will be defaulted into the Premier Wellwise PPO plan effective the 1st of the month following the notification of the denial.

Likewise, any eligible dependents determined ineligible by CMS for KPSA will result in the retiree and all eligible dependents defaulted into the Premier Wellwise PPO plan effective the 1st of the month following the notification of the denial.

If a retiree is aging in, the above mentioned processes apply, except the retiree will have a 90-day time frame to submit their application and receive CMS approval.

4. **A Medicare Private-Fee-For-Service (PFFS) Plan: Blue Cross SmartValue Custom and Blue Cross Standard** accept Parts A & B only. These plans require that your Medicare Parts A & B and D be assigned to the health plan. If you enroll in this type of plan you may not enroll in an individual or group plan offered by another carrier. When you enroll in a PFFS, you are making a Medicare assignment, which requires that your Medicare be assigned to a health plan.

With either the BlueCross SmartValue Custom plan or the BlueCross Smart Value Standard plan coverage, you have the freedom to receive health care services from any doctor you choose and with no referrals required. As long as your doctor participates in Original Medicare and is willing to accept the terms and conditions of BlueCross SmartValue, the choice is yours. It is important for you to know that care or services you get from providers who are not willing to accept the terms and conditions of the BlueCross SmartValue plans will not be covered, with few exceptions, such as emergencies. In most cases, you will be responsible for charges billed by these non-plan providers.

If you elect to enroll in the Blue Cross SmartValue Custom or Standard plan and your enrollment is not approved by Centers for Medicare and Medicaid (CMS), you will be defaulted into the Blue Cross Traditional HMO plan. If you have dependents not eligible for Medicare who are enrolled in a Blue Cross Select rather than the Traditional HMO, you will be default into the same plan that they are enrolled.

If your dependent elects to enroll in the Blue Cross SmartValue Custom or Standard plan and their enrollment is not approved by Centers for Medicare and Medicaid (CMS), they will be defaulted into the Blue Cross Traditional HMO plan. If you are not eligible for Medicare and are enrolled in a Blue Cross Select rather than the Traditional HMO, your dependent will be default into the same plan that you are enrolled.

After you have made your decision, either enroll via the Benefits Center Web Site simply by logging onto www.benefitsweb.com/countyoforange.html or contacting the Resources Line by dialing the toll-free phone number at 1-866-325-2345. A Benefits Specialist will be available from Monday through Friday 7:30 am to 5:30 pm Pacific Time, except on holidays, to take your elections.

Plan information is shown on the Health Plans at a Glance in the center of this guide. Note: In many places on the chart you will see a comment regarding coverage that explains the service or care is: “Covered per Medicare guidelines.” This means that the plan coverage is the same as Medicare coverage. For Example: Medicare does not cover routine eye exams. Therefore, if the plan coverage is per Medicare guidelines for vision care, then the plan will not cover routine eye exams.

The chart includes additional detail and co-payment information for each plan, after you have made your decision; either enroll through the Benefits Center Web Site simply by logging on at www.benefitsweb.com/countyoforange.html or by speaking to a Benefits Specialist at the Benefits Center Resources Line by dialing toll-free 1-866-325-2345.

Contact the Social Security Administration at 1-800-772-1213 or visit www.Medicare.gov 90 days prior to the month you will turn age 65 to obtain information about enrolling in Medicare.

► Health Plans at a Glance for Members Eligible for Medicare

Determine the monthly cost of your County of Orange health plan coverage you are considering — and apply your retiree medical insurance grant (if applicable) so you know how much you will pay for your own coverage each month. Next, consider dependent coverage, adding dependents may and will change the amount you'll pay each month for your health insurance coverage. You should review your Retiree Medical Plan Grant. This will be used to offset part of your health insurance premium. The net amount remaining after your Grant is applied is the amount that is deducted from your monthly retirement pension check you receive from OCERS, if applicable.

Medicare eligibility usually changes a person's health care options. If you are eligible (or will soon become eligible), be certain you understand your options and have any questions in advance of making your decision.

		Maximum Lifetime Benefits	Calendar year Deductible	Member Coinsurance	Prescription Drug Benefits	
					Retail Pharmacy	Mail order
HMO PLANS						
CIGNA Plan		N/A	\$0	N/A	\$10 Generic; \$20 Brand; \$40 Non-Formulary (up to 30 day supply)	\$10 Generic; \$20 Brand; \$40 Non-Formulary (up to 90 day supply)
Kaiser Senior Advantage Plan		N/A	\$0	N/A	\$10 Generic; \$20 Brand (up to 100 day supply)	\$10 Generic; \$20 Brand (up to 100 day supply)
PRIVATE FEE-FOR-SERVICE PLANS						
Blue Cross Custom PFFS Plan PART A&B		N/A	\$0	N/A	\$10 Generic; \$15 Brand (up to 30 day supply)	\$20 Generic; \$30 Brand (up to 90 day supply)
Blue Cross Standard PFFS Plan PART A&B		N/A	\$0	N/A	\$10 Generic; \$30 Brand; \$60 Non-Formulary (up to 30 day supply)	\$20 Generic; \$60 Brand; \$120 Non-Formulary (up to 90 day supply)
PPO PLANS						
Premier Wellwise	In Network	\$3,000,000	\$300/\$600	10%	20%/25%/30% Drug Card Program	20%/25%/30% Drug Card Program
	Out of Network	\$3,000,000	\$500/\$1000	30%		
Premier Sharewell	In Network	\$1,000,000	\$5,000 per family	10%	20%	20%
	Out of Network	\$1,000,000		20%	20%	20%
Exclusive Care	Tier 1 - Exclusive Care Network	\$1,000,000	\$250/\$750	10%	\$15 generic, \$25 brand, \$40 non-formulary deductible does not apply, Medco pharmacies only	\$30 generic, \$50 brand, \$80 non-formulary (90 day supply) Medco pharmacies only
	Tier 2 - Medicare Provider		\$500/\$1500	20%		

Physical & Professional Services (continued)					
	Immunizations (Flu and Pneumonia)	Home Health Care	Skilled Nursing Facility	Chiropractic Therapy	
HMO PLANS					
CIGNA Plan	\$0 copay	\$0 copay	\$0 copay (up to 100 days)	\$15 copay per visit (30 visits/year)	
Kaiser Senior Advantage Plan	\$0 copay	\$0 copay	\$0 up to 100 days	\$15 copay up to 30 visits per year	
PRIVATE FEE-FOR-SERVICE PLANS					
Blue Cross Custom PFFS Plan PART A&B	\$0 copay	\$0 copay	\$0 copay up to 100 days	\$15 copay (30 visits/year)	
Blue Cross Standard PFFS Plan PART A&B	\$0 copay	\$25 copay; if you pre-notify copay is \$0	\$150 copay p/day; if you pre- notify copay is \$75. Responsible for 15% coinsurance of the Medicare allowed amt.	\$20 copay	
PPO PLANS					
Premier Wellwise	In Network	No charge	10%	Limited 60 Days 10% coinsurance for In Network, 30% coinsurance for Out of Network, max benefit of \$1,000 per calendar year	
	Out of Network	Not covered	30%		
Premier Sharewell	In Network	No charge	10%	Limited 60 Days 10% (50 visits/yr) 20% (50 visits/yr)	
	Out of Network	Not covered	20%		
Exclusive Care	Tier 1 - Exclusive Care Network	\$10 copay	10% up to 100 days	10%	Not covered
	Tier 2 - Medicare Provider	\$25 copay	20% up to 100 days	20%	Not covered

Preventative Services					
	Annual Physical Exam	Well Woman Exams	Routine Vision Exam	Durable Medical Equipment	
HMO PLANS					
CIGNA Plan	\$15 copay	\$15 copay, breast and pelvic only. may self-refer w/in group	\$15 copay	\$0 copay when prescribed by PCP	
Kaiser Senior Advantage Plan	\$15 copay	\$15 copay, may self-refer to a Kaiser provider; mammography \$0 copay	Vision allowance: \$150 Frame and Lens Allowance Every 24 Months; contact lenses at no charge when medically necessary	\$0 copay	
PRIVATE FEE-FOR-SERVICE PLANS					
Blue Cross Custom PFFS Plan PART A&B	\$15 copay (1 per year)	Mammogram - \$0 copay Pelvic/Pap - \$15 copay - see health plan for further details	\$15 copay	\$0 copay for DME charges over \$750 if you pre-notify	
Blue Cross Standard PFFS Plan PART A&B	\$20 copay (1 per year)	Mammogram - \$0 copay Pelvic/Pap - \$0 copay - see health plan for further details	Not covered	\$100 copay for DME charges over \$750; \$0 copay if you pre- notify; 20% coinsurance on all Medicare approved DME	
PPO PLANS					
Premier Wellwise	In Network	750 in & out of network	750 in & out of network	N/A	Covered
	Out of Network	750 in & out of network	750 in & out of network	N/A	Covered
Premier Sharewell	In Network	No charge, up to a max annual benefit amount of \$250 (\$250 annual limit does not apply to specific procedures listed under "Wellness Benefit" in plan document		N/A	Covered
	Out of Network	Liimited to specific procedures listed under "Wellness Benefit" in plan document		N/A	Covered
Exclusive Care	Tier 1 - Exclusive Care Network	\$10 copay	\$10 copay	\$10 copay	10% up to a max of \$1,000
	Tier 2 - Medicare Provider	\$25 copay	\$25 copay	\$25 copay	20% up to a max of \$1,000

► Retiree Medical Information

Current retirees that were represented by American Federation of State, County and Municipal Employees (AFSCME) with a date of retirement *prior* to September 30, 2005

If you retired prior to September 30, 2005 and you were an (AFSCME) Eligibility Worker on the date of retirement you are eligible to participate in the County's health plans and the Retire Medical plan.

When you retire you may be eligible to receive a Retiree Medical Plan Grant (Grant to use toward the cost of your County health plan and/or your Medicare premium. The Grant is not a vested nor entitled benefit and is not guaranteed. To be eligible for the Grant, you must:

- Have retired prior to September 30, 2005,
- Have a minimum of 10 years of continuous eligible County service, if you have a normal retirement. However, if you've been granted a non-service-connected disability, you must have a minimum of five years of service. If you've been granted a service-connected disability, there is no minimum-service requirement.
- Be at least 50 years old on your date of retirement,
- Receive a monthly retirement allowance from the Orange County Employees Retirement System (OCERS), and
- Be enrolled in a County health plan when you retire.
- The amount of the Retiree Medical Plan Grant you receive is based on your years of eligible service hours to a maximum of 25 years multiplied by a base dollar amount. The base dollar amount is adjusted up or down annually up to a maximum of 5%.
- The Retiree Medical Plan Grant will be applied first to offset the cost of your and/or your spouse's Medicare premium reimbursement, if applicable. You cannot receive the Medicare reimbursement if you're currently receiving Medicare reimbursement from another source.
- If the total of your monthly County health plan premium and your Medicare premium reimbursement is less than the total monthly Retiree Medical Plan Grant, the excess Grant is forfeited.

Retirees who gain health coverage elsewhere following retirement and who wish to use their Grant to reimburse Medicare premiums will be required to enroll in Medicare once eligible. Both the subscriber and an eligible dependent must enroll in Medicare A & B (Part A, if at no cost), even if they are actively working with coverage elsewhere.

Survivor Benefits

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

Survivor Health Care Coverage

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

- Be covered under the deceased employee’s or retiree’s County health plan at the time of his or her death
- Receive a month retirement allowance from OCERS, exceptions to the rule include:
 - Dependent children under age 19 (or under age 23 if a full-time student) who aged out of received a monthly retirement allowance from OCERS but are still eligible under the plan
 - Incapacitated children and surviving spouses who aren’t eligible for a monthly retirement allowance but are eligible for heath plan coverage

Survivor Retiree Medical Grant Benefits

To be eligible for a Survivor Grant, you must:

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

Current retirees that were represented by American Federation of State, County and Municipal Employees (AFSCME) on the date of retirement *on or after September 30, 2005*

If you retired on or after September 30, 2005 and you were an (AFSCME) Eligibility Worker on the date of retirement you are eligible to participate in the County’s health plans if you were enrolled when you retired: however, you are not eligible to participate in the Retiree Medical Plan.

Survivor Health Care Coverage

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

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

▶ Helpful Information

You can find answers to most of your questions about benefits and enrollment by contacting the County of Orange Benefits Center. If you need additional information after contacting the Benefits Center, you can contact the plans directly.

For Questions About...	Click or Call...
Benefits or Enrolling	
• Benefits Center Web Site	www.benefitsweb.com/countyoforange.html
• Benefits Center Resource Line	1-866-325-2345 Benefits Specialists are available Monday through Friday between 7:30 a.m. and 5:30 p.m., Pacific Time, except holidays
• Employee Benefits	www.oc.ca.gov/hr/employeebenefits
Your Health Plans	
• American Specialty Health Plans (HMO chiropractic care)	www.ashcompanies.com 1-800-678-9133 P.O. Box 509002 San Diego, CA 92150-9002
PPO Health Plans	
• Blue Shield of California Plan Administrators (claim administrator for the Premier Wellwise and Premier Sharewell PPO plans and provider network)	www.blueshieldca.com/oc 1-888-235-1767 P.O. Box 272540 Chico, CA 95927-2540
• Exclusive Care Select Plan PPO Plan	www.exclusivecare.com 1-800-962-1133 P.O. Box 1508 Riverside, CA 92502
HMO Health Plans	
• Blue Cross HMO health plans (Traditional & Select)	www.bluecrossca.com/countyoforange 1-800-700-2541 P.O. Box 60007 Los Angeles, CA 90060-0700
• CIGNA Health Plan HMO	www.cigna.com/countyoforange 1-800-244-6224 North Brand Blvd. Glendale, CA 91209
• Kaiser Health Plan HMO	www.kp.org 1-800-464-4000
Medicare Advantage Health Plan	
• Kaiser Senior Advantage	www.kp.org 1-800-443-0815 Kaiser California Service Center P.O. Box 232400 San Diego, CA 92193
Private-fee-for-Service Health Plans	
• Blue Cross (SmartValue Custom Plan & SmartValue Standard Plan)	www.bluecrossca.com/countyoforange 1-877-326-2201 P.O. Box 795180 San Antonio, TX 78279

Prescription Drugs	
• Walgreens Health Initiatives, (WHI) (for the Premier Wellwise PPO Plan)	www.mywhi.com 1-800-573-3583 P.O. Box 691569 Orlando, FL 32869
Vision Plan	
• Vision Service Plan (CIGNA HMO)	www.vsp.com 1-800-877-7195 P. O. Box 997105 Sacramento, CA 95899-7105
Retirement Benefits	
• Orange County Employees Retirement System (OCERS)	www.ocers.org 1-888-570-6277 2223 Wellington Ave. Santa Ana, CA 92701
• Retired Employees Association of Orange County (REAOC)	www.reaoc.org 1-714-840-3995
• Social Security Administration (Medicare coverage)	1-800-772-1213
COBRA	
• COBRA Continuation Services	www.ceridian-benefits.com 1-800-877-7994 34th Street South St. Petersburg, FL 33711
Billing	
• Benefits Billing Services	www.ceridian-benefits.com 1-800-995-9935 3201 34th Street South St. Petersburg, FL 33711

Network Directories Online

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

To View Network Directories for...	Go to...
CIGNA Health Plan	www.cigna.com/countyoforange
Kaiser Health Plan Kaiser Senior Advantage Plan	www.kp.org
Premier Wellwise Plan	www.blueshieldca.com/oc
Premier Sharewell Plan	www.blueshieldca.com/oc
Exclusive Care Select Plan	www.exclusivecare.com
Blue Cross Traditional HMO Health Plan	www.bluecrossca.com/countyoforange
Blue Cross Select HMO Health plan	www.bluecrossca.com/countyoforange
Blue Cross SmartValueCustom Plan	www.bluecrossca.com/countyoforange
Blue Cross SmartValue Standard Plan	www.bluecrossca.com/countyoforange

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

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