QUICK START
BROCHURE

TO GET YOU ON THE RIGHT BENEFITS PATHWAY

County of Orange

What's Inside

This brochure describes important information about the County of Orange health care plan benefits. Every effort has been made to ensure the accuracy of the information in this brochure. To the extent there is a conflict between the information in this brochure and the official plan documents, the plan documents will govern in all cases.

Step 1:

When Do I Enroll, and Who Can I Cover?

We understand it is hard to find time in your busy life to follow the benefits pathway that is right for you and your family. We also understand that selecting the right path isn't always easy. This is why the County created this Quick Start Brochure. It can help you easily locate the tools and resources you need to choose the right benefits and avoid the pitfalls that can occur if you don't understand your benefit provisions and requirements.

While this brochure highlights key information, it does not include everything you need to know about your benefits. So, it is important to review the additional information provided in the *Benefits Enrollment Guide* as well as the plan documents and each plan's Summary of Benefits and Coverage posted on the **Benefits Center Web Site** to fully understand all of your benefit plans.

QUICK START TO YOUR RESOURCES FOR ENROLLMENT HELP AND BENEFITS INFORMATION

The Benefits Center is your centralized resource for benefits eligibility, enrollment, information, and assistance. The Benefits Center is dedicated to providing you with high quality service and access to benefits information in the most efficient way.

Benefits Center Web Site: *www.benefitsweb.com/countyoforange.html*. Available 24 hours a day, 7 days a week. Here you can:

- Enroll yourself and your eligible dependents
- Report Qualified Life Events (QLEs) such as birth or marriage and make eligible changes to your benefits (you must make changes within 30 days of the event)
- Update your personal and dependent information
- Review and compare Summary of Benefits and Coverage (SBC) documents for each County-offered health plan.
- Review monthly direct billing and COBRA invoices and your payment history
- Link to health plan provider directories and web sites to get detailed information about your benefits
- Research medical conditions and procedures, or calculate the tax savings you might achieve by enrolling in a Health Care or Dependent Care Reimbursement Account.

Benefits Resource Line: 1-866-325-2345. Talk to a Benefits Specialist Monday through Friday, 7:30 a.m. to 5:30 p.m., PT, except holidays. By speaking with a Benefits Specialist you can:

- Enroll yourself and your eligible dependents
- Report Qualified Life Events (QLEs) such as birth or marriage, and make eligible changes to your benefits (you must notify the Benefits Center within 30 days of the event)
- Get answers to questions or additional guidance
- Inquire about communications you received from the Benefits Center
- Connect with a translation service for assistance in another language at no cost to you. For TDD communication services for the hearing impaired, call toll-free 1-800-TDD-TDD4 (833-8334).

When Do I Need to Enroll?

When:

- You are a new employee
- It is the Annual Open Enrollment period
- You experience a Qualified Life Event (QLE) or a change in job status (you must notify the Benefits Center within 30 days of the QLE)
- You have moved out of your health plan's coverage area (HMO plans)
- You are going out or returning from a Leave of Absence

More information is available in *Step 3* of this brochure.

Who Can I Cover?

Yourself

You are eligible for health plan coverage if you are either a:

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

Your Dependents

You can enroll your eligible dependents for County of Orange health plan coverage. Dependents must satisfy certain requirements to qualify. When you enroll your eligible dependents, you must provide documentation of eligibility. See "What Documents Must I Provide?" on page 3 for details. Your dependents are eligible if they are your:

- Legal spouse or registered domestic partner. Same sex spouses who are legally married in a state that recognizes same sex marriage may be enrolled as a legal spouse. (see note on page 3 for tax treatment of benefits for domestic partners)
- Children under the age of 26, including stepchildren, foster children, children placed for adoption, legally adopted children, and children of domestic partners. (see note below for tax treatment of benefits for children of domestic partners)
    - The term "children" does not include your dependent child's spouse or domestic partner or the children of your dependent child (your grandchildren).
    - Incapacitated children age 26 and over who are dependent on you for support and were incapacitated prior to their 26th birthday. These children did not have to be covered by the County of Orange when they became incapacitated if the event was prior to their 26th birthday. Your health plan will determine whether a dependent meets the criteria for an incapacitated child.
    - **IMPORTANT DEPENDENT ELIGIBLITY CHANGE FOR COUNTY HEALTH PLANS:** Effective January 1, 2014, dependent children ages 19 through 25 may be covered under a County health plan even if they are eligible for other employer health plan coverage (i.e., through their or their spouse's employer). Previous restrictions on coverage have been eliminated. You are still required to provide dependent verification documents. See "What Documents Must I Provide?".

DOMESTIC PARTNER COVERAGE

The County of Orange offers many of its benefit plans to the registered domestic partners of eligible employees and eligible dependent children of those domestic partners. You can find out more about domestic partner coverage by calling the toll-free Benefits Resource Line at 1-866-325-2345 and speaking with a Benefits Specialist. Benefits Specialists are available Monday through Friday, 7:30 a.m. to 5:30 p.m. PT, except on holidays.

Please note: Employer contributions to health premiums for a domestic partner or children of an employee's domestic partner may be treated as imputed income. [1] Your employee health premium contribution will also be made after taxes are withheld from your wages instead of before they are taxed. Please consult your tax advisor for guidance.

[1] The portion of cost the County incurs (after you pay the employee cost) to ensure your qualifying domestic partner (and eligible dependents, if any). This cost is accrued and added to your gross income as imputed income. Imputed income is subject to federal, state and local income tax withholding and is reflected in your year-end W-2 statement.

Note: Special rules apply to state income taxation of coverage for state-registered domestic partners.

What Documents Must I Provide?

By enrolling or continuing enrollment in any of the County's benefit plans, 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 will be required to provide written documentation of eligibility at the time of enrollment. Forms of written documentation may, among other things, include:

- Marriage certificate
- Birth certificate
- Tax return documentation (or other documents verifying ongoing marriage status)

Please see the Eligibility Definitions and Required Documentation list that is available on the Benefits Center Web Site for a complete list of the required documentation for your dependent.

IMPORTANT DEADLINES!

30 Days to Report your Qualified Life Events/Changes: You will have 30 days from the event that made you or your dependent eligible (hire date, date of birth or marriage, etc.) to notify the Benefits Center to make your dependent elections.

60 Days to Provide Required Documentation: You will have 60 days from the event that made you or your dependent eligible (hire date, date of birth or marriage, etc.) to return a signed and completed Dependent Verification Form and documentation of eligibility to the County of Orange Benefits Center. The form and instructions will be included with your Benefits Confirmation Statement. Once your documents are received and reviewed, you will receive an acceptance or denial letter followed by a Benefits Confirmation Statement. You may send any required documents to the Benefits Center by fax at 1-973-837-3330. Be sure to include your social security number and daytime phone number on the fax and identify yourself as a County of Orange benefit plan member. Also, be sure to save a copy of your fax confirmation page for your records.

If you fail to respond with the form and required documentation within the 60 days, coverage for your dependent will be cancelled at the end of the month in which the 60-day period ends even if you have already received your health ID card. You will be responsible for any medical expenses incurred after coverage ends. If your dependent's coverage is denied or cancelled for failure to provide the required documentation, **you will not be permitted to enroll your dependent(s) again until the next Annual Open Enrollment period** unless you experience a new Qualified Life Event as defined by IRS regulations.

At any time you may verify the receipt and review status of your dependent documentation by visiting the Benefits Center Web Site at www.benefitsweb.com/countyoforange.html and selecting **My Benefits > Verify My Dependents.**

WHEN YOUR DEPENDENT LOSES ELIGIBILITY

If your dependent loses eligibility, you must notify the Benefits Center within 30 calendar days of any event that causes your covered dependent to no longer meet eligibility requirements (the "loss of eligibility event"). If an ineligible dependent has been enrolled, or you fail to report a loss of eligibility event, such as a divorce, within 30 days of the event, you may be responsible for repayment of the County's portion of your premiums retroactive to the date of ineligibility as well as the cost of medical services provided to ineligible dependents. In addition, if you fail to report the loss of ineligibility within 30 days of the event, your dependents may not be eligible for continuation of coverage through COBRA.

Step 2:

What Do I Need to Do and How Can I Get Help?

Quick Start to Understanding Your Responsibilities

It is your responsibility to enroll in the benefits plan that is right for you and your family and to report and make changes to your benefits when you experience a Qualified Life Event (QLE). While this brochure highlights key information, it does not include everything you need to know about your benefits. It is important you take the time to review the additional information provided in the Benefits Enrollment Guide as well as the plan documents posted on the Benefits Center Web Site to fully understand all of your benefit plans.

Follow these steps as you prepare to enroll.

1. Review the enclosed Benefits Enrollment Summary for all your options, costs, instructions, and deadlines to finalize your enrollment.
2. Review the Benefits Enrollment Guide that is available online at the Benefits Center Web Site and discuss your options with your entire family to ensure you make an enrollment choice that works for everyone you cover.
3. Know what your plans do and do not cover, as well as how to access services or file claims. All plans have limitations and exclusions and some plans have prior authorization requirements. You should be aware of all of these factors before you enroll. Review each plan's Summary of Benefits and Coverage, available on the Benefits Center Web Site, to compare plan offerings.
4. Make your elections and be sure to receive and review your Benefits Confirmation Statement for accuracy. Errors/corrections in elections you made must be reported within 10 business days.
5. If you are enrolling a new dependent, complete and sign a Dependent Verification Form and submit the form with documentation of eligibility to the County of Orange Benefits Center within the 60 day deadline. See "What Documents Must I Provide?" on page 3 for details.
6. Report life events or changes on-line or over the telephone within 30 days of the event.

Once you enroll in the plan that meets your needs, learn as much as you can about how to maximize your experience as a member. The Benefits Center Web Site and many of the insurance carriers offer tools and resources to help you manage your health, use the plans effectively, and reduce your out-of-pocket expenses [2].

[2] Out-of-pocket expenses are the total of all of your payments (excluding premiums) before the insurance pays at 100 percent.

Benefits Center Web Tools to Help You Make the Right Choice

Compare/Evaluate Health Plans Tool

The **Benefits Center Web Site** features the Health Plan Evaluator tool that allows you to estimate and compare your out-of-pocket health care expenses for each health plan option.

Get Doctor and Hospital Quality Ratings

The Get Doctor and Hospital Quality Ratings tool offers three options to identify providers and hospitals:

- "Search By Provider" allows you to find health care professionals located closest to your address. You can also search by specialty and quality ratings.
- "Search By Hospital" allows you to find hospitals located closest to your address. You can also search by specialty and quality ratings.
- "Search By Condition" allows you to find health care professionals or hospitals that specialize in treating specific conditions. Like the other searches, you can sort results by those closest to your address and quality ratings.

Calculate Life Insurance Needs

The Calculate Life Insurance Needs tool allows you to estimate how much life insurance coverage your family may need to cover future expenses in the event of your death.

Calculate Flexible Spending Account Needs

The Spending Calculator can help you determine how you might benefit by enrolling in a Health Care or Dependent Care Reimbursement Account.

- A Health Care Reimbursement Account allows you to pay eligible medical expenses, including medical and prescription co-payments/co-insurances (the fees you pay) and deductibles (the specified amount of health care expenses that you pay each year before the plan begins to pay for your care), with before-tax contributions. You may contribute up to the annual allowable limit to a HCRA.
- A Dependent Care Reimbursement Account enables you to set aside before-tax contributions to reimburse you for payment of eligible dependent care expenses.

WHEN YOU ENROLL, YOU SHOULD HAVE THE FOLLOWING INFORMATION WITH YOU:

- Social Security Number
- Dependent's Social Security Number
- Personalized Benefits Enrollment Summary (included in this enrollment package)
- Your Personal Identification Number (PIN)

REGISTER FOR "FORGOT YOUR PIN":

Don't worry about remembering your PIN. You can access the Web Site securely without a PIN after you sign up for the "Forgot Your PIN?" feature. When you first receive your PIN as a new employee, or prior to receiving your Annual Open Enrollment package each year, log on to the Benefits Center Web Site and register for the "Forgot Your PIN?" feature. When you do, you will always have immediate access to the Benefits Center Web Site even if you forget your PIN.

Benefits Enrollment Summary

Your personalized Benefits Enrollment Summary makes selecting your benefits easier. In this package you will find a personalized summary that shows:

- The benefits you are eligible to enroll in
- Your cost for each benefit
- Your automatic benefits coverage, special instructions, and deadlines.

You will be enrolled in the automatic benefits coverage shown on your Benefits Enrollment Summary if you do not make any elections/changes before the enrollment deadline, so be sure to review it carefully. You will also receive an Eligibility Definitions and Required Documentation list in case you want to enroll new dependents.

The Last Step on Your Pathway to Enrollment – Benefits Confirmation Statements and dependent forms and documents

After you enroll, or whenever you make changes, you will receive a Benefits Confirmation Statement in the mail. You can also print out a Confirmation Statement if you enroll online. Your online Confirmation Statement should include an assigned number in the right upper corner. Always review your Confirmation Statement to ensure it correctly reflects your benefit elections.

In addition, if you added a newly eligible dependent, you must complete and return the Dependent Verification Form along with the required documentation of eligibility within the 60 day deadline in order to avoid cancellation of your dependent coverage. You will receive your health plan identification cards directly from the health plan once your dependent is enrolled; however, if you fail to submit the required documentation, coverage for the dependent will be cancelled even if you have already received your card.

IMPORTANT: If any of the information on your Benefits Confirmation Statement is incomplete or incorrect, or if you make a change but do not receive a Benefits Confirmation Statement in the mail, call the Benefits Resource Line right away at 1-866-325-2345 to speak with a Benefits Specialist. **You have 10 business days from the date of your Benefits Confirmation Statement to report errors in the elections you made.** You are solely responsible for informing the Benefits Center of any errors in your benefit election.

Two-Way Communication Between You and the Benefits Center

The Benefits Center will notify you in writing at your home address whenever your benefits or costs are changing or you are required to take action to continue enrollment for you and/or your dependents.

It is your responsibility to understand your benefits, and to report Qualified Life Events, such as marriage, birth of a child, or divorce, to the Benefits Center within 30 calendar days of the event.

Keep Mailing Address Current

Since all your benefits communications will be sent to your mailing address that is in the County's payroll system, it is very important that you keep your address current. It is your responsibility to keep your address current. Contact your Department Human Resource Services representative to update your mailing address.

Step 3:

What Events Trigger Enrollment?

Quick Start for New Employees

If you are a new County employee, you have 30 calendar days from the event date on your Benefits Enrollment Summary to enroll in your benefits for the first time. This date is included in your enrollment package. After this period, you won't be allowed to make changes to your benefit elections until the next Annual Open Enrollment period, unless you have a Qualified Life Event (QLE). At this time you should:

- Review your options carefully by reviewing each plan's Summary of Benefits and Coverage, and enroll before the deadline
- Log on to www.benefitsweb.com/countyoforange.html or call the Benefits Resource Line at 1-866-325-2345 for more information and to enroll
- If you enroll dependents, remember to complete and sign a Dependent Verification Form and submit the form with documentation of eligibility to the County of Orange Benefits Center as soon as possible, but no later than the 60 day deadline. See "What Documents Must I Provide?" on page 3 for details.

IMPORTANT: if you don't enroll in a County health plan within the 30-calendar-day enrollment period, and you are a full time employee, you will be enrolled in the Wellwise health plan and your dependents (if any) will not receive County health care coverage. [3]

Quick Start for Annual Open Enrollment

Annual Open Enrollment is your only opportunity to make changes to your benefits unless you experience a Qualified Life Event during the plan year.

You will be notified each fall of the Annual Open Enrollment period and provided instructions for making enrollment changes. At that time you should:

- Review your options carefully by reviewing each plan's Summary of Benefits and Coverage, and enroll before the deadline.
- Log on to www.benefitsweb.com/countyoforange.html or call the Benefits Resource Line at 1-866-325-2345 for more information and to make changes to your benefits.
- Enroll or re-enroll in a Health Care and/or Dependent Care Reimbursement Account. If you are currently enrolled in a Reimbursement Account, you MUST re-enroll during the Annual Open Enrollment period to participate again for the upcoming year.
- If you enroll new dependents, remember to complete and sign a Dependent Verification Form and submit the form with documentation of eligibility to the County of Orange Benefits Center as soon as possible, but no later than December 31, 2013. See "What Documents Must I Provide?" on page 3 for details.
- You will receive your health plan identification card(s) directly from the health plan once your dependent is enrolled; however, if you fail to submit the required documentation by December 31, 2013, coverage for your dependent will be cancelled retroactively even if you have already received your identification card(s).

IMPORTANT: You can log onto the Benefit Center Web Site to review and compare the Summary of Benefits and Coverage (SBC) documents for each health plan offered by the County. Go to *My Benefits* and under *Documents and Forms* to see the current plan options that are available to you. You can easily compare your current health plan benefits to those of other County-offered health plans.

The benefits you elected during Annual Open Enrollment are effective January 1st of the following year.

[3] Part-time employees who don't complete their enrollment are automatically enrolled in the Sharewell health plan with employee-only coverage.

Quick Start for Qualified Life Events (QLEs)

Typically, you can only make your benefit elections when you become eligible for coverage and make changes during Annual Open Enrollment. However, you are allowed to make changes during the plan year if you experience a Qualified Life Event (QLE). Note: Most QLEs do not permit you to change health plans; however, you may be eligible to add and/or remove dependents to your coverage and/or make changes to your Reimbursement Account elections and other benefits (if applicable).

Had a QLE? Notify the Benefits Center within 30 Days!

- You must notify the County of Orange Benefits Center within 30 days of the date the QLE occurs.
- To report a QLE, log in to the Benefits Center Web Site or call the Benefits Resource Line at 1-866-325-2345 when a QLE occurs.
- If the Benefits Center does not receive notification of your change within 30 calendar days of the QLE, new dependents will not be eligible for coverage until the next Annual Open Enrollment period or when you experience another QLE.
    - If required documentation of eligibility is not received within 60 days of the QLE for new dependents they will be terminated from coverage.
- If you do not remove ineligible dependents within 30 days of the event which made them ineligible (e.g., divorce), you may be financially responsible for the cost of premiums paid for or services provided to those dependents after their eligibility ended.
- Refer to the **Making Changes to Your Benefits** section of your *Benefits Enrollment Guide* for more details.

Leave of Absence

When your agency processes your leave of absence, the Benefits Center will send you a new Benefits Enrollment Summary reflecting your new options and costs.

- The amount you are required to pay for your coverage while on leave will likely increase and is based upon the type and/or length of the leave
- Details on your options and instructions for continuing health insurance while on leave will be provided
- Refer to the Leave of Absence section of your Benefits Enrollment Guide for more details or print out the leave brochure available at www.ocgov.com/hr/employeebenefits
- If you are on an unpaid Leave of Absence and elect to maintain your health coverage, you will be sent a monthly invoice by the Benefits Center. If you don't pay the invoice in full each month, your coverage will be cancelled until your return to work.

If your coverage is cancelled you will have a lapse until your health coverage becomes effective again the first of the month following 30 days after you return to work.

If you leave County employment while currently on a leave with no health coverage, you will not be eligible to receive COBRA and/or if you retire, you will not be eligible to enroll in a retiree health plan.

QLE EXAMPLES:

- You get married
- You have a baby, adopt a child, or acquire step children due to marriage
- Your spouse/domestic partner begins or ends employment and either gains or loses health coverage
- A dependent dies
- Your spouse/domestic partner changes his or her benefits during his or her employer's open enrollment (held at a different time than the County's Annual Open Enrollment)
- Your Covered child loses eligibility
- You get a divorce or legally separated, or your marriage is annulled

IMPORTANT: Please contact the Benefits Resource Line before the 30-day period is over to ensure that your coverage is up-to-date.

Health Care and Dependent Care Reimbursement Accounts

You Must Re-Enroll Every Year

You are offered the option of enrolling in a Health Care and/or Dependent Care Reimbursement Account. You can enjoy tax savings by setting aside before-tax dollars to pay for health care and/or dependent care expenses. If you are eligible, you may enroll as a new hire, if you experience certain Qualified Life Events (QLEs), and during Annual Open Enrollment. Don't forget: You must re-enroll every year during Open Enrollment to continue participating the following year.

You may want to calculate the amount to contribute to your Health Care and/or Dependent Care Reimbursement Account for 2014 by using the "Calculate Flexible Spending Account Needs" tool available on the Benefits Center Web Site.

You cannot adjust your contributions during the year unless you experience a Qualified Life Event and you must use all of the funds in your account during the plan year or you will lose them.

You can find a list of eligible and ineligible expenses at the IRS web site: www.irs.gov (look for publication 502). Please be advised that there are some differences between the expenses eligible under a reimbursement account and those that are eligible for an IRS tax deduction.

If you leave County employment, including if you retire, you may only file claims for expenses incurred through your last date of employment.

Refer to the Health Care and Dependent Care Reimbursement Account section of your Benefits Enrollment Guide as well as the Benefits Center Web Site for more details.

HEALTH CARE REIMBURSEMENT ACCOUNT

You may contribute up to the allowable annual limit. This amount may change annually so review your Benefits Enrollment Summary for details.

Over-the-counter medications, such as pain relievers and allergy medicines, cannot be reimbursed through HCRA, unless they are prescribed by a doctor.

If you leave County employment, including if you retire, you may only file claims for expenses incurred through your last date of employment.

Because eligible children may participate on the health plan up through age 25, the eligible expenses for those children may be reimbursed through the HCRA.

BE AWARE: DEPENDENT CARE REIMBURSEMENTS STOP WHEN YOUR CHILD TURNS 13

It is important to remember when you enroll in the Dependent Care Reimbursement Account that reimbursements for a dependent child's expenses stop on his/her 13th birthday. Be sure to consider the impact this will have on your annual calculation.

DCRA expenses are reimbursed only if there are sufficient funds in your account. If your claim is for more than you have in your account, you'll be reimbursed for the amount in your account and may resubmit the unreimbursed expense later.

Ask your tax advisor whether the DCRA or the federal dependent care tax credit will save you more.

Step 4:

What Important Legal Information Should I Know?

Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA)

The County of Orange has some plans that are considered "grandfathered health plans" under the Patient Protection and Affordable Care Act (PPACA).

Grandfathered Health Plans	PPACA Compliant plans eff. 1/1/2014 (non-Grandfathered)*
Premier Wellwise PPO	Wellwise Choice PPO
Premier Sharewell PPO	Sharewell Choice PPO
CIGNA HMO	CIGNA Choice HMO
Kaiser HMO	Kaiser Choice HMO

*applies to certain employees based on bargaining unit.

As permitted by the Patient Protection and Affordable Care Act (PPACA), a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. However, grandfathered health plans must comply with certain consumer protections in PPACA, for example, the elimination of lifetime limits on benefits.

The protections in PPACA which do apply to these grandfathered plans are:

- Extension of dependent coverage for dependents until age 26
- Elimination of individual lifetime maximums in the PPO health plans
- Elimination of individual annual dollar limit for Preventive Care and the Mental Health/ Substance Abuse $50 per visit limit in the PPO health plans

All other provisions of the Act do not currently apply to grandfathered plans. If you have questions regarding the grandfathered health plan provision, or other provisions under the Act, you may contact the Employee Benefits Security Administration, U. S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform/. You may also contact the U. S. Department of Health and Human Services at www.healthreform.gov/.

For information about your County of Orange health plans, you may contact the County of Orange Benefits Center at 1-866-325-2345.

Health Insurance Marketplace

PPACA requires all U.S. citizens and resident aliens to have medical coverage beginning January 1, 2014 (or pay a penalty). To make affordable coverage available to everyone, the government has created Health Insurance Marketplaces. On October 1, each state unveiled a "Health Insurance Marketplace" – which in California is called "Covered California." Residents may investigate health plans, and possibly enroll in a plan in their state's Marketplace however because the County already meets the standards for providing minimum coverage, most likely you will not take any action at this time.

- The County of Orange offers medical coverage that meets the minimum essential coverage and minimum value standards set by PPACA and meets the affordability requirement. The Sharewell PPO plan meets the minimum value standard and is offered to employees at no cost.
- You (and your dependents, as applicable) will most likely not be eligible for a subsidy or premium credit toward a Marketplace health plan because the County's Sharewell PPO plan meets the "minimum value" and "affordability" levels. This means County of Orange coverage likely provides a better value for you.
- You can still buy private medical insurance through the Marketplace, but you probably won't qualify for a discount on your private monthly premium if you are eligible to receive coverage through the County's plans.

The Federal healthcare website, **www.healthcare.gov,** provides a link to the Marketplace for all 50 states. Information on the California marketplace can be found at **www.coveredca.com.**

Continuing Your Coverage Under COBRA

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) gives you the right to choose to continue health care coverage if you and/or your eligible dependents lose County coverage. You may continue health care coverage for up to 18, 29, or 36 months, depending on the situation and who is being covered. Within a few weeks of the loss of coverage, you will receive a separate COBRA notification explaining your rights. If you leave the County, the County will notify you of your right to continue health plan coverage under COBRA; your dependents will also receive notification of their rights to continue coverage. Likewise, if you die, your dependents will receive such notification. This notification will explain in detail how COBRA works.

If you believe your or your dependents' health care coverage will end because of an event that will result in a loss of eligibility under a County plan, there are certain things you must do to continue coverage under COBRA.

- If you divorce or legally separate or your child loses dependent status under a group health plan, you or your covered dependents are responsible for notifying the County within 30 days from the date of these events. The County will then notify your dependents of their right to continue health care coverage under COBRA. This notification will explain in detail how COBRA works. COBRA rights are forfeited if the County is not notified within 30 days of the qualifying event.
- If your domestic partnership ends, your domestic partner and his or her children are not eligible for COBRA. However, a qualified recipient receiving COBRA coverage under the County plans may elect COBRA coverage for a domestic partner and his or her children.
- If COBRA is an option for you, you must make an election and pay for coverage by certain deadlines. For more information, refer to your Benefits Enrollment Guide and contact the the Benefits Center.

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 employees and dependents the opportunity to enroll outside Annual Open Enrollment in certain situations
- Can't discriminate on the basis of health status with respect to eligibility for plan participation and premium costs
- Can't impose discriminatory lifetime or annual benefit limits on individuals with mental illness
- Must permit hospital admissions (if otherwise covered by the plan) of at least 48 hours in case of normal deliveries and 96 hours in the case of Cesarean sections

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

The County's HMO plans comply with HIPAA.

Certification of County Health Plan Coverage

HIPAA requires the County to provide certification of coverage for plan individuals whenever County health insurance coverage is ended. This certification shows the period of time for which the subscriber and dependents were covered under the County health plan. If, after the County coverage ends, a former health plan individuals enroll in another group health plan that excludes coverage for pre-existing medical conditions, the former plan individuals may be required to provide the HIPAA certification.

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

Women's Health and Cancer Rights Act of 1998

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a covered mastectomy:

- 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 a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes)

The Plan will determine the manner of coverage in consultation with you and your attending doctor. Coverage for breast reconstruction and related services is subject to deductibles and coinsurance (the amount you pay before your insurance begins to pay) that are consistent with those that apply to other benefits under the Plan.

For more information about any of the County's legal requirements, review the additional information provided in your Benefits Enrollment Guide as well as the plan documents posted on the Benefits Center Web Site.

Step 5:

Where Do I Go for More Information?

While this brochure highlights key information, it does not include everything you need to know about your benefits. It is important you take the time to review the additional information provided in the Benefits Enrollment Guide as well as the plan documents posted on the Benefits Center Web Site to fully understand all of your benefit plans. We encourage you to get as much information about your benefit options as you can before you enroll.

- Go to the Benefits Center Web Site at www.benefitsweb.com/countyoforange.html or call the Benefits Resource Line at 1-866-325-2345.
- Contact the insurance carriers directly for details about your coverage and how the plans work.
- Each plan has issued a Summary of Benefits and Coverage (SBC) that is available on the Benefits Center Web Site, on the County of Orange Employee Benefits Web Site or by calling the Benefits Resource Line and requesting a copy be mailed to you. Review these documents to compare the benefits offered by each plan.
- Find a complete directory of plan contacts in the Helpful information section of your Benefits Enrollment Guide.

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