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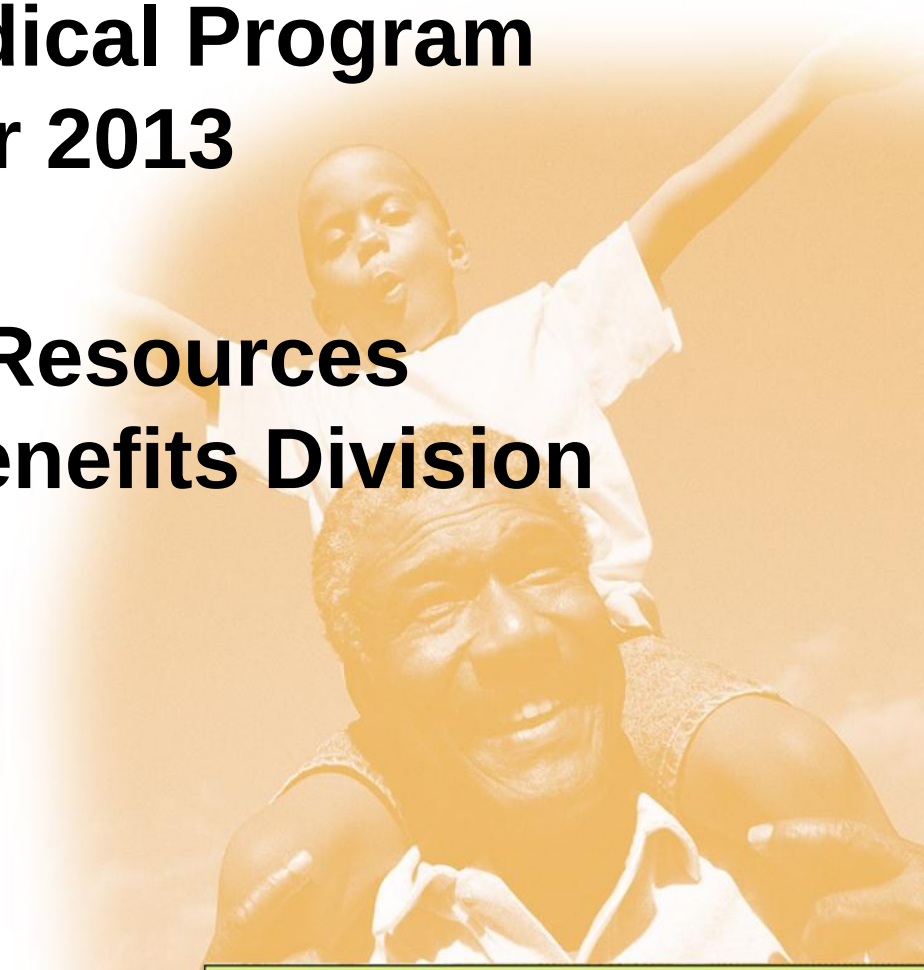
Retiree Medical Program
Year 2013

Human Resources
Employee Benefits Division



Today's Agenda

- Benefits Overview
- The County of Orange Retiree Medical Plan
- Who is Eligible
- Grant Guidelines
- Retirees and Medicare
- Things to Consider
- Health Plan Options
- Enrollment Process
- Resource for Help and More Information
- Questions and Answers

Benefits Overview

- This presentation is an overview of the benefits available to you. The plan documents and insurance policies for each plan provide the detailed, legal information about your coverage. If there is any difference between this presentation and the plan documents or insurance policies, the plan documents and insurance policies will govern.

The County of Orange Retiree Medical Plan

- Retiree medical benefits in the County of Orange are subject to the conditions set forth in the formal plan document adopted by the Board of Supervisors
- The Plan Document is entitled the “Third Amended and Restated County of Orange Retiree Medical Plan,” adopted by the Board of Supervisors on June 23, 2009. The plan confirms that the benefits are not vested and are subject to change
- A copy of the Third Amended and Restated County of Orange Retiree Medical Plan is available on the Benefits Center Web Site or by calling the Benefits Resource Line

Who is Eligible?

- Current County of Orange employees who
  - Are covered by a County Health Plan
  - Are at least age 50, with 10 years of **eligible** County **service hours** on day employment ends
  - Have no breaks in County service since **August 1,1993**
  - Will receive a monthly retirement check from OCERS during retirement

Buyback Provisions

- Differs from OCERS
  - Maximum one-year buyback of extra help time to qualify for the 10-year minimum service requirement; Grant based on 9 years
  - Grant based on actual eligible service hours
  - Buyback for service after August 1, 1993 not applied to eligibility for Grant

Grant Guidelines: 2013 Retiree Medical Grant

- For 2013, Grant is calculated at $19.91 per month for each year of County service to a maximum of 25 years. The amount of your monthly Grant will depend upon a variety of factors, including:
  - Age at Retirement and Medicare eligibility
- Grant may be used for:
  - First, for payment of County health plan premiums
  - Second, for reimbursement of retiree and spouse Medicare Part B premiums (if not reimbursed elsewhere)
- Tax-free benefit, therefore the amount of the Grant received cannot exceed health plan and Medicare Part B premiums combined

Grant Guidelines: Monthly Grant Amount

- Age at Retirement: Age Reduction factor is determined at the time you retire.
  - Employees retiring <u>before</u> age 60 will have a 7.5% reduction in the monthly Grant for each year retiring before age 60.
  - Employees retiring at age 60, no Grant adjustment
  - Employees retiring at age 61 or later will have a 7.5% increase in the monthly Grant for each year retiring at age 61 through age 70.
  - Maximum annual Grant adjustment: capped at 3%.
  - Age reduction does not apply to Safety

Grant Guidelines: Monthly Grant Amount

- Medicare Eligibility -
  - 50% reduction in monthly Grant when you become eligible for Medicare Parts A & B or if you are already eligible for Medicare at the time you retire.
  - Health plan rates will be reduced (if documentation has been provided) when you become Medicare eligible.

Grant Guidelines: Net Health Plan Rate

- Full health plan rate less Grant amount determines your monthly net cost
- Rates and Grants may change (annually and upon reaching age 65 or becoming Medicare eligible)
- The County maintains the discretion to set the rates and make changes to the plans in the future.

Grant Guidelines: Grant and Survivors

- Benefits for survivors of covered retirees
  - Must contact Benefits Center to activate survivor benefits
  - Continued coverage for dependents covered by retiree's health plan at the time of death
  - Survivor's Grant equal to 50% of retiree's Grant
  - Must receive a monthly OCERS pension check

Grant Guidelines: Retiree Married to Retiree (RMR) or Retiree Married to Employee (RME)

- County retiree married to County retiree
  - Same health plan — combined Grant;
- County retiree married to County employee
  - If covered as spouse's dependent, Grant suspended until your coverage as a dependent ends and you elect retiree coverage
- Must elect to enroll as RMR/RME then submit completed RMR/RME Enrollment form through the Benefits Center Resource Line

Retirees and Medicare

- Medicare enrollment ***required*** for retiree and covered spouse age 65 and older
  - Medicare Part A: Required if you are eligible at no cost
  - Medicare Part B: Required; everyone is eligible for Part B
- Medicare enrollment is required if you are employed and covered by your employer's health plan
- Must self-identify to the Benefits Center if eligible for Part B only

Retirees and Medicare

- Enroll in Medicare
  - 90 days prior to retirement (if already age 65), or
  - 90 days prior to 65th birthday
  - Provide documentation of Medicare enrollment to the Benefits Center
    - Signed Medicare Verification form
    - Copy of Medicare Card showing an effective date in the current year
    - If Medicare effective in a previous year, also:
      - Statement of payment from Medicare; or
      - Letter from Medicare indicating you have current coverage

Retirees and Medicare

- It is your responsibility to enroll, maintain and continue payment for your Medicare Part B and Part A (if at no cost). Otherwise, this will negatively impact your enrollment in the Retiree Medical Program.
  - Grant will be suspended.
  - Higher Non-Medicare rates will apply.
  - You may be responsible for repayment for services rendered.
  - Could result in you no longer being eligible for your elected health plan (if Medicare Advantage).

Retirees and Medicare

- If you do not submit your Medicare documentation in a timely manner, and your Grant is suspended, once you do provide the documentation to the Benefits Center, your Grant will not be restored retroactively; your Grant will be reinstated the first of the month following receipt of the documentation.
- May be responsible for any adjustments related to health plan rates and Grant if you lose Medicare Part B eligibility or if you do not self-identify as Part B only

Things to Consider

- Your 2013 Health Plan options depend on your and your dependent's Medicare status and/or your address.
- Coverage — how much you pay for services
- Premiums — how much you pay each month
- Choice of providers
  - HMO vs PPO
  - Access to HMO or PPO providers while traveling

Things to Consider

- Life Insurance – portability of insurance contact the plan administrator for more information
- Reimbursement Accounts – you may only file claims for expenses incurred through your last date of employment
- Deferred retirement — Must enroll in Retiree Medical Program within 30 days of activating OCERS Pension
- Keep your address current with the Benefits Center as well as OCERS
- Annual Open Enrollment is held during the Fall each year

Health Plan Options

- Types of coverage
  - The County offers several different Retiree Health Plans
  - Service area/residence limitations
    - HMO: Generally defined by zip code **within the state of California**
    - Confirm with either the Benefits Center or the HMO Plan directly
  - No Service area/residence limitations
    - PPO

Health Plan Options

- **2013 Health Plan options for <u>Non-Medicare Eligible</u> (Subscriber and/or dependents):**
  1. Wellwise Retiree PPO
  2. Sharewell Retiree PPO
  3. Kaiser HMO
  4. Anthem Blue Cross Traditional HMO
  5. Anthem Blue Cross Select HMO

Health Plan Options

- **2013 Health Plan options for <u>Medicare Part B only</u> (Subscriber and/or dependents):**
  1. Wellwise Retiree PPO
  2. Sharewell Retiree PPO
  3. Kaiser Senior Advantage HMO
  4. Anthem Blue Cross Traditional HMO
  5. Anthem Blue Cross Select HMO

Health Plan Options

- **2013 Health Plan options if all are <u>Medicare Parts A & B Eligible</u> (subscriber and dependents):**
  1. Wellwise Retiree PPO
  2. Sharewell Retiree PPO
  3. SCAN Health Plan
  4. Kaiser Permanente Senior Advantage HMO
  5. Anthem Blue Cross Senior Secure HMO
  6. Anthem Blue Cross Custom PPO
  7. Anthem Blue Cross Standard PPO

Health Plan Options

- **2013 <u>Mixed Medicare A&B</u> Health Plan options (one participant is Medicare A & B Eligible and one is not Medicare Eligible):**
  1. Kaiser HMO & Kaiser Sr. Advantage HMO
  2. Anthem Blue Cross Senior Secure Medicare HMO & Anthem Blue Cross Traditional HMO
  3. Anthem Blue Cross Senior Secure Medicare HMO & Anthem Blue Cross Select HMO
  4. Anthem Blue Cross Custom PPO & Anthem Blue Cross Traditional HMO
  5. Wellwise Retiree PPO
  6. Sharewell Retiree PPO

Medicare Part D Prescription Drug Coverage

- Creditable Coverage letter - mailed to eligible participants by the Benefits Center to home addresses.
  - Anthem Blue Cross Traditional, Select HMO, and Wellwise Retiree plan members *should not enroll* in a Medicare prescription drug plan because their County prescription drug coverage is equal to or better than Medicare.
  - Kaiser Senior Advantage, SCAN, and Anthem Blue Cross Medicare Advantage plan members *do not have to enroll* in a Medicare prescription drug plan because the health plan will automatically enroll you in these benefits.

Medicare Part D Prescription Drug Coverage

- Non-Creditable Coverage letter - mailed to eligible participants by the Benefits Center to home addresses.
  - Medicare-eligible Sharewell Retiree, *we strongly recommend you enroll* in a Medicare prescription drug plan because Medicare Part D provides additional prescription drug benefits and to avoid possible late enrollment penalty should you decide to enroll in Medicare Part D later.
- Important: Do not sign up for Medicare Part D plan outside of your County health plan, except if you are enrolled in Sharewell Retiree.

CIGNA HMO no longer available to retirees:

- Active employees who are currently enrolled in the CIGNA HMO health plan will no longer be able to continue their CIGNA HMO health plan as a retiree.
- Your Benefits Enrollment Summary will provide you options and costs of health plans that will be available for you to choose.

Health Plan Options

- If you are currently enrolled in CIGNA you will need to make an election; if you do not –
  - Non-Medicare eligible retirees will you will be automatically enrolled into the Anthem Blue Traditional HMO plan. Anthem Blue Cross will also designate a Primary Care Physician for you. If you live outside the service area, you will be placed in the Wellwise Retiree PPO health plan.
  - Medicare eligible retirees will be automatically enrolled into the Wellwise Retiree PPO health plan.

Medicare and Retiree Health Plans

- Medicare is primary with all health plans but not assigned to these health plans:
  - Wellwise Retiree PPO
  - Sharewell Retiree PPO
- Medicare must be assigned to:
  - Kaiser Senior Advantage HMO
  - SCAN HMO
  - Anthem Blue Cross Senior Secure HMO
  - Anthem Blue Cross Custom PPO
  - Anthem Blue Cross Standard PPO

Medicare Advantage Plan Process

- The Centers for Medicare and Medicaid Services (CMS) must approve enrollment in a Medicare assignment plan.
- Enrollment requires the health plan to verify your coverage under Medicare Parts A & B & D.
- If not approved timely, you will either remain in your current plan or be automatically enrolled into the Wellwise Retiree PPO, based on the reason for the CMS denial. Denials due to non-payment of Medicare Part B may result in suspension of your Grant and/or late enrollment penalties. You may also be responsible for payment of services accessed.

Medicare Assignment

- All health plans offered to Medicare eligible retirees are Medicare Advantage plans, with the exception of the Wellwise Retiree PPO plan and Sharewell Retiree PPO plan.
- Medicare Advantage plans require that you “assign” your benefits to that health plan.
- The health plan receives reimbursement from the Centers for Medicare and Medicaid Services (CMS) to provide benefits. You pay any deductibles or co-payments.

Medicare Assignment

- Failure to enroll in or maintain your Medicare coverage will impact your enrollment in a Medicare Advantage plan and will result in an increase in your monthly health plan rates and suspension of your Retiree Medical Grant (if applicable).
- Assigning your Medicare Parts A, B and D, to another plan (including an individual prescription drug plan) can result in enrollment into another County health plan at significantly higher rates.

Medicare Advantage Enrollment Form and CMS Approval Required

- If you elect the Kaiser Senior Advantage Plan, you must complete an enrollment form that will accompany your Benefits Confirmation Statement and return it to Kaiser as soon as possible within the allotted amount of time.
  - Your election will be pended until your form is received and your enrollment approved by CMS.
- If you elect any of the Anthem Blue Cross Medicare Advantage plans or the SCAN HMO plan no enrollment form is required.

Medicare Advantage Enrollment and CMS Approval Required

- Pending status:
  - If you select Kaiser - you will remain in your current plan unless you are in Cigna, (if you are not currently enrolled in the Kaiser HMO plan) and pay applicable rates until approved based upon your Medicare status.
  - If you select SCAN – you may be placed in the Wellwise Retiree PPO health plan and pay applicable rates until approved based upon your Medicare status
  - If you select an Anthem Blue Cross plan - you may be placed in the Wellwise Retiree PPO health plan and pay applicable rates until approved based upon your Medicare status

Medicare Advantage Enrollment and CMS Approval Required

- Benefits Center will inform you of approval or denial with confirmation statement
- If CMS does not approve your enrollment, you will be placed into a designated plan to ensure you have continuous retiree health plan coverage.
- It is important you respond to any calls, questions or inquiries by the Medicare Advantage health plan and provide any requested documentation as soon as possible. Providing this information as soon as possible will help to eliminate delays in processing your enrollment.

Wellwise Retiree - PPO

- Freedom of Choice
- "Network"- Blue Shield PPO Network (90% / 10%)
  - **Calendar year deductible** – (increase from Premier Wellwise)
  - Individual $500 (Network) $750 (Non-Network)
  - Family $1,000 (Network) $1,500 (Non-Network)
- "Non-Network" (70% / 30%)
  - **Out of pocket maximum –** (instead of Major expense benefit)
  - Individual $2,500 (Network) $5,000 (Non-Network)
  - Family $5,000 (Network) $10,000 (Non-Network)

Wellwise Retiree - PPO

- Network Providers can be verified by calling Blue Shield 1-888-235-1767 or logging on the their Web Site at www.blueshieldca.com/oc , click on doctor directory
- No Individual Lifetime maximum
- Required to submit claim forms for payment or reimbursement of medical expenses
- Prescription Drug Program through Catamaran Rx

Wellwise Retiree & Sharewell Retiree PPO Non-Network benefit

- Non-Network Outpatient ambulatory surgery centers
- 70% of Blue Shield URC, up to $1,500 maximum per day for facility charges
- Non-Network facility benefit- Non-Network facility claims will be paid based on Blue Shield URC (usual, reasonable, and customary) schedule.
- Non-Network Dialysis reimbursement
- California residents – 70% of Blue Shield URC, up to $600 maximum per day
- Outside of California- 70% of Blue Shield URC

Wellwise Retiree Prescription Benefit

- Administered by Catamaran Rx
- Wellwise Retiree participants will use a Preferred Medication List (formulary) which will include three coinsurance levels.
  - 20% Generic
  - 25% Preferred Brand-Name Drugs
  - 30% Non-Preferred Brand-Name Drugs
- Mail order drug program (maintenance Rx) (greater than 30 days)
- Advantage 90 Plan – obtain a 90-day supply of medications at select retail locations

Wellwise Retiree Prescription Benefit

- Med Monitor
  - Medication Therapy Management Program offered at no cost to you by the County
- Step Care Therapy
  - For specific drug classes you will be required to try one or more prerequisite medications first before other medications will be approved, unless you obtain prior medical exception authorization from Catamaran Rx
- Diabetic Sense
  - Voluntary enrollment to have access to Certified Diabetic Educators, help you manage your Diabetes

Sharewell Retiree - PPO

- Freedom of Choice
- Annual $5,000 Deductible per family
- "Network"- Blue Shield PPO Network (90% / 10%)
- Network Providers -verify by calling Blue Shield 1-888-235-1767 or at web site at www.blueshieldca.com/oc, click on doctor directory
- "Non-Network" (70% / 30%) (change from Premier Sharewell 80%/20%)
- Out of pocket maximum – (instead of Major expense benefit) $6,000 (Network) $12,000 (Non-Network)

(*)The out of pocket maximum is based on the amount paid out-of-pocket, including deductibles and coinsurances.

Sharewell Retiree - PPO

- Prescription Drug Discounts
- You can fill your prescription at Blue Shield Network pharmacies and you will be able to receive a discount.
- You can still use other non-Blue Shield Network pharmacies; however, you will not receive the discount and must submit your claims to Blue Shield for reimbursement.
- Your deductible must be met first, for pharmacy benefit to apply.
- To locate an network pharmacy call 1-888-235-1767; or log onto www.blueshieldca.com/findapharmacy

Sharewell Retiree - PPO

- Non-Network benefit changes
- Outpatient Ambulatory Surgery Centers – limited to $1,500 per day
- Outpatient Dialysis – limited to $600 per day
- Bariatric surgery – must use Blue Shield network facilities
- Knee & Hip Replacements & Transplants –encouraged to use Blue Shield network facilities
- No Individual Lifetime maximum
- May be required to submit claim forms for medical expenses
- HSA Compliant (for Non-Medicare eligible)

Health Maintenance Organizations - HMO

- Managed Care Programs
- Preventative, diagnostic & comprehensive major medical coverage included
- Co-pays for health services & prescriptions
- No claim form
- No annual deductible to satisfy
- No lifetime maximums
- You must receive all health care services from HMO provider

Kaiser HMO

- Health facilities are Kaiser-owned and physicians and specialist are Kaiser employees
- Prescription co-payments:
  - Tier 1 Level: Co-pay $10 for generic drugs
  - Tier 2 Level: Co-pay $20 for brand name drugs
- If currently enrolled in Kaiser and Medicare Eligible, you must elect Kaiser Senior Advantage during the election period

Kaiser Permanente Senior Advantage (KPSA)

- Kaiser and CMS will process your application.
- Your election into KPSA is pending until your application has been received and approved.
- While waiting for approval you will remain in your existing health plan, unless you are enrolled in Cigna and will pay those monthly rates.
- If you are enrolled in Cigna as an active employee you will go into Wellwise Retiree PPO while awaiting approval.

Kaiser Permanente Senior Advantage (KPSA)

- If you are not approved you will be enrolled in the Wellwise Retiree PPO plan. If you are currently enrolled in Kaiser HMO and not approved, you will be automatically enrolled into the Wellwise Retiree PPO health plan effective the first of the month when your retiree coverage starts or you turn 65.
- County of Orange Benefits Center will send you notification if you were approved or denied
- Enrolling into Kaiser Senior Advantage allows you to continue with your current Kaiser physician(s)

SCAN HMO

- Benefit Highlights
  - $15 co-pay for Primary Care Physician/Specialist
  - $100 co-pay for Hospital Admission
  - Unlimited Transportation
  - Independent Living Power® (ILP)
  - Reside within SCAN County Service Areas
- Prescription Drug Coverage, 30 Days/90 Days

Generic Drug	$10	$20
Brand-Name Drug	$20	$40
Non-Formulary Drug	$40	$80

SCAN HMO

- Your enrollment into Scan will be pending approval of CMS
- County of Orange Benefits Center will send you notification if you were approved or denied
- If you are not approved to be enrolled in Scan, you will be automatically enrolled into the designated health plan outlined on your Benefits Enrollment Summary.

Anthem Blue Cross Traditional HMO

- You have the full Blue Cross HMO Network to select your Primary Care Physician from
- Office Visit Copay- $15 Per Visit
- Emergency Room Copay- $100 Per Visit
- Hospitalization Copay- $100 Per Admission
- Prescription Drug Coverage, 30 Days/90 Days

Generic Drug	$10	$20
Brand-Name Drug	$20	$40
Non-Formulary Drug	$40	$80

Anthem Blue Cross Select HMO

- Blue Cross HMO Network – offers a more select network to choose your Primary care physician from
- Office Visit Copay- $15 Per Visit
- Office Visit Copay Specialist- $30 Per Visit
- Emergency Room Copay- $100 Per Visit
- Hospitalization Copay- 100% Coverage
- Prescription Drug Coverage, 30 Days/90 Days
- Deductible- $100 Applicable to Brand Name Drug

Generic Drug	$10	$20
Brand-Name Drug	$25	$50
Non-Formulary Drug	$40	$80

Anthem Blue Cross Senior Secure HMO

- Office Visit Copay - $15 Per Visit
- Office Visit Copay Specialist- $15 Per Visit
- Emergency Room Copay- $50 Per Visit
- Hospitalization Copay- 100% Coverage
- Prescription Drug Coverage, 30 Days/90 Days

Generic Drug	$10	$20
Brand-Name Drug	$20	$40
Non-Formulary Drug	$40	$80

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Anthem Blue Cross Custom PPO

- Same Benefits In or Out of Network
- Office Visit Copay- $15 Per Visit
- Office Visit Copay Specialist- $15 Per Visit
- Emergency Room Copay- $50 Per Visit
- Hospitalization Copay- $15 Per Visit
- Prescription Drug Coverage, 30 Days/90 Days

Generic Drug	$10	$20
Brand-Name Drug	$15	$30
Non-Formulary Drug	$15	$30

Anthem Blue Cross Standard PPO

- Different benefits In and Out of network
- Office Visit Copay- $25 Per Visit
- Office Visit Copay Specialist- $40 Per Visit
- Emergency Room Copay- $50 Per Visit
- Hospitalization Copay- $100 Per Visit
- Prescription Drug Coverage, 30 Days/90 Days
- Deductible- $300 Applicable to Brand Name Drug

Generic Drug	$15	$30
Brand-Name Drug	$45	$90
Non-Formulary Drug	no coverage	

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Health Plan Effective Dates

- Active employee coverage ends on the last day of the month in which you remain an active employee
- Retiree coverage starts on the first day of the month following your separation date
- Example
  - Last day of work: June 15
  - Active coverage ends June 30
  - Retiree coverage starts July 1

Health Plan ID Cards

- If you switch to a different health plan
  - New health plan ID cards are mailed within 30 days of confirmation statement issued after you actually retire
  - If electing either the Wellwise Retiree or Sharewell Retiree PPO plans, you will receive a new ID card
  - If you do not receive your ID cards, contact the health plan
  - If you need to use your medical or prescription drug benefits before your ID card arrives, call the Benefit Resource Line to have your coverage verified with your provider or pharmacy

Enrollment Process

- **Step 1: Meet with OCERS** 60 days before your last day at work
  - OCERS notifies the Benefits Center of upcoming retirements twice a month
  - The Benefits Center
    - Calculates the amount of your grant (if applicable)
    - Sends you a retiree enrollment packet
      - Personalized Benefits Enrollment Summary
      - Benefits Enrollment Guide
- Your packet will be sent 1 – 2 weeks after the Benefits Center receives your “intent to retire” information from OCERS.

Enrollment Process

- **Step 1** (continued):
  - If you are currently employed and over 65, you will want to go to Social Security 60-90 days prior to your retirement date to ensure your Medicare is in place. By starting this process early, you will avoid delays and/or being denied enrollment into a Medicare Advantage health plan.

Enrollment Process

- **Step 1** (continued):
  - You need to go to Social Security and get your Medicare in order. You may be given a Verification of Employment form. Please bring that form to:

    Employee Benefits

    333 W Santa Ana Blvd., 2nd floor

    Santa Ana, CA 92701
  - Employee Benefits will complete this form and you can then return it to Social Security
  - You may call 714-834-6282 for assistance

Enrollment Process

- **Step 2: Elect your retiree health plan coverage** within 30 days from the date on your Benefits Enrollment Summary
- To enroll
  - Use the Benefits Center Web Site, or
  - Call the Benefits Resources Line
- If you make no new elections, or if you elect KPSA and your enrollment form is not submitted timely and approved, you receive automatic coverage as shown on your Benefits Enrollment Summary

Enrollment Process

Dependent Eligibility

- You are required to provide documentation of eligibility for any newly added dependents:
  - Marriage certificates; and
  - Tax documents/Proof of Joint Debt (if applicable)
- If you do not submit documentation for a newly added dependent within 60 days of the date of the event which made your dependent eligible, your dependent will be terminated from your coverage
- It is your responsibility to notify the Benefits Center within 30 days when a dependent becomes eligible or ineligible for coverage.

Enrollment Process

- **Medicare Documentation Requirements**:
- If you and/or your dependent spouse are Medicare eligible, you are required to provide current documentation of Medicare enrollment within the time frame noted on your Benefits Confirmation Statement
  - You must submit a copy of your Medicare Card showing an effective date in the current year
  - If Medicare eligible previously, provide documentation of Medicare enrollment in the form of letter from Medicare showing current coverage with current year date, or statements showing payment of Medicare premiums within the current year

Enrollment Process

- If you fail to provide the required documentation your Grant will be suspended and you will be required to pay the higher non-Medicare rates until the Benefits Center receives such required documentation. Your Grant and rates will be reinstated the 1st of the month following the receipt of the required proof.
- To review specific documentation requirements for each dependent type, please refer to the Benefits Center Web Site or call the Benefits Resources Line and speak with a Benefits Specialist.

Enrollment Process

- **Step 3: Review your *two* confirmation statements and report any errors to elections you've made within 10 business days from date on Statement**
  - First statement follows health plan selection
    - Coverage changes are *pended until you actually retire*
  - Second statement follows separation/retirement date
    - Coverage changes are *activated*

Enrollment Process

- **Confirmation Statements**
  - Review carefully for any additional instructions or requirements, such as submitting documentation of dependent eligibility or documentation of Medicare enrollment. Failure to follow the instructions such as providing required documentation could result in termination of dependent coverage, or placement into a non-Medicare Advantage plan (if applicable) and/or termination of your Retiree Medical Grant, per plan rules.

Enrollment Process

- **Step 4: Pay your share of the health plan rates**
  - Initially you are billed directly for your retiree health plan rates (if applicable)
  - Between 60 – 90 days after you retire automatic pension deductions will occur on your monthly OCERS pension

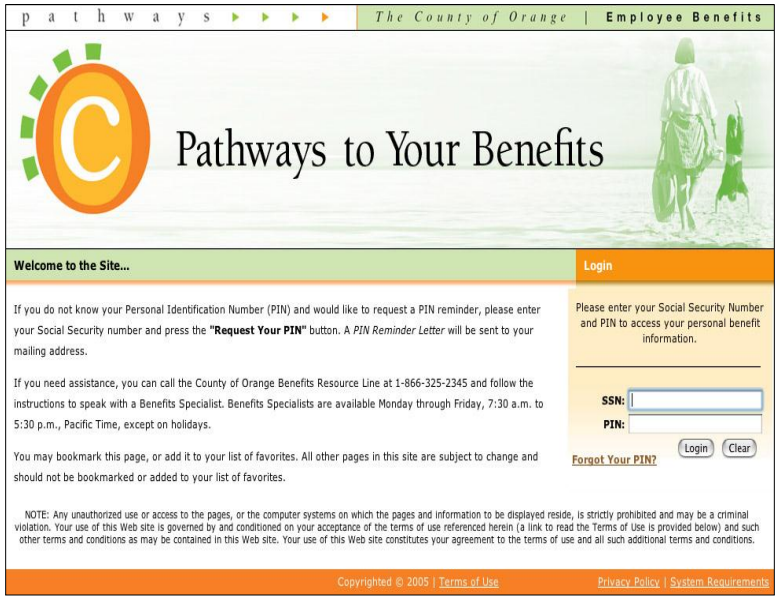
Enrollment Process

- **Immediate Retirement**
  - Benefits Center may not recognize you as an “Intent to Retire”; will only see termination notification from agency
  - Inform Benefits Center of late notification to OCERS
  - May have appearance of lapse in coverage
  - If you need immediate services or a prescription drug filled, work with Specialist at Benefits Center
  - Note: If you switch to an HMO plan upon retirement, you may be required to select a Primary Care Physician

Enrollment Process
Click: To Enroll Online

www.benefitsweb.com/countyoforange.html

24 hours a day, 7days a week



- Go to the Benefits Center Web Site from any computer with Internet access
- Type the Web Site address into your Web browser and press "Enter" on your keyboard

Enrollment Process: Click: To Enroll Online

- After you **save** your changes and click “submit” button, your Benefits Confirmation Statement will appear on your screen:
  - Review your benefit elections for 2013
  - Make sure you see a confirmation number
  - Print a copy for your records
- You will also receive a Benefits Confirmation Statement by mail within 7 to 10 business days

Enrollment Process
Call: To Enroll by Phone

1-866-325-2345, toll-free

Weekdays, 7:30 a.m. to 5:30 p.m. PT

- Use a touch-tone phone to access the Benefits Resource Line
  - You'll be prompted to enter your Social Security number and PIN
    - If you do not have your PIN, wait for instructions to speak to a Benefits Specialist

Summary

Enrollment Process

Enrollment Process

- **Step 1:** Meet with OCERS *60 days* before your last day at work
  - If you and/or your spouse are Medicare eligible, make sure your Medicare is in place
- **Step 2:** Elect your retiree health plan coverage within *30 days* from the date on your Benefits Enrollment Summary
- **Step 3:** Review your *two* confirmation statements and report any errors to elections you've made within *10 business days* from the date on your statement

Enrollment Process

- **Step 4:** Pay your share of the health plan rates (if applicable)
- **Step 5**: Review all other benefits, such as Health Care Reimbursement Account (HCRA). Eligibility for your HCRA ends upon retirement date unless you elect COBRA

County of Orange Benefits Center

- www.benefitsweb.com/countyoforange.html
- Benefits Resource Line: 1-866-325-2345
- FAX: 1-973-837-3330
- Mailing address:

PO Box 199712

Dallas, TX 75219-9768

Xerox, HR Solutions – Direct Bill

- www.benefitsweb.com/countyoforange.html
- Phone: 1-866-325-2345
- Payment Mailing address:

  P. O. Box 382147

  Pittsburgh, PA 15251-8147

Employee Benefits Web Site

www.ocgov.com/hr/employeebenefits

- For general information about your County of Orange benefits:
  - Retiree Enrollment Guide
  - 2013 Retiree Health Plan Monthly Rates
  - New Retiree Checklist
  - Health Plan Contact Information

Wellwise Retiree & Sharewell Retiree PPO Plans

- Blue Shield of California Plan Administrators
  - Benefits, preferred providers, hospital information
  - www.blueshieldca.com/oc
  - Phone: 1-888-235-1767
- Catamaran Rx – Wellwise Retiree Plan Participants
  - Prescription drug information
  - www.mycatamaranrx.com
  - Phone: 1-800-573-3583

Anthem Blue Cross Medicare Advantage Plans

- Anthem Blue Cross Custom PPO Plan & Standard PPO Plan
  - www.anthem.com/ca/countyoforange
  - First Impressions Phone: 1-877-411-1647
- Anthem Blue Cross Senior Secure HMO
  - www.anthem.com/ca/countyoforange
  - First Impressions Phone: 1-877-826-1831

SCAN Health Plan

- SCAN HMO Plan
  - www.scanhealthplan.com/CountyofOrange
  - First Touch Phone:1-877-212-7654

Other HMO Plans

- Kaiser: www.kp.org
  Phone: 1-800-464-4000
- ASHP (Chiropractic): www.ashcompanies.com
  Phone: 1-800-678-9133
- Anthem Blue Cross HMO Health Plans (Traditional & Select)
  - www.anthem.com/ca/countyoforange
    First Impressions Phone: 1-888-831-2238

Resources

- Benefits Center Web Site
- Benefits Resource Line – Toll free
- Employee Benefits Web Site
- Health Plan Administrators
- Benefits Enrollment Guide
- Handouts from this presentation

Questions?