



# QUICK START BROCHURE

TO GET YOU ON THE RIGHT BENEFITS PATHWAY



County of Orange



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# Step 1:

## When Do I Enroll, and Who Can I Cover?

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

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

### QUICK START TO YOUR RESOURCES FOR ENROLLMENT HELP AND BENEFITS INFORMATION

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

**Benefits Center Web Site:** [www.benefitsweb.com/countyoforange.html](http://www.benefitsweb.com/countyoforange.html). Available 24 hours a day, 7 days a week. Within the site you can:

- Enroll or make eligible changes to your coverage
- Update your personal and dependent information
- Link to health plan provider directories and Web Sites to get detailed information on your benefit plans
- Use online tools to help you compare plans and research medical conditions and procedures, or to calculate the tax savings you might achieve by enrolling in a Health Care or Dependent Care Reimbursement Account.

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

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



## When Do I Need to Enroll?

### When:

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

More information is available in Step 3 of this brochure.

## Who Can I Cover?

| You are eligible for health care coverage if you are either a:  | Your eligible dependents for health care coverage include your:  |
|---|--|
| <ul style="list-style-type: none"> <li>– Full-time employee working 40 hours a week</li> <li>– Part-time employee working at least 20 hours a week</li> </ul> | <ul style="list-style-type: none"> <li>– Unmarried children under age 19 (or under age 23, if full-time student), including stepchildren, foster children, children placed for adoption, legally adopted children, and children of domestic partners. Children who are full-time students must attend an accredited school, high school, college, or university (12 units or more) and must be dependent on you for financial support to continue to be covered. Income may be imputed for children of domestic partners if you can not claim them as your dependent</li> <li>– Unmarried incapacitated children of any age who are dependent on you for support and were incapacitated prior to their 19th birthday. These children did not have to be covered by the County of Orange when they became incapacitated if the event was prior to their 19th birthday. Determination of whether a dependent meets the criteria for an incapacitated child must be made by your health plan</li> <li>– Legal spouse or registered domestic partner (income may be imputed for domestic partners).</li> </ul> |
| <p>When you enroll your eligible dependents you must provide proof of dependent eligibility. See <i>Proof of Eligibility</i> on page 3 for details.</p>       |  |

### Domestic Partner Coverage

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

**Please note:** Imputed income<sup>1</sup> may apply to domestic partners and their dependents who receive these benefits. Please consult your tax advisor for guidance.

<sup>1</sup> The portion the County incurs (after you pay the employee cost) to insure your qualifying domestic partner (and eligible dependents, if any). This cost is accrued and added to your gross income. Imputed income is subject to federal, state and local income tax withholding and is reflected in your year-end W-2 statement. Note: Special rules apply to state income taxation of coverage for state-registered domestic partners.

## PROOF OF ELIGIBILITY

By enrolling or continuing enrollment in any of the County's benefit plans, you are certifying to the County that the information supplied by you, your spouse/domestic partner, and any of your dependents is true and correct. You will be required to provide written proof of dependent eligibility at the time of enrollment. Forms of written proof may include:

- Marriage certificate
- Birth certificate
- College transcript
- Tax return documentation (verification of ongoing marriage status and/or dependent support)

You must notify the Benefits Center within 30 calendar days of the date on which your covered dependent no longer meets eligibility requirements. Some examples of loss of eligibility may include divorce, marriage of a dependent child or loss of student status. If an ineligible dependent is enrolled, or you fail to report loss of eligibility, you may be responsible for repayment of the County's portion of your premiums paid retroactive to the date of ineligibility as well as the cost of medical services provided to ineligible dependents.

# Step 2:

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

### Quick Start to Understanding Your Responsibilities

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

Follow these steps as you prepare to enroll.

- 1 Review the enclosed Benefits Enrollment Summary for all your options and costs.
- 2 Review the *Benefits Enrollment Guide* that is available online at the **Benefits Center Web Site** and discuss your options with your entire family to ensure you make an enrollment choice that works for everyone you cover.
- 3 Know what your plans do and do not cover, as well as how to access services or file claims. All plans have limitations and exclusions and some plans have prior authorization requirements. You should be aware of all of these factors before you enroll.
- 4 Make your elections and be sure to receive and review your confirmation statement of your elections for accuracy.
- 5 Act within the deadline whether that is during open enrollment or the 30 days you have to notify the Benefits Center – online or over the telephone – that you've had a qualifying life event.

Once you've enrolled in the plans that meet your needs, learn as much as you can about how to maximize your experience as a participant. The **Benefits Center Web Site** and many of the insurance carriers offer tools and resources to help you manage your health, use the plans effectively and reduce your out-of-pocket expenses.



## BENEFITS CENTER WEB TOOLS TO HELP YOU MAKE THE RIGHT CHOICE

### Compare/Evaluate Health Plans Tool

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

### Research Medical Conditions & Find a Hospital

The Research Medical Conditions & Find a Hospital tool offers four main features:

- “Health Topics” provides background information about medical conditions, describes treatment options, helps you research questions to ask your doctor, and details other issues to consider before you make a treatment decision
- “Health Encyclopedia” gives you detailed information about medical conditions and procedures
- “Treatment Options” helps find the best hospitals for you, based on criteria you rate as important. The hospitals displayed in the Hospital Advisor tool may or may not be in your plan’s network. Always check your plan’s network listing before choosing a hospital or any other health care facility or provider
- “Additional Tools” lets you dig deeper into health care information, recommended Web Sites, links to related decisions, and other information.

### Health Care Spending Calculator

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

- A Health Care Reimbursement Account allows you to pay eligible medical expenses, including medical and prescription copayments and deductibles, with before-tax contributions
- A Dependent Care Reimbursement Account enables you to set aside before-tax contributions to reimburse you for payment of eligible dependent care expenses.

## What to Have With You When You Enroll

When you enroll, you should have the following information with you:

- Your Social Security number
- Your dependents’ Social Security numbers
- Your personalized Benefits Enrollment Summary (included in this enrollment package)
- Your Personal Identification Number (PIN).

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### REGISTER FOR “FORGOT YOUR PIN?”

**Don’t worry about remembering your PIN. You can access the Web Site securely without a PIN after you sign up for the “Forgot Your PIN?” feature.**

## Benefits Enrollment Summary

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

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

You will be enrolled in the automatic benefits coverage shown on your Benefits Enrollment Summary if you do not make any elections/changes before the enrollment deadline, so be sure to review it carefully.

## The Last Step on Your Pathway to Enrollment – Benefits Confirmation Statements

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

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

## Two-Way Communication Between You and the Benefits Center

- The Benefits Center will notify you in writing at your home address whenever your benefits or costs are changing or you are required to take action.
- It is your responsibility to understand your benefits, and to report Qualified Life Events, such as marriage, divorce, or dependent child who is no longer a full-time student, to the Benefits Center within 30 calendar days of the event.



# Step 3:

## What Events Trigger Enrollment?

### Quick Start for New Employees

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

**IMPORTANT:** If you don't enroll in a County health plan within the 30-calendar-day enrollment period, a full-time employee will be enrolled in Premier Wellwise health plan with employee-only coverage. If you are a part-time employee you will be automatically enrolled in the Premier Sharewell health plan with employee-only coverage.

### Quick Start for Annual Open Enrollment

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

- You will be notified each fall of the Annual Open Enrollment period and provided instructions for making enrollment changes
- Review your options carefully and enroll before the deadline
- You can log on to [www.benefitsweb.com/countyoforange.html](http://www.benefitsweb.com/countyoforange.html) or remember to call early — some employees experience long hold times when they wait until the last minute to call a Benefits Specialist
- If you are currently enrolled in a Health Care and/or Dependent Care Reimbursement Account you **MUST** re-enroll during the Annual Open Enrollment period to continue participating
- The benefits you elect during Annual Open Enrollment are effective January 1<sup>st</sup> of the following year.

## Quick Start for Qualified Life Events (QLEs)

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

### Had a QLE? Be Sure to Notify the Benefits Center within 30 Days

- You are required to notify the County of Orange Benefits Center within 30 days of the date a QLE occurs
- To make changes consistent with your QLE, log in to the Benefits Center Web Site or call the Benefits Resource Line at 1-866-325-2345
- If the Benefits Center does not receive notification of your change within 30 calendar days of a QLE, new dependents (due to marriage, birth, or adoption) will not be eligible for coverage and you may be financially responsible for the cost of premiums paid for or services provided to dependents who became ineligible but were not removed from coverage (divorce, no longer a student)
- Refer to the **Making Changes to Your Benefits** section of your *Benefits Enrollment Guide* for more details.

### Leave of Absence

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

- The amount you are required to pay while on leave is based upon the type and/or length of the leave
- Details on your options and instructions for continuing health insurance while on leave will be provided
- Refer to the **Leave of Absence** section of your *Benefits Enrollment Guide* for more details about your benefits while on Leave of Absence, including a leave under the Family Medical Leave Act.

## Health Care and Dependent Care Reimbursement Accounts

The County also offers you the option of enrolling in a health care and/or dependent care reimbursement account. Consider enrolling if you aren't participating, to take advantage of the tax savings!

If you are eligible, you may enroll as a new hire, if you experience certain Qualified Life Events, and during Annual Open Enrollment. If you are already enrolled, you must re-enroll every year to continue participating.

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

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### QLE EXAMPLES:

- You get married
- You have a baby, adopt a child, or acquire step children due to marriage
- Your spouse/domestic partner begins or ends employment
- Your dependent child becomes eligible for coverage or loses eligibility
- You get divorced or legally separated, or your marriage is annulled
- A dependent dies.



# Step 4:

## What Important Legal Information Should I Know?

### Continuing Your Coverage Under COBRA

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) gives you the right to choose to continue health care coverage if you and/or your eligible dependents lose County coverage. You may continue health care coverage for up to 18, 29, or 36 months, depending on the situation and who is being covered. Within a couple of weeks of the loss of coverage, you will receive a separate COBRA notification explaining your rights.

If you believe your or your dependents' health care coverage will end because an event occurred causing ineligibility under a County plan, there are certain things you must do to continue coverage under COBRA.

If you divorce or legally separate or your child loses dependent status under a group health plan, you or your covered dependents are responsible for notifying the County within 30 days from the date of these events. The County will then notify your dependents of their right to continue health care coverage under COBRA. This notification will explain in detail how COBRA works. COBRA rights are forfeited if the County is not notified within 30 days of the qualifying event.

If your domestic partnership ends, your legal spouse/domestic partner and his or her children are not eligible for COBRA. However, a qualified beneficiary receiving COBRA coverage under the County plans may elect COBRA coverage for a domestic partner and his or her children.

If you leave the County, or in the event of your death, the County will notify you and/or your dependents of your right to continue health plan coverage under COBRA. This notification will explain in detail how COBRA works.

If COBRA is an option for you, you must make an election and pay for coverage by certain deadlines. For more information, refer to your *Benefits Enrollment Guide* and visit the **Benefits Center Web Site** (see Step 5).

For more information, call COBRA Continuation Services at the number listed under the Helpful Information section located in your *Benefits Enrollment Guide*.

### Health Insurance Portability and Accountability Act (HIPAA)

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

- Is limited in imposing pre-existing condition exclusions
- Must offer employees and dependents the opportunity to enroll outside open enrollment in certain situations
- Can't discriminate on the basis of health status with respect to eligibility for plan participation and premium costs
- Can't impose discriminatory lifetime or annual benefit limits on participants with mental illness
- Must permit hospital admissions (if otherwise covered by the plan) of at least 48 hours in case of normal deliveries and 96 hours in the case of Cesarean sections.

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

The County's HMO plans comply with HIPAA.

## Certification of County Health Plan Coverage

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

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

## Women's Health and Cancer Rights Act of 1998

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

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes)

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

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

# Step 5:

## Where Do I Go for More Information?

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

- Go to the **Benefits Center Web Site** at [www.benefitsweb.com/countyoforange.html](http://www.benefitsweb.com/countyoforange.html) or call the **Benefits Resource Line** at 1-866-325-2345
- Reach out to the insurance carriers for details about your coverage and how the plans work
- Find a complete directory of plan contacts in the Helpful information section of your *Benefits Enrollment Guide*.

