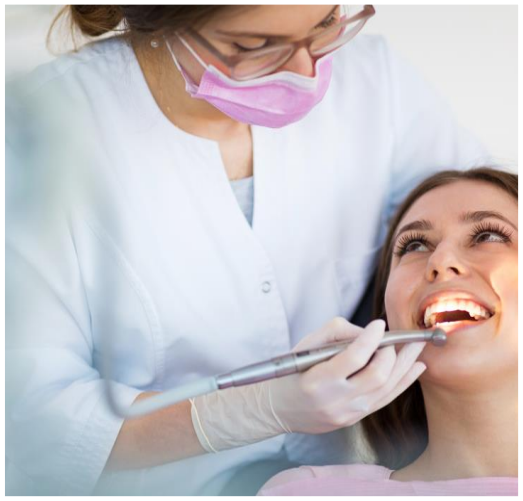
2025 BENEFITS HANDBOOK

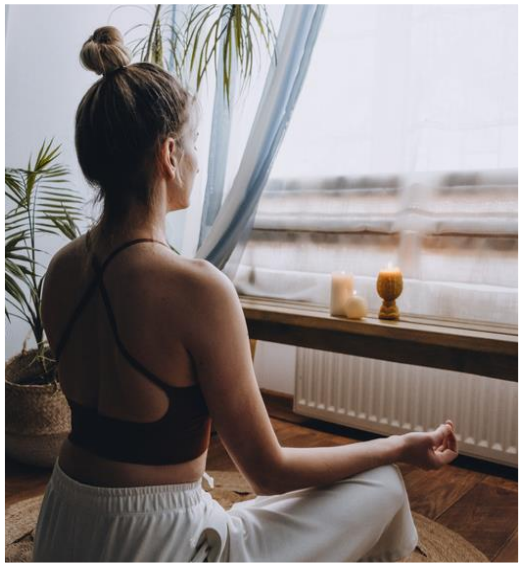
For benefits and rates effective

January 1, 2025- December 31, 2025

ORANGE COUNTY EMPLOYEES

Benefits, It's Your Choice!





Plan Contact Information

Name Cigna Healthcare -Medical, Rx, Mental Health

- **Phone** 1-800-244-6224
- **Mail Order Pharmacy** 1-800-285-4812
- **Website** www.mycigna.com
- **Onsite Rep.** OCRep@cigna.com
- **Onsite Rep. Ph.** 407-403-8108/407-795-1110

Name Cigna Dental

- **Phone** 1-800-244-6224
- **Group No.** 3337200
- **Website** www.mycigna.com
- **Onsite Rep.** OCRep@cigna.com
- **Onsite Rep. Phone** 407-403-8108/407-795-1110

Name MetLife Vision

- **Phone** 1-833-393-5433
- **Group No.** 236252
- **Website** MetLife Vision | (Superior Vision network)
- **Network** Superior Network
- **Member ID =** 00000 (5 zeros) + EE ID

Name Life Insurance and AD&D - The Standard

- **Phone** 1-844-870-8634
- **Group No.** 641718-F
- **Onsite Rep.** OCLifeAndDisability@standard.com
- **Onsite Rep. Appt.** Book time to meet with me

Name Short Term Disability (STD) - The Standard

- **Phone** 1-844-870-8634
- **Group No.** 641718-D
- **Onsite Rep.** OCLifeAndDisability@standard.com
- **Onsite Rep. Appt.** Book time to meet with me

Name Long Term Disability - The Standard

- **Phone** 1-844-870-8634
- **Group No.** 641718-E
- **Onsite Rep.** OCLifeAndDisability@standard.com
- **Onsite Rep. Appt.** Book time to meet with me

Name Flexible Spending Accounts

Chard Snyder, a Wex Company

- **Phone** 1- 888-993-4646
- **Website** www.chard-snyder.com
- **E-Mail** AskPenny@chard-snyder.com

Name HSA Bank- Health Savings Account

- **Phone** 1-800-244-6224
- **Website** www.mycigna.com
- **Onsite Rep.** OCRep@cigna.com
- **Onsite Rep. Phone** 407-403-8108

PLAN CONTACT INFORMATION

Name **Orange County HR Benefits**

Phone 407-836-5661

E-Mail benefits@ocfl.net

Name **Florida Retirement System (FRS)**

Phone 1-866-446-9377

Website www.myFRS.com

Name **MEDICARE**

Phone 1-800-MEDICARE (1-800-633-4227)

Website www.medicare.gov

Name **Vanguard -Deferred Compensation 457(b)**

Phone 1-800-523-1188

Website www.vanguard.com

Group No. 078082

Name **Employee Assistance Program (EAP)**

ComPsych

Phone 1-855-221-8925

Website https://guidanceresources.com

Company ID = ORANGECOUNTY

Revised 09/10/2024

Table of Contents

Wellness for Life Plan

What is the Wellness for Life Plan?

The Wellness for Life Plan is a comprehensive employee benefits program offered to eligible employees of Orange County. This program gives you the opportunity to choose between a variety of taxable and tax-free benefits, allowing you to customize your benefits to meet your needs. Section 125 of the Internal Revenue Code has authorized the pre-tax payment option.

The following depicts the tax treatment of benefits offered in the Wellness for Life Plan:

Pre-Tax

- Medical
- Dental
- Vision
- Supplemental Life
- Flexible Spending Accounts (FSAs)
- Health Savings Account (HSA)

Post-Tax

- Spouse Life
- Child Life
- Short Term Disability

How do I enroll in the Wellness for Life Plan?

Complete and sign your benefits enrollment form, then submit it with all required documentation within 30 calendar days of your date of hire. If you have group medical coverage elsewhere and decide not to enroll in medical benefits through Orange County, you are still required to complete an enrollment form, or you may be auto enrolled in Core medical coverage. Contact Human Resources for further information.

What is Core coverage?

You have 30 calendar days from your date of hire to submit your benefits enrollment form and any applicable dependent verification documentation. Failure to submit all required documents or opt-out by the deadline will result in automatic enrollment in core coverage. You will have an opportunity to change your coverage elections during annual open enrollment or if you experience a qualified life event.

Duplicate coverage notice: If you are currently covered as a dependent under another county employee's plan, your coverage will be terminated to avoid duplicate benefits, as per our contract.

Core coverage, at time of hire is as follows:

- Long-term disability (LTD) coverage in an amount equal to 60% of your annual salary (up to $10,000 per month) after a 180-day waiting period *(employer paid)*
- Basic Life insurance is equal to one time your annual salary *(employer paid)*
- Basic AD&D coverage is equal to two times your annual salary *(employer paid)*
- Employee Assistance Program *(employer paid)*

Core medical coverage is as follows:

- OrangePrime Local SureFit medical coverage for employee only.

Qualified life events that permit mid-year changes include:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of your spouse or child
- Loss or gain of other coverage, such as through a spouse's employment
- Change in employment status that results in a change to benefits.
- You, your spouse, or your dependent enrolls in or loses eligibility for Medicare or Medicaid
- Loss or gain of dependent eligibility.

If one of these situations occur, you have 60 days from the date of the event to change your benefits.

Any changes you make must be consistent with the event allowing you to make the change and documentation of the qualified event will be required. If you would like more information about qualified life events (family status changes), contact Human Resources. Please refer to the inside cover of this handbook for contact information.

Opt Out Credit

Employees who opt out of the County's medical insurance as a new hire, during annual open enrollment, or as a result of a qualified life event (family status change), will receive a credit of up to $25 per pay period to help offset the cost of other optional benefits. The credit cannot be used to cover the cost of spouse life insurance, child life insurance or short-term disability Insurance; nor can it be deposited into a spending account. The credit may only be used to lower your benefit costs; the credit cannot be taken in cash.

If you have coverage under another group insurance plan and waive County's medical coverage, the credit will be applied to other benefits in the following order:

- Tricare supplement plan (if applicable)
- Dental
- Vision
- Supplemental life insurance and AD&D

How do I receive the Opt Out Credit?

To receive the Opt Out Credit, employees must waive the County's medical coverage or elect the Tricare Supplement plan during one of the following enrollment periods:

- Annual Open Enrollment

- During passive enrollment periods, an election is not required. Therefore, currently waived coverage will roll over and the opt-out credit will apply.

- Special 30-day New Hire Enrollment
- Special 60-day Qualified Life Event Enrollment

Are there Tax Implications?

There are some important details that you need to know. First, there may be an impact to your Social Security benefits. Because you are paying less FICA taxes, less money is going into your personal Social Security account. The effect is minimal and the current tax savings is significantly greater than the reduction in future Social Security benefits. For more information about your personal situation and an estimate of your retirement benefits, contact the Social Security Administration. If you would rather pay your contributions on an after-tax basis, please indicate so on your enrollment form which is available at your Human Resources Service Center. Note: You may request post-tax deductions annually during open enrollment. If you choose post-tax deductions, this will apply to all benefits.

Second, if you choose to participate in the Wellness for Life Plan, your election is for the entire plan year. The Wellness for Life Plan year is January 1–December 31. The Internal Revenue Service permits employees to select or change their choices only once each plan year, during open enrollment, with the exception of qualified life events.

What else do I need to understand about the Wellness for Life Plan?

While the County is committed to offering quality benefits to employees, it reserves the right to amend or discontinue any of the benefits plans provided under the Wellness for Life Plan should federal or state regulations or the County's needs or ability to fund the plans change significantly in future years. This Benefits Handbook describes the Wellness for Life Plan in general terms. Should any conflict arise between the content of this handbook or any other enrollment materials and the plan documents, the terms of the plan documents will govern in all cases.

Eligibility & Rules

Who is eligible for the Wellness for Life Plan?

Regular full and part-time employees (regular employees scheduled to work 20 hours or more per week) and their qualifying family members are eligible for group insurance coverage offered under the Wellness for Life Plan.

Which family members are eligible?

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

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

- Children (age 26 to 30):
  - Additional details can be found in this handbook – refer to *Optional Coverage for Dependents Age 26 - 30*

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

- Disabled Children:
  Age 26 or older, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of *mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage*.
  - Children considered to be disabled by a physician for any of the following permanent conditions: Legally blind, legally deaf, suffering from paralysis, mentally disabled, or requires assistance with basic daily activities such as eating and bathing.
  - Children considered to be disabled through Social Security Administration regardless of whether the child receives Social Security Income or not.
  - Single and incapable of self-care, dependent on employee for support due to physical or mental disability
  - Disability must occur before child eligibility ceases due to age

Am I required to provide proof of dependent eligibility?

Employees who add dependents within 30 days of hire, within 60 days of a qualified life event, or during open enrollment, must provide dependent verification documentation as proof of dependent eligibility in order for the dependent to be added.

Dependent Verification Requirements

Required Documentation for Spouses

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

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

*Marriage licenses written in a foreign language must be officially translated by a translation organization before being submitted to Human Resources.

Note: In addition to the dependent documentation listed above, your **marriage date, spouse's date of birth, and spouse's social security number** are required for enrollment.

For spouses with no SSN. Please contact HR Benefits for assistance if your spouse is working through the immigration process but has not yet obtained a SSN. *A SSN is not required for enrollment as a spouse under the plan, utilizing an Individual Tax Identification Number (ITIN) may be a temporary option.*

Required Documentation for Dependent Children

Birth Child Under Age 26	Stepchild Under Age 26	Adopted Child or Child Placed for Adoption Under Age 26
❑ Official Birth Certificate* *(Hospital certificate will not be accepted, parents must be listed)*, OR ❑ Court Order or DNA Testing establishing Paternity or Parental Responsibility (*Including, but not limited to; Financial and or Healthcare Coverage Obligations, DNA/Paternity Results*).	❑ Copy of birth certificate* or proof of other dependent relationship, AND ❑ Copy of employee's legal marriage license to stepchild's parent, AND ❑ Verification of current marital status (see above requirements verification of current relationship status)	❑ Adoption Certificate, OR ❑ Placement Letter (document establishing placement preceding a formal adoption)

Child under Age 26 for Whom You Are the Legal Guardian	Child of a Covered Dependent (Grandchild) Under 18 months	Disabled Child
❑ Proof of legal guardianship[1]	❑ Official Birth Certificate* or birth record *(covered dependent's name must be listed as parent)*, AND ❑ Verification that parent of child is eligible and covered as dependent child noted above	❑ Official Birth Certificate*, AND ❑ Proof of continuous coverage (no break in coverage), AND ❑ Social Security Administration award letter, OR ❑ A recent Social Security Income statement, OR ❑ A signed physician's statement.

* Birth certificates written in a foreign language must be officially translated by a translation organization before being submitted to Human Resources.

Note: In addition to the dependent documentation listed above, your **dependent's name, date of birth, and social security number** are required for enrollment.

For children with no SSN Please contact HR Benefits for assistance if your dependent is working through the immigration process but has not yet obtained a SSN. *A SSN is not required for enrollment as a child under the plan, utilizing an Individual Tax Identification Number (ITIN) may be a temporary option.*

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

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

Dependent Eligibility Changes

Dependents who no longer meet the plan's eligibility requirements must be removed from the plan. It is the responsibility of the employee to notify Human Resources within 60 days when there is a change in dependent eligibility*, especially if eligibility is lost.* Failure to drop ineligible dependents from the plan within 60 days is considered fraud against the plan and may result in financial responsibility to – equal to all premium and/or claims costs paid by the County on behalf of an ineligible dependent or spouse and may also result in disciplinary action up to and including termination of employment.

Any employee who fails to provide the required information and documentation, falsifies information and documentation, or lists ineligible individuals as eligible dependents, shall cause his or her dependents to be removed from the County's benefit plans. Additionally, that employee may be subject to disciplinary action up to and including termination of employment, may be required to reimburse the County for the benefits costs paid on behalf of the ineligible individual(s), and may be excluded from coverage altogether under the County's benefits plans.

When does coverage begin?

Employees are *enrolled* in the following coverage effective the date of hire:

- Basic Life Insurance and AD&D
- Long Term Disability
- Employee Assistance Program (EAP)
- Florida Retirement System

Employees are *eligible for* the following additional coverage effective the date of hire. Coverage will not begin until after all required enrollment documentation has been received and processed:

- Medical (with or without HSA*)
- Dental
- Vision
- Supplemental Life and AD&D
- Spouse Life Insurance
- Short Term Disability
- Child Life Insurance
- Flexible Spending Accounts
- Deferred Compensation 457(b) Plan

**Special rules apply for HSAs.*

When does coverage end?

If…	Coverage Ends
You stop working for Orange County, retire, pass away, or you no longer meet eligibility rules	The end of the pay period in which your employment or eligibility ends
If…	**Coverage Ends**
You choose to stop coverage for yourself and/or your dependents because of a qualified status change	Upon approval, but no earlier than the first day of the first pay period after the new election form is completed and returned to HR
Your dependents no longer meet the eligibility requirements (other than child turns 26 or grandchild turns 18 months old)	Upon approval, but no earlier than the first day of the first pay period after the new election form is completed and returned to HR
You choose to stop coverage for yourself and/or your dependents during the open enrollment period	The last day of the current calendar year
Your child turns 26	The beginning of the pay period following the end of the month in which the child turns 26
Your grandchild (child of a covered dependent) turns 18 months old	The beginning of the pay period following the end of the month in which the grandchild turns 18 months old

Leave of Absence (LOA)

Employees on leave of absence may have benefit options available to them. If you are on a leave of absence, it is important to keep track of your employment status and leave balances. Doing so will help you plan accordingly for your healthcare needs. The following chart explains the benefit provisions for employees on LOA.

Leave Category	Benefit Cost	Benefit Payment Method
FML, Paid	Active employee rates	Paycheck deduction
FML, Unpaid	Active employee rates	Employee should notify Payroll of unpaid status and send payments to Payroll
Non-FML, Paid	Active employee rates	Paycheck deduction
Non-FML, Unpaid	Active employee rates (0-90 days)	Employee should notify Payroll of unpaid status and send payments to Payroll
Non-FML, Unpaid	COBRA rates (90 days or more)	Employee will receive COBRA enrollment materials and send payments to COBRA administrator

Can I change my benefit elections because of a Leave of Absence?

Commencing a leave of absence qualifies as a qualified event under the plan. Changes must be made within 60 days of going on leave. If you choose not to continue coverage during an unpaid leave of absence, and you return to work, you must re-enroll in the benefit plans for coverage to be effective the date of return. Medical underwriting applies (see life insurance section). You also have the option to make changes to your coverage within 60 days of the date you return to work. Your coverage will begin the date of your return and deductions will be taken for that entire pay period.

Optional Coverage for Dependents Age 26 - 30

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

Who is eligible for this coverage?

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

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

What coverage is available for these dependents?

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

What is the cost of this coverage?

For these dependents, the full cost of the plan premium is required plus a 2% administrative fee. For 2025, that amount is $1,067.16 per month for the OrangePrime Plus Plan (HDHP) or $1,160.65 per month for the OrangePrime Plan (LDHP) or $1,027.18 per month for the OrangePrime Local SureFit Plan. Premiums for these dependents cannot be taken through employee payroll deductions. Instead, you will be billed directly by our third-party administrator.

How do I sign-up?

Contact Human Resources for enrollment information and assistance. After signing up, our third-party administrator will send payment coupons with the monthly payment amount for the elected plan(s).

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

Benefit Plan Options

Medical Insurance

What medical plans are available?

Orange County offers three medical plans:

- OrangePrime Plus Plan - HDHP (HSA eligible)
- OrangePrime Plan - LDHP
- OrangePrime Local Plan - SureFit

What is an annual deductible?

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

Is the deductible for medical separate from the pharmacy deductible?

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

What is coinsurance?

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

What are the copayments (copays)?

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

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

No. Copays will count toward your out-of-pocket maximum.

What does medical coverage cost?

Please refer to the premium section of this handbook.

What is an out-of-pocket maximum?

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

Is there out-of-network coverage?

Only the HDHP and LDHP medical options allow you to access care out-of-network. However, you will have a separate deductible and out-of-pocket maximum for those services, and it will not be combined with the expenses you have incurred in-network throughout the year. NOTE: The OrangePrime Local SureFit option does *NOT* have out-of-network benefits. The out-of-network deductible, coinsurance, copayments, and out-of-pocket maximum amounts are listed in the *Medical Plan Comparison Chart*.

Is there a pre-existing condition clause?

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

Do I need a referral to see a specialist?

The HDHP and LDHP medical options are open access plus plans, which means you have the freedom to access medical care at any time through any participating network physicians, including specialists, without a referral. NOTE: The OrangePrime Local SureFit option does require a referral for specialist visits with some exceptions for emergency room visits, urgent care, OBGYN, labs, x-rays, and behavioral health services.

Are pregnancy programs available?

Yes, call 1-800-615-2906 to enroll. Members on either medical plan who enroll in the Cigna Healthy Pregnancies, Healthy Babies Program (HPHB) in their first trimester (defined as 0-13 weeks) or second trimester (defined as 14-26 weeks) of pregnancy and complete the entire program, including the post-delivery assessment, will receive a $400 or $200 deposit from the County. Funds will be issued into employees' Health Savings Account (HSA) where applicable, or via paycheck (taxation rules may apply). Dependent children can enroll in the program but are not eligible for the financial incentive. The incentive will be paid out in the middle of the quarter following the completion of the outcome assessment through Cigna. **Employees must still be actively employed at the time of the deposit in order to receive it.**

Program completed 1/1 - 3/31	Program completed 4/1 - 6/30	Program completed 7/1 - 9/30	Program completed 10/1 - 12/31
$200/$400 *paid in May*	$200/$400 *paid in August*	$200/$400 *paid in November*	$200/$400 *paid in February*

OrangePrime Plus Plan (HDHP)

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

The OrangePrime Plus plan is made up of two parts – the medical plan and the employer HSA contribution:

- The Medical Plan:
  - Annual Deductible, Copays, Coinsurance, and Out-of-Pocket Maximum
  - Pharmacy coverage without a separate deductible
  - Preventive care coverage of 100%, even before you reach your deductible
  - Some preventive drugs covered at 100% before deductible
  - Outpatient Mental Health/Substance Abuse

- The Employer HSA Contribution:
  - Helps off-set the OrangePrime Plus plan deductible
  - Contribution based on level of medical coverage in place at time of funding
    - Up to $1,000 contribution for employee only coverage*
    - Up to $1,550 contribution for employee plus dependent(s) coverage*
  - You must be an active employee and be enrolled in the OrangePrime Plus plan, at the time of funding, in order to receive the employer contribution.
  - Contribution can be made into a County sponsored Health Savings Account (HSA) or if the employee is ineligible for an HSA or does not have an open/active county HSA account, then the funds will be issued via paycheck and are subject to applicable taxation rules.
    ** Proration rules apply for employees enrolling outside of the open enrollment period.*

Health Savings Account (HSA)

You must have an open, active HSA account in order to receive funding into your account.

What is an HSA?

An HSA is a tax advantaged savings account that is used in conjunction with an HDHP. An HSA allows you to save for eligible medical expenses that the HDHP does not cover. An HSA will:

- Help you pay for your eligible expenses today and in the future
  - Medical
  - Pharmacy
  - Dental
  - Vision
  - Durable medical supplies
- Reduce your taxes three ways
  - Money deposited can be tax-free
  - You pay no tax on the interest you receive
  - Withdrawals for eligible expenses are tax-free
- Carryover from year to year and go with you if you change jobs

What are the eligibility requirements for an HSA?

According to the IRS, to be an eligible individual and qualify for an HSA, you must meet the following requirements:

- You must be covered under a high deductible health plan (HDHP)
- You must have no other health coverage that is not a high deductible health plan including TRICARE or TRICARE for Life
- You must not be covered by a general purpose Medical Flexible Spending Account (FSA) or a Health Reimbursement Account (HRA), either yours or your spouse's (you can have a Limited Purpose Spending Account (LPFSA) and will have a separate debit card for this).
- You are not enrolled in Medicare
- You cannot receive VA medical benefits, unless for a service-related disability, within the 3 months prior to contributing
- You cannot be claimed as a dependent on someone else's tax return (Note: filing married/jointly is not the same as being claimed as a dependent)

How do I open an HSA?

- Go to https://secure.hsabank.com/group_enrollment/enrollment.aspx?id=596000773
- Click "begin online enrollment". Step one will require you to input your name, date of birth, social security number, address, and contact information. Step two will provide you with an opportunity to review your application. Step three is your confirmation – be sure to print a copy of your application for your records.

How do I receive reimbursement for my eligible expenses?

You will receive a debit card to pay for your eligible expenses directly at the point of sale.

When will I have access to the funds I contribute to my HSA?

The HSA is very much like a checking account, in that the money has to be in the account before you can spend it. So, if the payroll deduction has not yet occurred, the funds will not be in the account for you to spend.

How do I contribute to my HSA?

If you elect the OrangePrime Plus plan with an HSA through Cigna, you must first open a new HSA account. Then you will be able to contribute pre-tax dollars to your account through payroll deductions. Payroll deduction amounts can be started, changed, or stopped at any time during the year without reason. Simply complete, sign, and submit the HSA election form which can be found on OrangeNet.

In addition to payroll deductions, you can also contribute directly to your HSA by sending a check to HSA Bank or by making an online payment or online transfer to the account. Specific instructions on these contribution methods will be provided in the welcome kit you receive from HSA Bank after you open your HSA.

Will the County make a contribution to my Health Savings Account?

Yes! The County will contribute for employees who elect the OrangePrime Plus plan during open enrollment or as a new hire employee.

If elected during open enrollment, you must apply for an HSA through Cigna in October. If you already have an HSA through Cigna, you need to ensure that the account is active and open. Accounts with a negative balance will be closed and unable to accept new employer contributions. For open enrollment elections, the contribution will occur in mid-January annually upon successful completion of the following requirements:

- Elect the HDHP during open enrollment
- Elect to receive the contribution into an HSA during open enrollment.
- Open an HSA account through the Cigna portal in October
- Still be an active, benefit-eligible employee at the time the HSA contributions are deposited in mid-January.

As a new hire, proration rules apply (refer to the table below).

Level	Benefits begin 1/1 - 3/31	Benefits begin 4/1 - 6/30	Benefits begin 7/1 - 9/30	Benefits begin 10/1 - 12/31
Employee Only	$1000 *paid in May*	$750 *paid in August*	$500 *paid in November*	$250 *paid in February*
Employee + Dependent(s)	$1550 *paid in May*	$1162.50 *paid in August*	$775 *paid in November*	$387.50 *paid in February*

Note: Employees must still be actively employed at the time of the deposit in order to receive it.

The purpose of the OrangePrime Plus plan contribution is to help off-set the deductible. The County will provide contributions, based on the medical coverage category of the employee at the time of funding. Those with employee only coverage can receive up to a $1,000 contribution, while those that cover tax-qualified dependents on the plan can receive up to a $1,550 contribution.

What if I am not eligible for an HSA; can I still get the employer contribution?

If you do not meet the eligibility requirements to receive contributions into an HSA, or do not have an open/active HSA account, then the funds will be issued via paycheck and are subject to applicable taxation rules. Complete the HSA attestation and indicate that you are not eligible for the HSA plan. Funds will be issued via paycheck and are subject to applicable taxation rules.

Are new hires able to receive the employer contribution?

Yes, however you may receive a prorated amount based on your benefits effective begin date. If you do not have an open active HSA account or are not eligible to receive contributions into an HSA account at the time of payment, you will receive the funding into your paycheck minus applicable taxes.

Is there a maximum contribution amount for HSA contributions?

Yes, the IRS sets the maximum contributions amounts on an annual basis. The contribution maximum includes all dollars that are added "into" your HSA during the year (*including* the County contribution and any other contributions you make independently or through payroll deductions). However, amounts that roll over from year to year are not included and can accumulate as high as you like. If you accidentally contribute more than the annual maximum to your HSA, you should contact HSA Bank regarding correcting this situation so that you don't have to pay income tax or IRS penalties for the over-contribution.

- Employee only (single coverage): $4,300
- Employee with dependents (family coverage): $8,550

The maximum amount is based on the medical coverage you have, not how you file your taxes. For example, even if you file married/jointly or head of household, if you are only covering yourself (single coverage) on the medical plan, your maximum is $4,300.

In addition, if you are 55 or older, you are allowed to make an additional "catch up" contribution amount of $1,000 per year. If you and your spouse are both 55 or older (and both covered on the medical plan), then your spouse can also open up his/her own HSA through a bank of his/her choosing and put in an additional $1,000 in catch up contributions. Note: your spouse cannot open up an HSA through Orange County's Cigna plan unless your spouse is also an employee. For more information regarding HSA regulations, you should contact HSA Bank.

What are the limitations or restrictions if my spouse is also a County employee?

If you are married to another County employee, you have the option to choose the coverage that works best for your family. For example, you can each sign up for "employee only" coverage if you like or one can do "employee + spouse" and the other can "waive medical." The choice is yours. Regardless of your coverage and HSA decision, your annual HSA contribution maximum for the 2025 plan year cannot exceed the family contribution limit of $8,550.

If you and your spouse both keep your own County medical coverage, then both spouses are able to open an HSA and receive the County's funding (assuming you both meet the requirements & are both otherwise eligible for the HSA). In other words, both individuals can have an HSA of their own, if they are both primary subscribers to their medical plans. Keep in mind that if you keep your coverage separate (for example, if both select "employee only"), then you will each have your own deductible and out-of-pocket maximum for the plan year and the amounts cannot be combined together. However, if you choose "employee + spouse" or "employee + family" coverage, then only the main subscriber can open and fund the HSA through the County.

OrangePrime Plan (LDHP)

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

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

- You pay copays year-round for the following services:
  - Doctor's office visits
  - Specialist office visits
  - Urgent Care
  - Prescriptions
  - Outpatient Mental Health/Substance Abuse
- The remaining medical services are subject to the following plan design:
  - You pay the Co-insurance of 20% after you meet the calendar year deductible for all other medical services
  - Co-pays and co-insurance amounts that you pay contribute to the out-of-pocket maximum
  - Preventive care coverage of 100%, even before you reach your deductible

Is there a financial contribution for the OrangePrime Plan?

No. Employees electing the OrangePrime Plan (LDHP) are not eligible for the OrangePrime Plus Plan (HDHP) contribution or the Opt Out Credit.

Can I fund an HSA if I elect the OrangePrime Plan?

No. The OrangePrime Plan is not an HSA-eligible plan so you can not contribute to an HSA. However, if you have funds remaining in an HSA and switch to the OrangePrime Plan, you can continue to spend them on qualified health-related expenses.

Can I see any doctor I want on the OrangePrime Plan?

Yes. while you cannot see any provider you want. You can see any in-network providers as long as you stay within Cigna's Open Access Plus (OAP) national network of providers, facilities and services.

OrangePrime Local SureFit Plan

What are the main components of the OrangePrime Local SureFit Plan?

The OrangePrime Local SureFit Plan is made up of two parts – copays and deductible:

- You pay copays year-round for the following services:
  - Doctor's office visits
  - Specialist office visits
  - Urgent Care
  - Prescriptions
  - Outpatient Mental Health/Substance Abuse
- The remaining medical services are subject to the following plan design:
  - You pay the Co-insurance of 20% after you meet the calendar year deductible for all other medical services
  - Co-pays and co-insurance amounts that you pay contribute to the out-of-pocket maximum
  - Preventive care coverage of 100%, even before you reach your deductible

Is there a financial contribution for the OrangePrime Local SureFit Plan?

No. Employees electing the OrangePrime Local SureFit Plan are not eligible for the OrangePrime Plus Plan (HDHP) contribution or the Opt Out Credit.

Can I fund an HSA if I elect the OrangePrime Local SureFit Plan?

No. The OrangePrime Local SureFit Plan is not an HSA-eligible plan so you can not contribute to an HSA. However, if you have funds remaining in an HSA and switch to the OrangePrime Local SureFit Plan, you can continue to spend them on qualified health related expenses.

Can I see any doctor I want on the OrangePrime Local SureFit Plan?

No. You must stay within the AdventHealth network of providers, facilities and services.

Will I have to select a primary care provider (PCP) at enrollment in the SureFit plan?

Yes. You and your covered dependent(s) are required to select PCPs. The PCP's name will be printed on your ID card. Each individual can select their own PCP. For example, the subscriber can choose a pediatrician for a child and an internist for themselves. If you do not select a PCP, one will automatically be assigned to you. However, you can change this selection at any time. This means you can use a network-participating PCP other than the one shown on your ID card and receive the same level of coverage.

Medical Plan Benefit Summaries

Benefit Period January 01, 2025 - December 31, 2025

OrangePrime Plus High Deductible Plan *w HSA option*

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed as Employee Responsibility)	
Deductible Per Benefit Period (PBP) Individual Family	 $1,650 / $3,300	 $3,000/ $6,000
Coinsurance	20%	50%
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and out-of-Network unless otherwise noted.	
EMPLOYER HSA Contribution Individual Family	*(proration apply)* up to $1,000 up to $1,550	
Out-of-Pocket Maximums PBP (includes deductible, coinsurance, and medical copays) Individual Family	 $3,000 $6,000	 $6,000 $12,000
Maximum Reimbursable Charge	Not applicable	110%
Lifetime Maximum	Unlimited	
Preventive - annual physical and gynecological exam	$0	50% after Deductible
Primary Care Office Visits (Internal Medicine, General Practice, Family Medicine, OB/GYN)	 $30 after Deductible	 *50% after Deductible
Specialist	$50 after	*50% after Deductible
MDLive (virtual)	$10 after Deductible	Not Covered
Virtual Primary Care-office visit	$30 after Deductible	*50% after Deductible
Virtual Specialty Care-office visit	$50 after Deductible	*50% after Deductible
Convenience Care Clinic	$30 after Deductible	*50% after Deductible
Urgent Care	20% after Deductible	20% after Deductible
Emergency Room	20% after Deductible	20% after Deductible
Maternity		
Initial Visit to Confirm Pregnancy	$30 after Deductible	*50% after Deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	20% after Deductible	50% after Deductible
Office Visits in Addition to Global Maternity Fee (performed by OB/GYN or specialist)	 $30 after Deductible	 *50% after Deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	20% after Deductible	*50% after Deductible
Ambulance (emergency)	20% after Deductible	20% after Deductible
Immunizations	$0	*50% after Deductible

OrangePrime Plus High Deductible Plan w HSA option

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed as Employee Responsibility)	
Allergy Treatment / Injections / Allergy Serum	$30 after Deductible	*50% after Deductible
Diagnostic Mammogram, PAP, and PSA Tests	$0	
Mammogram, PAP, and PSA Tests - Coverage includes the associated Preventive Outpatient Professional Services. Diagnostic-related PAP and PSA tests are covered at the same level of benefits as other x-ray and lab services, based on place of service. In-network diagnostic-related mammograms, including professional readings, are covered at 100%, no deductible.		
Diagnostic Breast Ultrasounds	$0	*50% after Deductible
Inpatient Hospital Admission	20% after Deductible	*50% after Deductible
Outpatient Surgery (Non-Hospital)	20% after Deductible	*50% after Deductible
Surgery - Physician's Office	$30 after Deductible	*50% after Deductible
Ambulatory Surgical Center		
Advanced Imaging (hospital)	20% after Deductible	*50% after Deductible
Advanced Imaging (non-hospital)	20% after Deductible	50% after Deductible
Short-Term Rehabilitation/Therapy	20% after Deductible	*50% after Deductible
Mental Health and Substance Use Disorder - Inpatient includes Acute Inpatient and Residential Treatment. Outpatient - Physician's Office and MDLIVE Behavioral Services - may include Individual, family and group therapy, psychotherapy, medication management, etc. Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.		
Mental Health/Substance (inpatient)	20% after Deductible	50% after Deductible
Mental Health/Substance (outpatient)	$50 after Deductible	50% after Deductible
MDLive Behavioral Services (outpatient)	$10 after Deductible	50% after Deductible
Skilled Nursing Facility, Rehab. Hospital, Subacute Facility	20% after Deductible	*50% after Deductible
Labs - Physician's Office	$30 after Deductible	*50% after Deductible
Labs - Independent Lab	20% after Deductible	*50% after Deductible
Labs - Outpatient Facility	20% after Deductible	*50% after Deductible
Radiology Services - Office Visit	$30 after Deductible	*50% after Deductible
Radiology Service - Outpatient Facility	20% after Deductible	*50% after Deductible
Advanced Radiological Imaging - MRI, MRA, CAT Scan, PET Scan, etc.		
Outpatient Facility	20% after Deductible	*50% after Deductible
Physician's Office / Office Visit	$30 after Deductible	*50% after Deductible
Outpatient Therapy Services	$30 after Deductible	*50% after Deductible
All Therapies Combined - Includes Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - 60 days. Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services max.		
Chiropractic Services (annual limit -20 days)	$30 after Deductible	*50% after Deductible
Acupuncture (unlimited)	$30 after Deductible	*50% after Deductible
Cardiac Rehabilitation Services (annual limit - 36 days)	$30 after Deductible	*50% after Deductible
Durable Medical Equipment (DME)	20% after Deductible	*50% after Deductible

Note: Pharmacy Coverage is detailed in the next section of this booklet. Effective 01/01/2025

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

**** Out-of-network deductible does not apply to preventive care for dependents under the age of 16. Details regarding specific eligibility, coverage exclusions, definitions, and other information are included in the full summary plan document.*

OrangePrime Low Deductible Plan

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed as Employee Responsibility)	
Deductible Per Benefit Period (PBP) Individual Family	 $1,500 $3,000	 **$3,000** **$6,000**
Coinsurance	20%	**50%**
Plan Year Accumulation	**Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and out-of-Network unless otherwise noted.**	
Out-of-Pocket Maximums PBP (includes deductible, coinsurance, and medical copays) Individual Family	 $3,000 $6,000	 **$6,000** **$12,000**
Maximum Reimbursable Charge	Not applicable	**110%**
Lifetime Maximum	**Unlimited**	
Preventive - annual physical and gynecological exam	$0 copay	**50% after Deductible**
Primary Care Office Visits (Internal Medicine, General Practice, Family Medicine, OB/GYN)	 $30 copay	 **50% after Deductible**
Specialist	$50 copay	**50% after Deductible**
MDLive (virtual)	$10 copay	**Not Covered**
Virtual Primary Care-office visit	$30 copay	**50% after Deductible**
Virtual Specialty Care-office visit	$50 copay	**50% after Deductible**
Convenience Care Clinic	$30 copay	**50% after Deductible**
Urgent Care	$50 copay	**20% after Deductible**
Emergency Room	20% after Deductible	**20% after Deductible**
Maternity		
Initial Visit to Confirm Pregnancy	$30 copay	**50% after Deductible**
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	20% after Deductible	**50% after Deductible**
Office Visits in Addition to Global Maternity Fee (performed by OB/GYN or specialist)	$30 copay	**50% after Deductible**
Delivery - Facility (Inpatient Hospital, Birthing Center)	20% after Deductible	**50% after Deductible**
Ambulance (emergency)	20% after Deductible	**20% after Deductible**
Immunizations	$0 copay	**50% after Deductible**
Allergy Treatment / Injections / Allergy Serum	$30 copay	**50% after Deductible**

OrangePrime Low Deductible Plan

Benefit	In-Network	Out-of-Network
	(Coinsurance and Copays displayed as Employee Responsibility)	
Preventative Mammogram, PAP, and PSA Tests	$0 copay	**50% after Deductible**
Mammogram, PAP, and PSA Tests - Coverage includes the associated Preventive Outpatient Professional Services.Diagnostic-related PAP and PSA tests are covered at the same level of benefits as other x-ray and lab services, based on place of service.In-network diagnostic-related mammograms, including professional readings, are covered at 100%, no deductible.		
Diagnostic Breast Ultrasounds	$0 copay	**50% after Deductible**
Inpatient Hospital Admission	20% after Deductible	**50% after Deductible**
Outpatient Surgery (Non-Hospital)	20% after Deductible	**50% after Deductible**
Surgery - Physician's Office	$30 copay	**50% after Deductible**
Ambulatory Surgical Center	$150 copay	**50% after Deductible**
Mental Health and Substance Use Disorder - Inpatient includes Acute Inpatient and Residential Treatment. Outpatient - Physician's Office and MDLIVE Behavioral Services - may include Individual, family and group therapy, psychotherapy, medication management, etc. Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.		
Mental Health/Substance (inpatient)	20% after Deductible	**50% after Deductible**
Mental Health/Substance (outpatient)	$50 copay	**50% after Deductible**
MDLive Behavioral Services (outpatient)	$10 copay	**50% after Deductible**
Skilled Nursing Facility, Rehab. Hospital, Subacute Facility	20% after Deductible	**50% after Deductible**
Labs - Physician's Office	$30 after Deductible	**50% after Deductible**
Labs - Independent Lab	20% after Deductible	**50% after Deductible**
Labs - Outpatient Facility	20% after Deductible	**50% after Deductible**
Radiology Services - Office Visit	$30 after Deductible	**50% after Deductible**
Radiology Service - Outpatient Facility	20% after Deductible	**50% after Deductible**
Advanced Imaging - MRI, MRA, CAT Scan, PET Scan, etc.		
Physician's Office / Office Visit	$30 after Deductible	**50% after Deductible**
Advanced Imaging (hospital)	20% after Deductible	**50% after Deductible**
Advanced Imaging (non-hospital)	20% after Deductible	**50% after Deductible**
Outpatient Therapy Services	$30 after Deductible	**50% after Deductible**
All Therapies Combined - Includes Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - 60 days. Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.		
Chiropractic Services (annual limit -20 days)	$30 after Deductible	***50% after Deductible**
Acupuncture (unlimited)	$30 after Deductible	***50% after Deductible**
Cardiac Rehabilitation Services (annual limit - 36 days)	$30 after Deductible	***50% after Deductible**
Durable Medical Equipment (DME)	20% after Deductible	***50% after Deductible**

Effective 01/01/2025

Note: Pharmacy Coverage is detailed in the next section of this booklet.

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

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

**** Out-of-network deductible does not apply to preventive care for dependents under the age of 16. Details regarding specific eligibility, coverage exclusions, definitions, and other information are included in the full summary plan document.*

OrangePrime Local - SureFit Plan

Advent Health Physician Network

Selection of a Primary Care Provider - This Plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, Cigna designates one for you. For information on how to select a primary care provider, and for a list of participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

Referrals are required for a specialist visit - Your PCP must submit a referral for you to visit a specialist, except to seek care from in-network OB/GYN or for behavioral health services. If you visit a specialist outside of your SureFit network, you will be responsible for the entire cost.

Direct Access to Obstetricians and Gynecologists - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Benefit	In-Network *(Coinsurance and Copays displayed as Employee Responsibility)*
Deductible Per Benefit Period (PBP) Individual Family	 **$1,500** **$3,000**
Coinsurance	**20%**
Plan Year Accumulation	**Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and out-of-Network unless otherwise noted.**
Out-of-Pocket Maximums PBP (includes deductible, coinsurance, and medical copays) Individual Family	 **$3,000** **$6,000**
Maximum Reimbursable Charge	**Not applicable**
Lifetime Maximum	**Unlimited**
Preventive - annual physical and gynecological exam	**$0 copay**
Primary Care Office Visits (Internal Medicine, General Practice, Family Medicine, OB/GYN)	 **$30 copay**
Specialist	**$50 copay**
MDLive (virtual)	**$10 copay**
Virtual Primary Care-office visit	**$30 copay**
Virtual Specialty Care-office visit	**$50 copay**
Convenience Care Clinic	**$30 copay**
Urgent Care	**$50 copay**
Emergency Room	**20% after Deductible**
Maternity	
Initial Visit to Confirm Pregnancy	**$30 copay**
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	**20% after Deductible**
Office Visits in Addition to Global Maternity Fee (performed by OB/GYN or specialist)	**$30 copay**
Delivery - Facility (Inpatient Hospital, Birthing Center)	**20% after Deductible**

Benefit	In-Network *(Coinsurance and Copays displayed as Employee Responsibility)*
Ambulance (emergency)	**20% after Deductible**
Immunizations	**$0 copay**
Preventative Mammogram, PAP, and PSA Tests	**$0 copay**
Mammogram, PAP, and PSA Tests - Coverage includes the associated Preventive Outpatient Professional Services. Diagnostic-related PAP and PSA tests are covered at the same level of benefits as other x-ray and lab services, based on place of service. In-network diagnostic-related mammograms, including professional readings, are covered at 100%, no deductible.	
Diagnostic Breast Ultrasounds	**$0 copay**
Inpatient Hospital Admission	**20% after Deductible**
Outpatient Surgery (Non-Hospital)	**20% after Deductible**
Surgery - Physician's Office	**$30 copay**
Ambulatory Surgical Center	**$150 copay**
Mental Health and Substance Use Disorder - Inpatient includes Acute Inpatient and Residential Treatment. Outpatient - Physician's Office and MDLIVE Behavioral Services - may include Individual, family and group therapy, psychotherapy, medication management, etc. Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.	
Mental Health/Substance (inpatient)	**20% after Deductible**
Mental Health/Substance (outpatient)	**$50 copay**
MDLive Behavioral Services (outpatient)	**$10 copay**
Skilled Nursing Facility, Rehab. Hospital, Subacute Facility	**20% after Deductible**
Labs - Physician's Office	**$30 after Deductible**
Labs - Independent Lab	**20% after Deductible**
Labs - Outpatient Facility	**20% after Deductible**
Radiology Services - Office Visit	**$30 after Deductible**
Radiology Service - Outpatient Facility	**20% after Deductible**
Advanced Imaging - MRI, MRA, CAT Scan, PET Scan, etc.	
Physician's Office / Office Visit	**$30 after Deductible**
Advanced Imaging (hospital)	**20% after Deductible**
Advanced Imaging (non-hospital)	**20% after Deductible**
Outpatient Therapy Services	**$30 after Deductible**
All Therapies Combined - Includes Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - 60 days. Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.	
Chiropractic Services (annual limit -20 days)	**$30 after Deductible**
Acupuncture (unlimited)	**$30 after Deductible**
Cardiac Rehabilitation Services (annual limit - 36 days)	**$30 after Deductible**
Durable Medical Equipment (DME)	**20% after Deductible**

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

Prescription Drug Coverage

What Prescription Drug Plan is available?

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

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

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

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

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

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

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

Is there a deductible for pharmacy?

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

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

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

What is Step Therapy?

It is a prior authorization program designed for you and your doctor to take one step at a time when choosing your medication. It works to help you find the most affordable medication appropriate for the treatment of a diagnosed condition, such as high cholesterol.

Often, you and your doctor have a choice of several different safe and effective prescription drugs to treat the same condition. Cost is often the biggest difference. Brand-name medications usually are the most expensive, while generic medications are the least expensive.

Several common ongoing medical conditions are subject to Step Therapy:

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

How Does Step Therapy Work?

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

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

Does Our Pharmacy Plan Have Home Delivery?

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

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

Are smoking cessation drugs covered?

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

Medical and Pharmacy Premium Contribution Chart

Medical and Pharmacy Premiums			*Bi-Weekly Rates*
Cigna	Total Premium	Employee Contribution	County Contribution
HDHP Employee only	$482.88	**$23.32**	$459.56
HDHP Employee + spouse	$1008.25	**$150.71**	$857.54
HDHP Employee + child(ren)	$912.06	**$119.34**	$792.72
HDHP Employee + family	$1330.03	**$266.15**	$1063.88
LDHP Employee only	$525.18	**$38.85**	$486.33
LDHP Employee + spouse	$1074.49	**$180.71**	$893.78
LDHP Employee + child(ren)	$979.61	**$147.17**	$832.44
LDHP Employee + family	$1419.87	**$310.24**	$1109.63
SureFit Employee only	$464.79	**$0**	$464.79
SureFit Employee + spouse	$950.92	**$138.45**	$812.47
SureFit Employee + child(ren)	$866.95	**$92.30**	$774.65
SureFit Employee + family	$1,256.58	**$230.76**	$1,025.82

Tricare Supplement Insurance Plan

In addition to the three medical plans mentioned in the previous section, Orange County offers some employees the opportunity to enroll in the Tricare Supplement Plan.

What is the Tricare Supplement Plan?

Tricare is the health insurance plan for members of the Armed Forces and their families. Orange County offers a *Tricare Supplement Plan* as an optional benefit for employees who are already enrolled/entitled to the basic Tricare health insurance due to their military affiliation. Orange County has contracted with Selman & Company to administer this plan on our behalf.

Who is eligible for the Tricare Supplement Plan?

Employees may elect the Tricare Supplement Plan if they meet the following eligibility requirements.

<u>Eligible Members are under age 65 and include the following:</u>

- Retired military receiving retired, retainer or equivalent pay
- Spouses, surviving spouses, some former spouses of a military retiree and Active-duty service member. (The former spouse must have been married to the military member for at least 20 years and not remarried)
- Reservists and National Guardsmen who are between the ages of 60 and 65 and have at least 20 years of creditable military service. Their eligible family members will also become eligible
- Qualified National Guard and Reserve members; Tricare Retired Reserve (TRR)

Are there any exceptions to the Age 65 Eligibility Rule?

- Participants/spouses over age 65 but are ineligible for Medicare. These Members must provide their HR Service Center with a copy of their Social Security Administration "Notice of Disallowance Statement"
- Participants/spouses who are over 65 but reside overseas. Since Medicare does not cover medical expenses incurred outside of the United States of America these individuals are eligible to enroll in the Supplement Plan. However, these individuals must be entitled to Medicare Part A and enrolled in Medicare Part B. Enrollment in Medicare results in automatic eligibility for Tricare for Life.

Who is not eligible for the Tricare Supplement Plan?

The following are eligible for a retail Tricare Supplement policy, but not through the group coverage being offered by Orange County. These members will need to contact the SelmanCo' s Customer Service Department at 1-800-638-2610, option 1.

- Families of disabled veterans who are eligible for CHAMPVA
- Active-duty service members, Reservists, National Guardsmen who are separating from active duty and their family members. These individuals have Transitional Assistance Management Program (TAMP) for 180 days after separating from active service

Can I cover my dependents on the Tricare Supplement Plan?

Eligible dependents include spouses and unmarried dependent children up to age 21. Is a full-time student up to age 23 or 26 is enrolled in the Tricare Young Adult Program. In addition, incapacitated dependents may continue coverage past the policy age limits as long as Tricare continues.

What happens to my Tricare Supplement coverage when I turn age 65?

Coverage under the Tricare Supplement plan will terminate automatically the month following a Member/spouse turning age 65 (Medicare age). For example, if the participant or spouse becomes Medicare eligible on June 15th, his/her Tricare Supplement coverage will terminate on July 1st. Notification of termination is sent 60 days prior to the participant's (or spouse's) 65th birthday. The member may choose to continue the coverage for his/her family through portability.

Please note that Medicare is effective on the first of the month that an individual attains age 65. However, for individuals who were born on the 1st of the month, Medicare is effective on the first of the prior month.

Can I continue my Tricare Supplement Plan once I terminate my employment at Orange County?

Members who terminate employment may continue the supplement by "porting" their coverage and paying their monthly premiums directly to Selman & Company. Portability (Continuation of Coverage) letters are mailed to the terminating Member within two days of receipt of the termination date from the employer. Former Members who enroll on portability will pay 2% less in monthly premium dollars than they would enrolling under COBRA, since portability is offered at the same cost paid by the employer. There is no separate administration fee required. The portability/continuation of coverage letter will include the monthly rates.

Please note that portability does not apply to a Member, spouse or dependent child who no longer meets the Supplement eligibility requirements (e.g., a Member or spouse who attains age 65 and is eligible for Medicare or a dependent child who reaches age 21/23 and is no longer listed in DEERS).

Can I use the Opt-Out Credit to help pay for the Tricare Supplement?

Yes. If you receive the County's Opt Out Credit by completing open enrollment premiums for the Tricare Supplement are eligible to be offset by the Opt Out Credit. This is allowable, because you are still "opting out" of the County's self-insured health insurance plans through Cigna.

How much does the Tricare Supplement cost?

Premiums for all benefit offerings are listed in the premium section of this booklet.

How does the Tricare Supplement Plan work?

TRICARE is the primary payer, and the TRICARE Supplement plan pays secondary. After TRICARE has been paid, the TRICARE Explanation of Benefits (EOB) is submitted to SelmanCo for secondary consideration. After you have met both your TRICARE and TRICARE Supplement insurance

deductibles, the supplemental insurance plan pays 100% of your approved expenses not paid by TRICARE. See the benefit summary on the next page.

Is there a deductible? Yes, the supplement plan has a $100 individual/$200 family deductible.

Tricare Supplement Benefit Summary

Reimbursement of the annual Tricare outpatient deductible under this plan is made only if the deductible is incurred after the effective date of coverage. It will be prorated if you are insured for less than a year.

2025 Tricare Supplement Benefit Summary			
Plan Name	**TRICARE Prime** *is responsible for*	**TRICARE Select** *is responsible for*	**TRICARE Returned Reserves** *is responsible for*
Supplement Deductible	Employee: $100 Family: $200	Employee: $100 Family: $200	Employee: $100 Family: $200
Primary TRICARE Deductible	50% of TRICARE Prime POS Deductible (eligible charges used to satisfy TRICARE Deductible applied to Supplement Plan Deductible)	Covers 100% of TRICARE Select deductible	Covers 100% of TRICARE Retired Reserves deductible
Inpatient and Outpatient Benefits, including Outpatient Surgery Services	100% of the Co-pays and Cost Share	Covers 100% cost shares and excess charges	Covers 100% cost shares and excess charges
Excess Charges	100% of all Covered Expenses in excess of the TRICARE allowed amount, not to exceed the Legal Limit	Covers 100% cost shares and excess charges	Covers 100% cost shares and excess charges
Pharmacy Reimbursement Benefit	100% of the Co-pays and Cost Share remaining	100% of the co-payments and cost share remaining	100% of the co-payments and cost share remaining

Tricare Supplement Premium Contribution Chart

TRICARE Supplement			*Bi-Weekly Rates*
Selman & Company	Total Premium	Employee Contribution	County Contribution
Employee only	$31.15	**$31.15**	$0
Employee + spouse	$61.15	**$61.15**	$0
Employee + child(ren)	$61.15	**$61.15**	$0
Employee + family	$82.38	**$82.38**	$0

Dental Insurance

What dental plans are available?

Orange County offers three dental plans through Cigna for you to choose from:

- Low Plan
- Middle Plan
- High Plan

What is the difference between the three dental plans?

The level of benefit varies depending on the plan selected.

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

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

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

What about the network?

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

What is a progressive plan maximum?

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

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

Is there a late entrant penalty?

No. The Cigna Dental plan does not have a late entrant penalty.

What's new or changing with the dental plans?

For 2025, there are changes to The High Plan only, as follows:

- The addition of Adult Orthodontia treatment
- Inlay and Onlays covered under Basic Services

Dental Plan Comparison Chart

2025 Cigna Dental Benefits			
Plan Options	**Low Plan**	**Middle Plan**	**High Plan**
Annual Maximum paid by insurance	$1,000 per person per calendar year	$1,000 per person per calendar year	$1,500 per person per calendar year
Progressive Maximum	$250 per year up to $1,750	$250 per year up to $1,750	$250 per year up to $2,250
Calendar Year Deductible	$50 per individual $150 per family	$50 per individual $150 per family	$50 per individual $150 per family
Preventive Services Oral exams, cleanings, routine x-rays, fluoride	100% - no deductible	100% - no deductible	100% - no deductible
Basic Services Sealants; fillings; oral surgery; root canals; repairs to dentures, bridges, and crowns (***High Plan Only*** : *inlays, onlays)*	Employee pays 40%, after deductible has been met	Employee pays 30%, after deductible has been met	Employee pays 20%, after deductible has been met
Major Services Periodontics, dentures, bridges, crowns, inlays, onlays	Employee pays 70%, after deductible has been met	Employee pays 60%, after deductible has been met	Employee pay 50%, after deductible has been met
Orthodontia Dependents up to age 19 on Middle Plan. Employees and Dependents eligible on High Plan.	Not covered Select network orthodontists provide a 15% discount for adults. Contact your provider for more details.	Employee pays 60%, no deductible. Lifetime limit of $1,000 Select network orthodontists provide a 15% discount for adults. Contact your provider for more details.	Employee pays 50%, no deductible. Lifetime limit of $1,000 Select network orthodontists provide a 15% discount for adults. Contact your provider for more details.

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

Dental Plan Premium Contribution Charts

Dental Premiums			*Bi-Weekly Rates*
Cigna Low Plan	Total Premium	Employee Contribution	County Contribution
Low Employee only	$7.10	**$7.10**	$0
Low Employee + 1	$14.49	**$14.49**	$0
Low Employee + 2 or more	$26.48	**$26.48**	$0

Cigna Middle Plan	Total Premium	Employee Contribution	County Contribution
Middle Employee only	$10.88	**$10.88**	$0
Middle Employee + 1	$22.53	**$22.53**	$0
Middle Employee + 2 or more	$42.36	**$42.36**	$0

Cigna High Plan	Total Premium	Employee Contribution	County Contribution
High Employee only	$17.71	**$17.71**	$0
High Employee +1	$36.07	**$36.07**	$0
High Employee + 2 or more	$65.55	**$65.55**	$0

Vision Insurance

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

What are the benefits?

Plan Frequencies:

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

What are the In-Network copayments?

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

Can I order my glasses and/or contacts online?

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

Are there any restrictions or limitations?

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

Could I have additional costs?

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

Is LASIK vision correction covered?

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

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

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

Vision Plan Premium Contribution Chart

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

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

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

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

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

Vision Comparison Chart

Vision Premiums			*Bi-Weekly Rates*
MetLife	Total Premium	Employee Contribution	County Contribution
Employee only	$2.20	$2.20	$0
Employee + 1	$4.40	$4.40	$0
Employee + 2 or more	$6.46	$6.46	$0

Life Insurance

What coverage is available?

Through The Standard Insurance Company, Orange County offers four options of Group Life Insurance coverage to all benefits-eligible employees: Basic Employee Life with Accidental Death and Dismemberment (AD&D) Insurance, Additional Employee Life with AD&D Insurance, Spouse Life with AD&D Insurance, and Child Life.

Who is eligible?

Eligibility begins when you become a member (date of hire) and are actively working 20 hours or more per week. In order to maintain eligibility, you must be actively working 20 hours or more per week (applies to all life insurance plans, including Basic).

- Flexibility applies in certain situations where an employee is on an approved leave of absence and premiums continue to be paid.
- Provisions apply for those with severe illness, injury, and/or disability.
- See current life insurance certificate (posted on OrangeNet) or reach out to oclifeanddisability@standard.com for additional information.

Basic Employee Life with AD&D Insurance

The County provides, at no cost to you, an amount of Basic Life Insurance equal to your annual base pay rounded up to the next multiple of $1,000, to a maximum of $200,000. Medical underwriting is not required for basic life insurance. As part of this coverage, the following services are available at no charge:

- Travel Assistance
  Services include a full range of medical, travel, legal and emergency transportation services when you travel more than 100 miles from home or internationally on trips up to 180 days. Download the Assist America Mobile App on Google Play or Apple App Store, enter the reference number 01-AA-STD-5201 and your full name.

- Life Services Toolkit
  Log on to http://www.standard.com/mytoolkit Username is "assurance".

  - Estate-Planning Assistance
    Online tools, found in the Legal Forms section, walk you through the steps to prepare a will and create other documents, such as living wills, power of attorney, health care agent forms and living trusts.
  - Health and Wellness
    Timely articles about nutrition, stress management and wellness help employees, and their families lead healthy lives.

  - Funeral Arrangements
    Use the website to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.

  - Identity Theft Prevention
    Check the website for ways to thwart identity thieves and resolve issues if identity theft occurs.

  - Additional Services and Resources are available to Beneficiaries (see flyer for more details).

What is AD&D Insurance?

Included with Basic Life Insurance, Additional Employee Life Insurance and Spouse Life Insurance is Accidental Death and Dismemberment (AD&D) Insurance. AD&D Insurance pays a benefit in addition to life insurance if the cause of death is due to a covered accident. The benefit is equal to two times the Life amount. For example, an employee with $34,000 of Basic Life Insurance would have $68,000 of Basic AD&D Insurance in addition to the $34,000 of Basic Life Insurance, and a spouse with $50,000 of Spouse Life Insurance would have $100,000 of AD&D Insurance in addition to the $50,000 of Spouse Life Insurance. AD&D insurance also pays benefits for the loss of sight, speech or hearing, hand or foot, thumb and index finger on same hand, para, hemi or

quadriplegia, resulting from a covered accident. The amount payable for certain losses is less than 100% of the AD&D Insurance Benefit.

Employee and Spouse AD&D Insurance also includes the following benefits:

- Seat Belt Benefit
  If you or your spouse die as a result of an automobile accident for which an AD&D Insurance Benefit is payable for loss of life and were wearing and properly using a seat belt at the time of the accident, the beneficiary named will receive an additional benefit equal to the lesser of (1) $10,000, or (2) the AD&D insurance benefit payable for loss of your life.

- Air Bag Benefit
  The beneficiary named will receive an additional benefit equal to the lesser of (1) up to $10,000; or (2) the AD&D insurance benefit payable for loss of life, if you or your spouse die as a result of an automobile accident for which a Seat Belt benefit is payable for loss of life, the automobile was equipped with an Air Bag System, the deceased was seated in the driver's or passenger's seating position intended to be protected by the Air Bag System, and the Air Bag System deploys.

- Child Care Benefit *(This only applies to the Employee)*
  If you die as a result of an accident for which an AD&D benefit is payable, up to $10,000, or 25% of the AD&D Insurance benefit, whichever is less, will be paid to your spouse to cover the childcare expenses incurred within 36 months after the date of your death for all children under age 13 in order for your spouse to work or to obtain training for work. The childcare provider must be licensed and not a member of your family.

- Career Adjustment Benefit *(This only applies to the Employee)*
  If you die as a result of an accident for which an AD&D benefit is payable, your spouse will receive up to $10,000, or 25% of the AD&D Insurance benefit, whichever is less, to cover tuition expenses within 36 months after the date of your death, exclusive of room and board, books, fees, supplies and other expenses, if he or she is registered and in attendance at an accredited institution of higher education or trades training program for the purpose of obtaining employment or increasing earnings.

- Higher Education Benefit (This only applies to the Employee)
  If you die as a result of an accident for which an AD&D benefit is payable, within four years after the date of your death, each of your qualified children who are registered and in full-time attendance at an accredited institution of higher education beyond high school within 12 months after the date you die will receive up to $20,000, or 25% of the AD&D Insurance benefit, whichever is less, to cover tuition expenses at an accredited institution of higher education, exclusive of board and room, books, fees, supplies and other expenses.

- Occupational Assault Benefit *(This only applies to the Employee)*

  Up to $25,000, or 50% of the AD&D Insurance benefit, whichever is less, will be paid to you if you suffer a loss for which an AD&D Insurance Benefit is payable while actively at work and the loss is a result of an act of physical violence against you that is punishable by law and is evidenced by a policy report.

- Public Transportation Benefit

  Up to $200,000, or 100% of the AD&D Insurance benefit, whichever is less, will be paid if you or your spouse die as a result of an accident for which an AD&D Insurance Benefit is payable for the loss of life and the accident occurs while the deceased is riding as a fare-paying passenger on public transportation.

Are insurance benefits reduced as the insured grows older?

Yes, the amount of insurance payable is reduced to a percentage of the eligible or elected amount. Reductions are effective January 1st of the following year. These reductions apply to Basic Employee Life and AD&D Insurance, Additional Employee Life and AD&D Insurance, and Spouse Life and AD&D Insurance as follows:

Employee/Spouse Age	Percentage
65 through 69	65%
70 through 74	50%
75 and up	35%

Can I receive my life insurance while still living?

Both the Basic Employee Life policy provided by the County and the Additional Employee Life Insurance include an Accelerated Benefit that allows an insured employee with a Qualifying Medical Condition to receive up to 75% of the amount of the insured's life insurance not to exceed $500,000. A Qualifying Medical Condition is a terminal illness or physical condition that is reasonably expected to result in death within 12 months. AD&D Insurance benefits will not be reduced if an Accelerated Benefit is paid. The receipt of this benefit may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlements, so you should consult your tax or legal advisor before you apply for an Accelerated Benefit.

Can I take my life insurance with me when I leave the County?

If your life insurance ends because your employment with the County ends, you may be eligible to "port" (or buy) Group Life Insurance coverage without being subject to medical underwriting. This portability option applies to Basic and Additional Life/AD&D, Spouse Life/AD&D and Child Life Insurance.

If your life insurance ends or is reduced for any reason other than non-payment of premiums, you may be eligible to "convert" some or all of your coverage to an individual Whole Life Insurance policy without being subject to medical underwriting. This conversion option applies to Basic and Additional Life, Spouse Life and Child Life Insurance. AD&D insurance is not eligible for conversion.

How much does it cost to Port or Convert my insurance?

Portability has smoker and non-smoker rates. The rates are different than the rates used in the group policy. Conversion rates are based on your state of residence and age when you apply for coverage. Please contact The Standard for detailed rate information.

How much time will I have to Port or Convert my insurance?

You will have 60 days after your employment terminates to apply and pay the premium for portability. For conversion, you will have 60 days after your coverage was reduced or ended. If you die during the 60-day period after the date your insurance ends or is reduced, your beneficiaries will be paid a death benefit equal to the maximum amount you had a right to port or convert, whether or not you applied for either option. For additional information call 1-800-378-4668, ext. 6785.

Additional Employee Life and AD&D Insurance

Eligible employees may apply for Additional Life insurance in increments of $10,000, up to five times their annual base pay, but not to exceed $300,000. Included with Additional Employee Life is AD&D Insurance, which provides a benefit that equals twice the amount of Additional Life Insurance elected.

How do I designate beneficiaries?

To designate beneficiaries for your Life and AD&D benefits, complete the Beneficiary Designation Form included with your new hire materials or available from your HR representative. Your Basic Life Insurance and your Additional Life Insurance may have separate beneficiaries. Your beneficiary designation must be the same for your Life Insurance and AD&D Insurance death benefits. You may assign multiple primary and contingent beneficiaries, as long as the percentages are in whole numbers, equal to 100 percent. The contingent beneficiaries will only receive a benefit if none of the primary beneficiaries survive you. You can change your beneficiaries at any time by contacting your HR representative.

Spouse Life and AD&D Insurance

Employees can purchase life insurance for spouses in increments of $10,000 up to $250,000, not to exceed the total amount of the Employee's combined Basic and Additional Life Insurance. Included with Spouse Life is AD&D Insurance, which provides a benefit that equals twice the amount of life insurance elected for the employee's spouse. *(Please note: Employees earning less than $20,000, who do not elect Additional Employee Life coverage, may purchase increments of $5,000 up to $20,000 of spouse life coverage.)*

The rates for Spouse Life and AD&D Insurance are the same as Additional Employee Life Insurance and are based on your spouse's age.

Spouse Life and AD&D Insurance Premiums

Employee Additional Life/AD&D and Spouse Life/AD&D Premiums*			*Bi-Weekly Rates*
Standard Insurance Company (rates are per $10,000 of coverage) Age as of 01/01/2025:	Total Premium	Employee Contribution	County Contribution**
Under 30	$0.32	**$0.32**	$0
30-34	$0.42	**$0.42**	$0
35-39	$0.65	**$0.65**	$0
40-44	$0.97	**$0.97**	$0
45-49	$1.38	**$1.38**	$0
50-54	$2.03	**$2.03**	$0
55-59	$2.31	**$2.31**	$0
60-64	$3.00	**$3.00**	$0
65-69***	$5.68	**$5.68**	$0
70 & up***	$11.26	**$11.26**	$0

** AD&D premiums are included with Additional Life and Spouse Life premiums*

*** Basic Employee Life Insurance is paid 100% by the County*

****Age reductions apply*

Employee/Spouse Age	Percentage
65 through 69	65%
70 through 74	50%
75 and up	35%

Child Life Insurance

Employees can purchase Dependent Life insurance for their eligible dependent children. All eligible children will be insured for the same amount. Parents who both work for Orange County may only cover their children under one parent. The coverage options for Child Life Insurance are $5,000 and $10,000 but cannot exceed 100% of the total amount of the Employee Basic and Additional Life Insurance.

Eligibility for child life insurance:

- Unmarried children from live birth through age 25
- Unmarried stepchildren and the child of your spouse through age 25 if living with you
- Unmarried disabled children
- Grandchildren cannot be covered by child dependent life insurance

Child Life Insurance Premiums

Child Life Insurance Premiums			*Bi-Weekly Rates*
Standard Insurance Company	Total Premium	Employee Contribution*	County Contribution
$5,000 per eligible child	$0.14	**$0.14**	$0
$10,000 per eligible child	$0.28	**$0.28**	$0

Evidence of Insurability: In some situations, the life insurance carrier requires applicants to complete a medical underwriting form (Medical History Statement) regarding past health history. Refer to the Medical Underwriting section of this handbook for details.

NOTE: This book provides a brief overview of your Life Insurance and AD&D Plans. For a complete explanation (including the exclusions, limitations, and reductions of your coverage) please refer to your Certificate of Coverage. You can view and print a copy of the Life Insurance Certificate of Coverage from CountyFiles on the OrangeNet Intranet site. If you do not have Intranet access, you can request a copy of the Certificate of Coverage from your HR Service Center.

This information was written in non-technical language and is not intended as a complete description of the Group Life and AD&D Insurance plans offered by The Standard. Employees should refer to their Certification of Coverage, which will contain more detailed information. The controlling provisions are in the Standard Insurance Company's group policy. This information does not modify that document or the insurance in any way.

Disability Insurance

The Standard Insurance Company is Orange County's provider for Long-Term Disability (LTD) and Short-Term Disability (STD) coverage.

Long-Term Disability (LTD)

The County provides this benefit at no cost to you. The LTD plan pays an amount equal to 60% of your salary to a monthly maximum of $10,000 (reduced by Deductible Income) upon completion of a 180-day waiting period. Since LTD premiums are paid by the County, the LTD benefits paid to employees are considered taxable.

What is deductible income?

Deductible income is income you receive, or are eligible to receive, from other sources. It includes but is not limited to the following (see your Certificate of Coverage for more details):

- Sick pay, annual or personal leave pay, severance pay, or other salary continuation, including donated amounts. Vacation pay is not a source of deductible income.
- Workers' Compensation benefits
- Social Security benefits, including those benefits that your spouse or children receive or are eligible to receive because of your disability or retirement
- Disability or retirement benefits from your employer's retirement plan
- Amount you receive or are eligible to receive because of a state disability benefit law or similar law
- Amount from any employment compensation law or similar act or law

When am I considered disabled?

For the first 36 months for which LTD Benefits are paid, you are considered disabled if, as a result of physical disease, injury, pregnancy, or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation and you suffer a loss of at least 20% of your pre-disability earnings when working in your own occupation. You are not disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

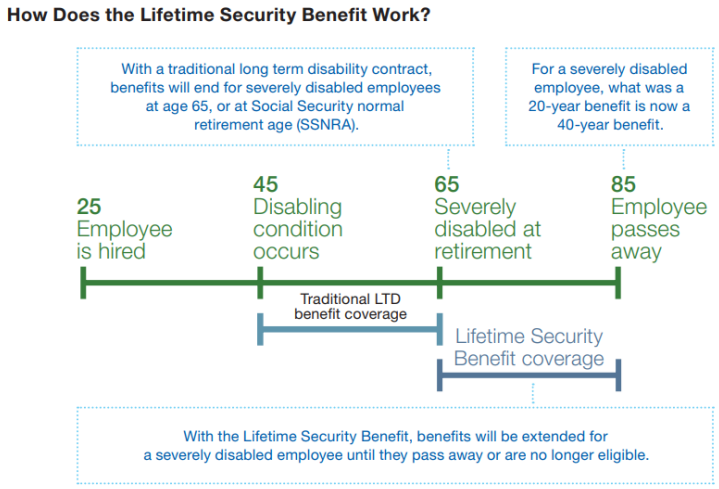
Thereafter, you are considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation which you are able to perform, whether due to education, training, or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 60% of your pre-disability earnings within twelve months following your return to work, regardless of whether you are working in that or any other occupation.

What is a Lifetime Security Benefit?

The Lifetime Security Benefit from The Standard provides severely disabled claimants with ongoing monthly income beyond the normal claim payment period, when other benefits may have ceased, until the claimant passes away or is no longer eligible.

How does the Lifetime Security Benefit work?

With a traditional long term disability policy, benefits will end for severely disabled employees at age 65, or at Social Security normal retirement age (SSNRA). With the Lifetime Security Benefit, benefits will extend for a severely disabled employee until they pass away or are no longer eligible.



How long can LTD benefits continue?

If you become continuously totally disabled before age 62, LTD benefits can continue until age 65, or to SSNRA, or 3 years 6 months, if longer. If you become continuously totally disabled at age 62 or older, LTD benefits can continue for a limited time.

Social Security Normal Retirement Age (SSNRA) means your normal retirement age under the Federal Social Security Act, as amended.

Age	Maximum Benefit Period
62	To SSNRA, or 3 years 6 months, whichever is longer
63	To SSNRA, or 3 years, whichever is longer
64	To SSNRA, or 2 years 6 months, whichever is longer
65	2 years
66	1 years 9 months
67	1 years 6 months
68	1 years 3 months
69	1 year

Assisted Living Benefit (Providing Added Income for the Severely Disabled)

The benefit is available for employees to whom LTD benefits are payable, whose condition is expected to last 90 days or more and who are experiencing the following limitations associated with their severe disability:

- The employee is unable to safely and completely perform two or more Activities of Daily Living* without assistance, or
- The employee requires supervision for health or safety due to severe cognitive impairment.

The Assisted Living Benefit is an additional 20% of your pre-disability earnings not to exceed $3,333. It is not reduced by deductible income.

**The six Activities of Daily Living are bathing, continence, dressing, eating, toileting and transferring.*

******* *Long Term Disability Insurance is paid 100% by the County*

Short-Term Disability (STD)

Employees have the option of enrolling in and paying premiums for an STD plan. The STD plan pays employees an amount up to 60% of their pre-disability salary to a weekly maximum of $2,500 (reduced by Deductible Income – see definition of deductible income above). STD premiums are deducted from employee pay after taxes, so STD benefits paid to employees are non-taxable.

When do STD benefits begin, and how long will they last?

STD benefits begin once you have exhausted all County paid sick, term, personal, and vacation leave and have met the required waiting period.

> Example: You are enrolled in the 15 day wait period benefit, but you have 30 days of time on the books. Apply for your STD benefit immediately as it takes some time to process the claim and you may be eligible for a $25 weekly benefit, while exhausting your County time. Upon approval of your STD claim, the effective date will be the beginning of your disability. Once your County time is exhausted, your STD benefit will begin to pay out unless you have already returned to work.

Because everyone's situation is different, there are five STD plan options – or waiting period buy-down options – to choose from. The waiting period buy-down options are 15, 30, 60, 90, and 120 calendar days. Before selecting the STD plan that best meets your needs, you should review and consider how much leave time you have accrued. STD benefits continue until you are no longer disabled, to the end of the maximum benefit period, or until LTD benefits begin, whichever happens first.

Benefit Waiting Period	Maximum Benefit Period
120 day wait	9 weeks
90 day wait	13 weeks
60 day wait	18 weeks
30 day wait	22 weeks
15 day wait	24 weeks

What is the cost of STD coverage?

STD is calculated based on the amount of weekly benefit you would receive. A formula for calculating your premium is provided in the premium section of this booklet.

Do I need to make an STD Election?

All benefits-eligible employees are automatically enrolled in the LTD Plan with the 180-day waiting period. However, employees who would like short term coverage must make an election for the STD Plan with the waiting period they desire.

Evidence of Insurability: In some situations, the STD insurance carrier requires applicants to complete a medical underwriting form (Medical History Statement) regarding past health history. Refer to the Medical Underwriting section of this handbook for details.

NOTE: This book provides a brief overview of your LTD and STD Plans. For a complete explanation (including the exclusions, limitations, and reductions of your coverage) please refer to your Certificate of Coverage. You can view and print copies of the LTD and STD Certificates of Coverage in from CountyFiles on the OrangeNet Intranet site. If you do not have Intranet access, you can request a copy of the Certificate of Coverage from your HR Service Center.

This information is written in non-technical language and is not intended as complete descriptions of the LTD and STD Insurance plans offered by The Standard. Employees should refer to their Certificates of Coverage, which will contain more detailed information. The controlling provisions are in the Standard Insurance Company's group policy. This information does not modify that document or the insurance in any way.

Short-Term Disability Premium Contribution Chart

Short-Term Disability Premiums			*Bi-Weekly Rates*
Standard Insurance Company (rates are per $10 of covered weekly benefit – see formula)	Total Premium	Employee Contribution	County Contribution
120 calendar day waiting period	$0.037	**$0.037**	$0
90 calendar day waiting period	$0.055	**$0.055**	$0
60 calendar day waiting period	$0.097	**$0.097**	$0
30 calendar day waiting period	$0.125	**$0.125**	$0
15 calendar day waiting period	$0.143	**$0.143**	$0

Formula for calculating Short-Term Disability bi-weekly premium:

1. Divide your gross annual salary by 52 (this gives you your weekly gross salary).
2. Multiply your gross weekly salary by 60%.
3. Divide that number by 10.
4. Multiply that number by the rate shown above for the STD waiting period you selected to get your bi-weekly premium.

Medical Underwriting Rules (Evidence of Insurability or EOI)

	2025 New Hire Elections	2025 Qualified Events	2025 Open Enrollment Elections
Child Life	❑ EOI **Not Required**	❑ EOI **Not Required**	❑ EOI **Not Required**
Spouse Life	❑ EOI **Not Required** up to $50K ❑ EOI **Required** for any amount greater than $50K	❑ <u>If newly married</u>: ❑ EOI **Not Required** up to $50K ❑ EOI **Required** for any amount greater than $50K ❑ <u>All other QEs</u>: ❑ EOI **Required** (*for any amount*)	❑ EOI **Not Required** for any increase ($50K max) ❑ EOI **Required** for any increase greater than $50K ❑ Spouses previously denied medical underwriting (MU) can re-apply.
Supplemental (Employee)	❑ EOI **Not Required** up to $200K ❑ EOI **Required** for any amount greater than $200K	❑ EOI **Required** *(See HR for exceptions)*	❑ EOI **Not Required** for any increase, ($200K max) ❑ EOI **Required** for any increase greater than $200K ❑ Employees previously denied medical underwriting (MU) can re-apply.
Short Term Disability	❑ EOI **Not Required**	❑ EOI **Required** *(See QE handbook for RTW exceptions)*	❑ EOI **Not Required**

Medical Underwriting (MU) is also commonly referred to as **Evidence of Insurability (EOI)**. EOI is only required for any amount above the guarantee.

EOI applications must be submitted directly to "The Standard" (HR <u>will not</u> accept any EOI documentation).

Apply online here:
https://myeoi.standard.com/641718
Group Name: Orange County Government
Policy Number: 641718

Reach out to The Standard for assistance.
<u>oclifeanddisability@standard.com</u>
Or call The Standard at (800) 843-7979

Flexible Spending Accounts

The County offers three Flexible Spending Accounts: a Medical Flexible Spending Account (Medical FSA), a Limited Purpose Flexible Spending Account (LPFSA) and a Dependent Care Flexible Spending Account (DCFSA). Chard Snyder, a Wex Company, is Orange County's administrator for Flexible Spending Accounts.

How does this program work?

You determine how much you wish to deduct from your paycheck each pay period to go into this account. You can contribute as little as $15 per pay period and as much as $3,200 per plan year. You need to estimate expenses carefully. Unused funds will only carry over until March 15th of the next plan year. This is a "use it or lose it" plan so any remaining funds after that date will be forfeited (lost).

The contributions made to FSA can be used for your portion of covered expenses and eligible expenses incurred by you or your eligible dependents. Eligible dependents for the FSA are generally defined as those individuals who you can claim as a dependent on your federal income tax returns. Eligible dependents under the FSA do not need to be covered under the County's medical plans.

How do I receive reimbursement for my eligible expenses?

You will receive a debit card from Chard Snyder, a Wex Company, to pay for your eligible expenses directly at the point of sale.

Always save your receipts! Chard Snyder, a Wex Company may also request you submit receipts for purchases you have made with your debit card, so they can ensure they are for eligible items only. If receipts are not submitted, your expenses may be considered taxable.

Another reimbursement option is to pay for your expenses up front and then submit a claim form along with your receipts to Chard Snyder, a Wex Company. A reimbursement check will then be mailed to you within 2 to 3 weeks. Employees may also be able to elect direct deposit as their preferred method of reimbursement. Direct deposit delivers funds into your personal bank account rather than waiting for a paper check. Interested employees should contact Chard Snyder, a Wex Company, for details.

What is the advantage of enrolling in this plan?

This benefit offers you the opportunity to set aside money on a pre-tax basis for predictable or unpredictable eligible expenses; thus, it can offer you significant savings on your income taxes.

Can I submit claims after I stop participating in the FSA?

When your FSA participation ends, you may submit claim forms only for eligible expenses incurred up to the date your participation ended. You have 90 days from your termination date, to submit

for reimbursement of eligible expenses incurred on or before your date of termination. For example, if you terminate employment or retire and your FSA participation ends on July 24, you may receive reimbursements for eligible expenses you incurred through July 24. You may continue to use your FSA funds after you terminate employment or retire only if you continue the plan and pay premiums through COBRA.

Can I have a Medical FSA and a Dependent Care FSA at the same time?

Yes. The IRS allows you to have a Medical FSA and a Dependent Care FSA at the same time.

Can I have an LPFSA and a Dependent Care FSA at the same time?

Yes. The IRS allows you to have an LPFSA and a Dependent Care FSA at the same time.

Can I have a Medical FSA and LPFSA at the same time?

No. The IRS does not allow you to have a Medical FSA and a Limited Purpose FSA at the same time.

Can I have a HSA and LPFSA at the same time?

Yes. The IRS allows you to have an LPFSA and a Health Savings Account at the same time.

What else do I need to know?

By using the FSA to help pay for predictable health care expenses, you may end up with more net income. Remember, you must plan carefully to take advantage of this program. Make sure you do not put more into the account than you will use during the plan year because unused funds *cannot* be returned to you. Also, you cannot make changes to your deductions during the plan year unless you experience certain qualifying events. Contact your HR Service Center for more information.

Plan Deadlines

The plan year runs from January 1st through December 31st. You can continue to incur expenses through March 15th of the following year. You have until June 15th of the following year to submit claims incurred January 1st through March 15th (15 months).

Need more information?

Participant Services representatives are happy to speak with you 8 am - 8 pm ET, Monday through Friday. Contact Chard-Snyder, a Wex Company, at 1- 800-982-7715, via email at askpenny@chard-snyder.com, or Find helpful FAQs, videos, reference guides, and other resources to help you understand your plan online at www.chard-snyder.com.

Medical Flexible Spending Account (FSA)

The Medical FSA allows you to set aside pre-tax dollars to pay for your portion of covered expenses, as well as eligible expenses not covered by your medical, dental or vision insurance.

What types of expenses are considered eligible for reimbursement?

A listing of eligible items can be found online: https://www.chard-snyder.com/benefits/flexible-spending-account-fsa/healthcare-eligible-expenses/. The following is a partial list of the types of expenses that may be eligible for reimbursement if not paid by insurance. If you would like more information, please call Chard Snyder.

- Chiropractic care
- Contact lenses
- Dental copayments
- Eyeglasses
- Hearing aids
- Medical copayments
- Medical deductibles and coinsurance
- Occupational therapy
- Orthodontia
- Prescription drug copayments
- Some over-the-counter drug items, with a note from your doctor
- Speech therapy
- Vision copayments

Who is eligible to elect a Medical FSA?

You can elect a Medical FSA if:

- You are on the OrangePrime Plus Plan (HDHP) but are ineligible for an HSA and are not electing a Limited Purpose FSA; or
- You are on the OrangePrime Plan (LDHP) and are not electing a Limited Purpose FSA; or
- You are on the SureFit Plan and are not electing a Limited Purpose FSA; or
- You are on the TRICARE Supplemental Plan and are not electing a Limited Purpose FSA; or
- You are waiving all County medical coverage and are not electing a Limited Purpose FSA

Need more information?

Participant Services representatives are happy to speak with you 8 am - 8 pm ET, Monday through Friday. Contact Chard-Snyder, a Wex Company, at 1- 800-982-7715, via email at askpenny@chard-snyder.com, or Find helpful FAQs, videos, reference guides, and other resources to help you understand your plan online at www.chard-snyder.com.

Limited Purpose Flexible Spending Account (FSA)

The Limited Purpose Flexible Spending Account (LPFSA) is traditionally paired with a Health Savings Account (HSA) and allows you to set aside pre-tax dollars to pay for your portion of covered expenses, as well as eligible expenses not covered by your dental, vision insurance or preventative care services.

What types of expenses are considered eligible for reimbursement?

A listing of eligible items can be found online: https://www.chard-snyder.com/benefits/flexible-spending-account-fsa/limited-eligible-expenses/. The following is a partial list of the types of expenses that may be eligible for reimbursement if not paid by insurance. If you would like more information, please call Chard Snyder.

- ❑ Vision copayments
- ❑ Eyeglasses
- ❑ Contact lenses
- ❑ Dental deductible
- ❑ Dental copayments
- ❑ Orthodontia
- ❑ Allergy shots
- ❑ Annual check-ups
- ❑ Blood pressure monitor
- ❑ Diagnostic procedures
- ❑ Flu shots
- ❑ Glucometers
- ❑ Lab work
- ❑ MRI
- ❑ Routine prenatal care
- ❑ Sunscreen
- ❑ Well child visits
- ❑ X-rays

Who is eligible to elect a Limited Purpose FSA?

The Limited Purpose FSA can be used by those with an HSA to increase their tax savings or by those without an HSA who cannot open a Medical FSA. Enrollment into this plan, does not require participation in the County's medical plans.

Need more information?

Participant Services representatives are happy to speak with you 8 am - 8 pm ET, Monday through Friday. Contact Chard-Snyder, a Wex Company, at 1- 800-982-7715, via email at askpenny@chard-snyder.com, or Find helpful FAQs, videos, reference guides, and other resources to help you understand your plan online at www.chard-snyder.com.

Dependent Flexible Spending Account (DCFSA)

The Dependent Care Flexible Spending Account (DCFSA) allows you to reimburse yourself on a pre-tax basis for childcare or adult dependent care expenses for eligible dependents that are necessary to allow you and your spouse to work, look for work, or attend classes as a full-time student. *Please note that this is not a health care flexible spending account for dependents.*

How does the program work?

You determine how much you wish to deduct from your paycheck each pay period to go into this account. You can contribute as little as $15 per pay period and as much as $5,000 per plan year. You need to estimate expenses carefully, as funds will only carry over until March 15th of the next plan year. This is a "use it or lose it" plan so any remaining funds after that date will be forfeited (lost).

What types of expenses are considered eligible for reimbursement?

A listing of eligible items can be found online: https://www.chard-snyder.com/benefits/flexible-spending-account-fsa/dependent-daycare-eligible-expenses/. The following is a partial list of the types of expenses that may be eligible for reimbursement. If you would like more information, please call Chard Snyder, a Wex Company.

- In-home or outside babysitter
- After school activities
- Daycare center or nursery school
- Elder custodial care
- Summer day camp
- Elder daycare

How do I receive reimbursement for my eligible expenses?

As you incur dependent day care expenses, you will pay out of pocket, then submit a claim form along with your receipts for reimbursement. The amount eligible for reimbursement cannot exceed the current contribution amount. Note: You will not receive a debit card for this plan.

Who is considered an eligible dependent?

Your eligible dependents are defined as your tax dependent under age 13, or your spouse or tax dependent of any age (including, but not limited to, your parents and parents-in-law) who is mentally or physically incapable of caring for himself or herself. This dependent must depend on you for more than 50% of their support and be claimed as a dependent on your federal income tax return. Enrollment into this plan, does not require participation in the County's medical plans.

What are the restrictions to consider if my spouse is also contributing to a Dependent Care FSA?

- If you are married and file a joint tax return and your spouse does not contribute to a dependent care FSA, you may contribute up to $5,000.
- If your spouse does contribute to a Dependent Care FSA, you can contribute up to $5,000 COMBINED per family.

- If you are married and file a joint tax return and your spouse earns less than $5,000 annually, you may contribute up to your spouse's annual earnings.
- If you are married and you and your spouse file separate tax returns, you may contribute up to $2,500 and your spouse may also contribute up to $2,500 to a separate Dependent Care FSA account.

Plan Deadlines

- The plan year runs from January 1st through December 31st. You can continue to incur expenses through March 15th of the following year. You have until June 15th of the following year to submit claims incurred January 1st through March 15th (15 months).

Need more information?

Participant Services representatives are happy to speak with you 8 am - 8 pm ET, Monday through Friday. Contact Chard-Snyder, a Wex Company, at 1- 800-982-7715, via email at askpenny@chard-snyder.com, or Find helpful FAQs, videos, reference guides, and other resources to help you understand your plan online at www.chard-snyder.com.

Spending Accounts – Comparison Chart

	Health Savings Account (HSA)	Medical Flexible Spending Account (FSA)	Limited Purpose Flexible Spending Account (FSA)	Dependent Flexible Spending Account (FSA)
Eligibility	❑ OrangePrime Plus required ❑ IRS criteria	❑ OrangePrime or OrangePrime Plus or Local SureFit ❑ Do not need to be on County Medical ❑ Cannot be contributing to an HSA	❑ OrangePrime or OrangePrime Plus or Local SureFit ❑ Do not need to be on County Medical	❑ OrangePrime or OrangePrime Plus or Local SureFit ❑ Do not need to be on County Medical
Eligible Expenses	Medical, RX, Dental, Vision, & Durable Medical Supplies	Medical, RX, Dental, Vision, & Durable Medical Supplies	Dental, Vision & **Preventive Care Services** only	Dependent care services
Maximum Contribution	$4,300 / $8,500 (reduced by County contribution)	$3,200 (not impacted by County contribution)	$3,200 (not impacted by County contribution)	$5,000
Fund Availability	Upon deposit	Front loaded	Front loaded	Upon deposit
Forfeitures	n/a	March 15th	March 15th	March 15th
Accessibility	Debit card, check, pay online	Debit card or submit claim for reimbursement	Debit card or submit claim for reimbursement	Submit claim for reimbursement

ComPsych Employee Assistance Program

The County's Employee Assistance Program, Guidance Resources by ComPsych, was designed with your personal needs and those of your family in mind. Some of the diverse services you'll benefit from include:

- Counseling services from licensed professionals
- Free confidential assistance for employees and family members residing with the employee
- Short-term problem resolution
- Referrals to community resources
- 24-Hour Access
- Multiple site locations
- Unlimited telephonic financial consultations with ComPsych's staff of financial professionals
- Unlimited telephonic legal consultations with ComPsych's staff of attorneys

How can ComPsych help?

ComPsych has experience with a wide variety of personal problems, including:

- Marital/Family concerns
- Financial problems
- Alcohol/Drug use
- Managing stress
- Coping with grief or loss
- Parent/Child conflicts
- Depression
- Workplace problems
- Time Management

How does ComPsych work?

For counseling services, simply call ComPsych and a specialist will help meet your needs by matching you with a counselor near your home or work. The counselors are all licensed, seasoned professionals, who are available to you 24 hours a day.

If counseling services are not needed, you can still obtain a variety of information and services available at www.guidenceresources.com. The website includes articles regarding family, work, community, health, and financial matters.

Work and Lifestyle Support

Child, elder and pet care
Moving and relocation
Shelter and government assistance

Legal Guidance

Divorce, adoption and family law

Wills, trusts and estate planning
Free consultation and discounted local representation

Financial Resources
Retirement planning, taxes
Relocation, mortgages, insurance
Budgeting, debt, bankruptcy and more

Digital Support
Connect to counseling, work-life support or other services
Tap into an array of articles, podcasts, videos, slideshows
Improve your skills with On-Demand trainings

Do I have to have Cigna medical to use ComPsych?

No. All full or part time regular employees who work at least 20 hours or more are considered "benefits eligible" and can use ComPsych services. You do not have to be covered on any of the medical plans to use ComPsych. Medical is separate from ComPsych services.

What are the counseling services of ComPsych?

You'll start with a clinical assessment, conducted by a licensed professional, to determine the level and type of counseling that will help you. Should short-term therapy be needed, you will work with a counselor by engaging in several therapy sessions. You have six free sessions per issue. If long-term therapy is required, every effort will be made to refer you to a qualified resource outside of ComPsych that will be approved by your insurance.

What is the cost?

There is no cost to you for any of the Guidance Resources services. The program is provided by the county as a part of your employee benefits.

Who will know I used ComPsych?

Our ComPsych provider is under the strictest confidentiality guidelines mandated by law for licensed counselors. The ComPsych plan provides utilization reports with aggregate statistical information only and your use of ComPsych services is strictly confidential.

Can my family members use ComPsych?

Your family is encouraged to utilize ComPsych as well. Your personal problems affect your family and your family's problems can also affect you and your job performance.

Can I continue to use services through ComPsych after I terminate from the County?

Yes, you and your family will have continued access to the services for up to 90 days after your last day of work.

Need more information?

Contact ComPsych at 1-855-221-8925, Company ID: ORANGECOUNTY, or online at https://guidanceresources.com/groWeb/login/login.xhtml

Deferred Compensation Retirement Plan

What is Deferred Compensation?

Orange County's Deferred Compensation Plan (457(b) Plan) provides an excellent way for you to invest for retirement while reducing your federal tax liability. Vanguard is the County's sole Deferred Compensation Plan provider.

The 457(b) Plan is designed for long-term savings and investment towards retirement, and the Plan has limited availability to withdraw funds during employment with Orange County. The money accumulated in your account(s) can be distributed to you after you have terminated your employment with Orange County.

Why participate in the 457(b) Plan?

The 457(b) Plan provides a unique benefit to you by giving you the ability to set aside money for your retirement on a "partially" pre-tax basis through payroll deductions. This benefit enables you to pay less tax while you save and invest for retirement. All contributions into your 457(b) Plan account are not subject to federal income tax, but they are subject to federal FICA, Social Security, and Medicare taxes. Since you don't pay taxes at the time you make the contribution into the program, you will pay taxes during retirement at the time you begin making withdrawals. Note: The annual maximum contribution amount may change annually, Vanguard can help you remain within the IRS guidelines.

Is there an after-tax contribution option?

Yes. Orange County's 457(b) Plan through Vanguard also offers a Roth after-tax investment option. Participants can choose to invest in the regular pre-tax account, the Roth after-tax account, or a combination of both account types. After you have terminated employment with Orange County, Roth assets, including any earnings, can be withdrawn tax-free if the plan participant is age 59½ or older and the Roth Account has been established for at least five years.

Investing in a Roth Account may not be right for everyone, as it depends greatly on your individual circumstances, including your current and estimated future tax rates. We recommend that you consult a tax advisor before taking any action.

When I retire, can I roll my lump sum pay outs into Vanguard?

Yes. In reference to Lump Sum payouts, when a retiree receives their final payout for Personal or TERM time, they can increase their Vanguard deduction to up to 100% to have the entire check deposited into their Deferred Compensation plan. Consult your tax professional about the benefits of rolling your lump sum payments over into Vanguard.

How do I enroll?

You can enroll anytime, there is no specific enrollment period, and no qualifying events are required. However, your personal information will not be sent to Vanguard until after your first paycheck. Once Vanguard has received your information from the County, you can enroll online at www.vanguard.com.

Important Information

2025 Wellness for Life Plan Premium Summary

Medical and Pharmacy Premiums			*Bi-Weekly Rates*
Cigna	Total Premium	Employee Contribution	County Contribution
HDHP Employee only	$482.88	**$23.32**	$459.56
HDHP Employee + spouse	$1,008.25	**$150.71**	$857.54
HDHP Employee + child(ren)	$912.06	**$119.34**	$792.72
HDHP Employee + family	$1,330.03	**$266.15**	$1,063.88
LDHP Employee only	$525.18	**$38.85**	$486.33
LDHP Employee + spouse	$1,074.49	**$180.71**	$893.78
LDHP Employee + child(ren)	$979.61	**$147.17**	$832.44
LDHP Employee + family	$1,419.87	**$310.24**	$1,109.63
SureFit Employee only	$464.79	**$0.00**	$464.79
SureFit Employee + spouse	$950.92	**$138.45**	$812.47
SureFit Employee + child(ren)	$866.95	**$92.30**	$774.65
SureFit Employee + family	$1,256.58	**$230.76**	$1,025.82

TRICARE Supplement Premiums *(Pending changes for 2025)*			*Bi-Weekly Rates*
Selman & Company	Total Premium	Employee Contribution	County Contribution
Employee only	$31.15	**$31.15**	$0
Employee + spouse	$61.15	**$61.15**	$0
Employee + child(ren)	$61.15	**$61.15**	$0
Employee + family	$82.38	**$82.38**	$0

Dental Premiums			*Bi-Weekly Rates*
Cigna	Total Premium	Employee Contribution	County Contribution
Low Employee only	$7.10	**$7.10**	$0
Low Employee + 1	$14.48	**$14.48**	$0
Low Employee + 2 or more	$26.48	**$26.48**	$0

Dental Premiums			*Bi-Weekly Rates*
Cigna	Total Premium	Employee Contribution	County Contribution
Middle Employee only	$10.88	**$10.88**	$0
Middle Employee + 1	$22.53	**$22.53**	$0
Middle Employee + 2 or more	$42.36	**$42.36**	$0
High Employee only	$17.71	**$17.71**	$0
High Employee +1	$36.07	**$36.07**	$0
High Employee + 2 or more	$65.55	**$65.55**	$0

Vision Premiums			*Bi-Weekly Rates*
MetLife	Total Premium	Employee Contribution	County Contribution
Employee only	$2.20	**$2.20**	$0
Employee + 1	$4.40	**$4.40**	$0
Employee + 2 or more	$6.46	**$6.46**	$0

Employee Additional Life/AD&D and Spouse Life/AD&D Premiums* *Bi-Weekly Rates*			
Standard Insurance Company (rates are per $10,000 of coverage) Age as of 01/01/2025:	Total Premium	Employee Contribution	County Contribution **
Under 30	$0.32	**$0.32**	$0
30-34	$0.42	**$0.42**	$0
35-39	$0.65	**$0.65**	$0
40-44	$0.97	**$0.97**	$0
45-49	$1.38	**$1.38**	$0
50-54	$2.03	**$2.03**	$0
55-59	$2.31	**$2.31**	$0
60-64	$3.00	**$3.00**	$0
65-69***	$5.68	**$5.68**	$0
70 & up***	$11.26	**$11.26**	$0

** AD&D premiums are included with Additional Life and Spouse Life premiums*
*** Basic Employee Life Insurance is paid by the County*
****Age reductions apply*

Employee/Spouse Age	Percentage
65 through 69	65%
70 through 74	50%
75 and up	35%

Child Life Insurance Premiums			*Bi-Weekly Rates*
Standard Insurance Company	Total Premium	Employee Contribution*	County Contribution
$5,000 per eligible child	$0.14	**$0.14**	$0
$10,000 per eligible child	$0.28	**$0.28**	$0

** Employee contribution includes all eligible children*

Short-Term Disability Premiums			*Bi-Weekly Rates*
Standard Insurance Company (rates are per $10 of covered weekly benefit – see formula)	Total Premium	Employee Contribution	County Contribution*
120 calendar day waiting period	$0.037	**$0.037**	$0
90 calendar day waiting period	$0.055	**$0.055**	$0
60 calendar day waiting period	$0.097	**$0.097**	$0
30 calendar day waiting period	$0.125	**$0.125**	$0
15 calendar day waiting period	$0.143	**$0.143**	$0

***** *Long Term Disability Insurance is paid by the County*

Formula for calculating Short-Term Disability bi-weekly premium:

1. Divide your gross annual salary by 52 (this gives you your weekly gross salary).
2. Multiply your gross weekly salary by 60%.
3. Divide that number by 10.
4. Multiply that number by the rate shown above for the STD waiting period you selected to get your bi-weekly premium.

Notice of COBRA Continuation Coverage Rights

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

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

Qualifying Events for Covered Employee

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

Qualifying Events for Covered Spouse and Dependent Children

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

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

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

Election Period and Coverage

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

Length of Continuation Coverage

18 Months:

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

24 Months:

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

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

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

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

Other Options

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

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

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

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

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

2025 Monthly COBRA Rates

Medical Plans	EE Only	EE + Spouse	EE + Child(ren)	EE + Family
HDHP	$1067.16	$2228.23	$2015.65	$2939.36
LDHP	$1160.65	$2374.62	$2164.93	$3137.91
SureFit	$1027.18	$2101.53	$1915.96	$2777.04

Dental Plans	EE Only	EE + 1	EE + 2 or more
Low	$15.69	$32.01	$58.52
Middle	$24.03	$49.80	$93.62
High	$39.14	$79.71	$144.85

Vision plan	EE Only	EE + 1	EE + 2 or more
Coverage	$4.87	$9.72	$14.27

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

Social Security Number Collection Disclosure

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2024 for coverage starting as early as January 1, 2025.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more

information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name Orange County Board of County Commissioners		**4. Employer ID Number** 59-6000774
5. Employer Address PO Box 1393		**6. Employer Phone Number** (407) 836-5661
7. City Orlando	**8. State** Florida	**9. Zip Code** 32802
10. Who can we contact at this job? HR Benefits & Wellness Administrator		
11. Phone number (if different from above)	**12. Email Address** Benefits@ocfl.net	

Use and Disclosure of Protected Health Information (PHI)

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

A. Use and Disclosure of Summary Health Information

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

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

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

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

B. Use and Disclosure of PHI

The Plan is permitted to use or disclose an individual's PHI without an authorization for:

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

  Activities include but are not limited to:
  - Determining eligibility
  - Adjudicating claims, claim audits, investigating and resolving payment disputes
  - Billing and collection
  - Coordination of benefits
  - Review for medical necessity, justification of charges
  - Utilization review
  - Disclosure to reporting agencies (limited to identifying information for member and provider and/or health plan and payment history)

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

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

The Plan Sponsor agrees to the following:

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

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

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

Medicare Creditable Coverage Notice

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

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

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

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

- Orange County Government has determined that the prescription drug coverage offered by Orange County Government's medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th . However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

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

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

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

The Orange County Government plan provides comprehensive prescription drug coverage through retail and mail providers. For the OrangePrime Plus Plan (HDHP), the copayments are as follows once the plan deductible has been met:

	Generic	Preferred Brand	Non-Preferred Brand	Specialty
Retail 30 Days	$10.00	10% + $30.00	10% + $50.00	10% + $100.00
Mail Order 90 Days	$25.00	10% + $75.00	10% + $125.00	10% + $200.00

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

For the OrangePrime Plan (LDHP) and OrangePrime Local SureFit Plan, there is no deductible for prescription coverage:

	Generic	Preferred Brand	Non-Preferred Brand	Specialty
Retail 30 Days	$10.00	10% + $30.00	10% + $50.00	10% + $100.00
Mail Order 90 Days	$25.00	10% + $75.00	10% + $125.00	10% + $200.00

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

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

Once you retire, if you do decide to join a Medicare drug plan and drop your current Orange County Government health plan, be aware that you and your dependents will not be able to get this coverage back.

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

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

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

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	October 01, 2024
Name of Entity/Sender:	Orange County Government
Contact:	Human Resources, Benefits
Address:	P.O. Box 1393 Orlando, FL 32802
Phone Number:	407-836-5661
Email:	benefits@ocfl.net

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272). If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

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

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

Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

TTY: Maine relay 711	

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://www.coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**

Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: https://www.pa.gov/en/agencies/dhs/resources/chip.html CHIP Phone: 1-800-986-KIDS (5437)	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
61565

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext.

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

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