TO ALL ACTIVE BENEFITS ELIGIBLE EMPLOYEES

OPTION TRANSFER

2005

October 1, 2004 …..October 29, 2004

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Flexible Spending Account Enrollment Form
Request to Decline and Waive Medical Health Ins. Cov. Form
Dental/Vision Change Form

All Forms MUST BE IN RISK MANAGEMENT BY
5:00 PM October 29, 2004

Orange County Division of Risk Management
30 Matthews Street, Suite 101, Goshen, NY 10924
Tel: (845) 291-2139
Throughout the month of October, during the annual open enrollment period, eligible* employees can request benefits changes that cannot ordinarily be made during the year.

Medical, dental and vision coverage are some of the most important benefits provided by your employer. You owe it to yourself and your family to carefully review your current coverage to determine whether it would be in your best interest to make changes to these benefits during this once a year opportunity.

As an eligible employee, you can enroll for coverage if not currently enrolled, upgrade or downgrade existing coverage, or take advantage of other benefits options, all of which will be described in this publication. The *Table of Contents* lists the benefits that can be selected or changed, as well as other important information that affects you and your dependents.

After your requests have been reviewed, approved and processed, all changes will become effective January 1st of the coming year.

Almost everyone will agree that to fully understand one’s health coverage is a difficult job. Even more confusing are the ever-changing laws and rules that have been designed to protect you and your family. These laws create rules and regulations that employers and plan sponsors, health plans and health care providers, as well as you and your covered dependents must follow.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) protects your rights to continue your coverage when you, or a covered dependent, would otherwise lose group health coverage. In addition, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates the most sweeping changes to the health care industry since the enactment of Medicare. These and other rules and regulations affect the way your benefits must now be administered by Risk Management. Documentation of eligibility will be checked; signed applications will be required. As always, confidentiality and privacy will be maintained.

Read the important reminders, on pages 2 – 3. Although some apply only to Option Transfer, most are reminders of your benefits-related obligations and responsibilities throughout the year.

Orange County Division of Risk Management is responsible for supplying you with this important Option Transfer information. You should review its contents carefully. **YOU, not your timekeeper or any other employee, are responsible for reading the information, following the instructions, and submitting all change requests to Risk Management by the 5:00 p.m., October 29, 2004 DEADLINE.** If you need assistance, please do not hesitate to call the Benefits Unit at Risk Management with your questions.

(*To be eligible for benefits, or “benefits eligible”, an employee must be hired for at least 3 months, and work a regularly scheduled work week of 20 or more hours.)

Orange County Risk Management
30 Matthews Street Suite 101, Goshen, NY 10924

Medical Plan Information 291-2130; Dental/Vision Information 291-2139; Main Number 291-2133
Regarding Your Benefits:

1. **NO photocopies** or faxes of enrollment or change forms will be accepted. Risk Management must have your original signature on the completed form(s).

2. It is your responsibility to **keep your address current**. Address changes must be reported through your Department Timekeeper.

3. **You must notify** Risk Management within 30 days of events that may affect your benefits. These include:
   
   **When you change your name,** usually through marriage or divorce; (your name change must be processed through a PPC before benefits records can be changed.)

   **When you marry,** and want to add your new spouse and his/her dependents, if any, to your coverage;

   **When you gain a dependent,** as in the case of a newborn or adopted child, or when your child (age 19 to 25) who had lost student status returns to school full time.

   **All change requests must be made by signed applications.** To have a dependent added to your medical, dental and/or vision coverage, you must complete two forms – one for your medical coverage and one for your dental/vision coverage.)

   You must notify Risk Management as soon as possible in order to comply with all applicable rules. **Failure to notify this office** in a timely manner may result in late enrollment penalties, or may prevent your dependent(s) from being added until the next open enrollment period.

4. **You must inform** Risk Management **immediately** if you experience the loss of a covered dependent through:

   **Death of Dependent**

   **Divorce** - When you divorce, you cannot keep an ex-spouse on your coverage, even if you are obligated to provide the former spouse with health insurance. (Step-children from the former marriage will also become ineligible unless you have adopted or obtained legal custody of them.) **If you have failed to remove an ex-spouse, do so NOW.**

   **Loss of Dependent Eligibility (former step-children) and Loss of student status** - you must submit notification to RISK as soon as your dependent is no longer a full-time student. Eligibility ends at the end of the month in which your non-student dependent reaches age 19. If a full-time student stops attending school, he/she also loses eligibility at the end of the month that school was last attended. If your dependent is not returning to school, he/she has no coverage between semesters. Contact the Benefits Unit to discuss Empire Plan three-month extensions for graduates, any extenuating circumstances regarding your student dependents, and for more specific information, including continuation coverage under COBRA.

   **Remember:** You may be liable for any benefits and/or services obtained by anyone on your medical, dental or vision coverage after eligibility ends. By law, you are obligated to notify Risk Management within 30 days of the loss of eligibility; Risk Management must issue a certificate.
indicating the period during which the dependent had medical coverage, and offer continuation coverage under COBRA provisions, when applicable.

5. **You cannot make changes during the year, unless an event occurs (a qualifying event) that would allow Risk Management to approve such a change. The rules, regulations and laws regarding benefits are very specific on what changes can and cannot be allowed mid-year.**

6. **Your current pre-tax benefits contributions, if any, will continue to be taken on the same basis for the coming year unless you submit a change request, in writing, to Risk Management.**

7. **You must be aware of Coordination of Benefits (rules that determine which insurance pays first) and how the changes you make during the Option Transfer period will affect you and your dependent(s) for the coming year. (See page 8 – Coordination of Benefits section)**

8. **When you and/or your spouse have Medicare and Orange County medical benefits, it is extremely important that you are providing your health care providers with correct and complete insurance information. There are insurance rules as well as federal law that govern the interaction of Medicare and group health plans. Medicare has the right to seek reimbursement when your claims have been incorrectly paid. If you do not understand how your medical plan(s) work with Medicare, contact the Benefits Coordinator at Risk Management for assistance.**

9. **Required deductions for next year’s coverage begin this December. All Option Transfer requests become effective January 1st.**

10. **If you have special situations or needs – including disabled children, guardianship, medical support orders, medical leaves for student dependents, requests for health premium waivers, contact the Benefits Coordinator at Risk Management for special assistance.**

11. **If you are thinking about retirement, consider how your health coverage will work for you (and your covered dependent) when you become a Retiree. If you are approaching age 65, over age 65, or already have Medicare in effect, you need to know how Retirement will affect your coverage. Contact the Benefits Coordinator with your questions.**

12. **All forms MUST be received by Risk Management no later than October 29, 2004. Any forms received AFTER 5:00 P.M., October 29th will be returned.**

**Employees of Orange County Community College should follow the Option Transfer instructions provided by the OCCC Human Resources Department.**

**The following Forms will be available on the County Intranet throughout the year:**
- Dental/Vision Enrollment Form
- Dental/Vision Change Form
- NYSHIP (Empire Plan) Enrollment / Change Form
- Orange County Government Section 125 Flexible Benefit Plan Enrollment Form
- Medical Buy-Out / Form - Request To Decline and Waive Medical Health Insurance

**The following Brochures will be available on the County Intranet throughout the year:**
- Dental Brochure Group 723 and 722
- Dental Brochure Group 718, 755, 719
- Vision Brochure
- Disability Brochure
- Health comparative summary (NYSHIP, GHI HMO, MVP Healthcare)
Orange County Government Section 125 Flexible Benefit Plan

This is a formal plan, established under Section 125 of the Internal Revenue Code, that is a way your employer has established to help you pay for certain expenses using pre-tax dollars. (Pre-tax contributions are not subject to federal, FICA, state and local taxes; State and local taxes may not be excluded in Pennsylvania.) Although you do not pay Social Security taxes on these pre-tax contributions, most tax planners agree that the tax savings experienced today will far outweigh any possible future reduction in Social Security benefits. These pre-tax contributions do not affect New York State Retirement System benefits.

These kinds of plans are often referred to as “Cafeteria Plans”. Orange County’s plan offers a premium payment plan and two flexible spending programs. The following is a simple description of each component.

The Premium Payment Plan, sometimes know as a premium only plan, was the initial flexible spending component, first offered January 1, 1999. The premium payment plan is designed for the sole purpose of helping an employee save money by allowing the employee’s share of insurance premiums (the bi-weekly amounts an employee pays for medical and family dental and/or vision coverage) to be paid with pre-tax dollars. This helps you save money because your employee contribution is taken before taxes are paid on it.

All active benefits-eligible Orange County employees who contribute toward medical, dental and vision coverage can take advantage of this tax-savings benefit. All qualified employees participate unless they instruct the Benefits Unit that they do not want to participate. Your current election will continue unless a change form is filed during this open enrollment period.

During the course of a plan year (January 1-December 31st) you cannot change your mind about your benefits elections, because your choices are “irrevocable”, unless you experience certain qualifying events, as defined by the Internal Revenue Service, that would allow you to make mid-year changes. Marriage and divorce are examples of “qualifying events”. Requests for changes must be requested within 30 days of the qualifying events.

The laws that govern cafeteria plans are very technical and complex, with many special rules that interact, COBRA (Consolidated Omnibus Budget Reconciliation Act) and HIPAA (Health Insurance Portability and Accountability Act) among them. If during the plan year, you think you have experienced a qualifying event that would allow a change in your benefits elections, and therefore your pre-tax contributions, please contact the Benefits Unit to discuss your status change.

Refer to pages 7-10 for information on available medical, dental and vision benefits.

Flexible Spending Accounts

In addition to the Premium Payment Plan, there are two flexible spending components you might want to consider.

Flexible Spending Plans – All active Orange County employees are eligible for the tax-savings benefits provided under the flexible spending plan components of the Section 125 Flexible Benefit Plan. The plan year is a calendar year, January 1 – December 31st. The Claims Administrator for the Orange County Section 125 Flexible Benefit Plan components is Fitzharris Administrators, Farmingdale, New York. See page 5 for information on the Health FSA and DCAP.
The Health Flexible Spending Account, or Health FSA, is a medical reimbursement plan funded by your tax-free contributions. Enrolling in the Health FSA allows you to set aside money on a pre-tax basis to pay for medical, dental and vision expenses that cannot be reimbursed through insurance or any other arrangement. Examples of Health FSA expenses are deductibles, eyeglasses and orthodontics.

This is a voluntary program. You can enroll for a minimum of $300, up to a maximum of $3,000 per year. During this open enrollment period, you should think about the out of pocket expenses you will have for yourself and your eligible dependents for the coming year.

You can participate in the Health FSA even if you do not participate in the medical, dental or vision plans. The expenses must be for health care incurred by you or your dependents. You cannot be reimbursed for expenses for which you claim a tax exemption. Your dependents include your spouse, your children under the age of 19 and your unmarried full-time student dependents ages 19 to 25.

The total amount you decide to set aside is your pledge amount. The FSA bi-weekly payroll contribution amount will be determined by dividing the pledge amount by the number of pay periods, usually 26 per year. (For example, a $300 pledge would cost only $11.54 per pay period) The first Health FSA contribution for the new plan year will be withheld in January.

Once your FSA becomes effective January 1, remember that you cannot make changes in your Health FSA unless you have a qualifying change in status that would allow a corresponding and consistent change to occur. There are specific reasons for which a change can be allowed. You will be requested to complete a Change in Circumstance Form, and provide acceptable documentation of the change in circumstances. This is an IRS rule.

You must use this money during the Plan Year or you will lose it. You cannot get it back, and you cannot roll it over to the next year. This “Use it or Lose it” rule is a federal regulation.

If you are enrolled in the Health FSA and go on a leave at some time during the plan year, or if you separate from employment, contact the Benefits Unit at Risk Management for further instructions.

Claims for reimbursement are paid by Fitzharris Administrators, our third party administrator. Technical questions can be answered by calling 1-800-635-5651, ext. 140.

The FSA enrollment form is included in this packet, and is also available on the County Intranet.

Your current FSA enrollment, if any, terminates December 31st. **This benefit is not automatically renewed.** You must apply for the new Plan Year. Please complete the attached Orange County Government Section 125 Flexible Benefit Plan form. Return to Risk Management by the October 29th deadline.

The Health FSA is subject to the Privacy Provisions under HIPAA’s (Health Insurance Portability and Accountability Act) Administrative Simplification requirements.

If you separate from employment, your Health FSA is a COBRA (Consolidated Omnibus Budget Reconciliation Act) covered benefit.
**Dependent Care Assistance Program - DCAP**

The Dependent Care Assistance Program, or DCAP, is another voluntary flexible spending account funded by your pre-tax salary contributions. This account helps you reduce taxes and increase your spendable income by paying dependent care expenses with pre-tax dollars.

This program is available to employees who have dependents under age 13, handicapped children, or adult parents who need care to allow you and your spouse to continue working.

Like the Health FSA, the DCAP Plan Year is January 1st - December 31st. The DCAP only reimburses expenses that have been incurred during the coverage period.

Unlike the health FSA, you must put the money in before getting it out. You must have sufficient contributions in your account to cover the amount you are requesting for reimbursement. There must be adequate claims substantiation (the employee must provide the name, address of the caregiver, caregiver’s tax ID, or Social Security number for an individual.)

You cannot carry over any unused contribution. The same “Use it or Lose it” rule applies to the DCAP, in accordance with federal regulations.

The annual minimum contribution is $300. There is a statutory limit on the amount of expenses that can be paid pre-tax under a DCAP. The maximum contribution, set by the IRS, is $5,000 (or $2,500 if married and filing separate returns).

You will need to decide whether you will claim the Dependent Care Tax Credit for eligible dependent care expenses. You may want to talk to your tax preparer to assist you with this decision.

**This benefit is not automatically renewed.** If you are currently enrolled in the Dependent Care Assistance Program (DCAP) it will terminate December 31st. **You must apply for the coming Plan Year.**

To enroll in one, or both of the flexible spending accounts, (Health FSA or DCAP), complete the **Flexible Spending Account Enrollment Form**, and return to Risk Management before the October 29th deadline.

All of the components of the Section 125 Flexible Benefit Plan operate under Internal Revenue Service rules. Therefore, once you have elected participation, you may not change your deduction(s) during the Plan Year **unless** you experience a qualifying event, as allowed by IRS regulations. You must contact Risk Management to discuss mid-year changes.

You will be required to complete a Change of Status form and provide acceptable proof of the qualifying event.
MEDICAL COVERAGE

The current medical health plans - GHI HMO, MVP Health Plan and the Empire Plan - will continue to be offered for the coming year.

The plans will continue to cover the same services as are covered now. Although the comparison summary sheets were not available at the time of this booklet’s printing, the summary comparison of the three medical plans will be available through the County Intranet under County Forms, Risk Management; or you can request Risk Management send you a copy through Inter-Office Mail.

The Employee Benefits Division of the New York State Department of Civil Service has indicated that, as a result of contract settlements at the State level, there will be some changes to the Empire Plan for the coming year. Information regarding these changes will be available as soon as Risk Management receives official notification, and will be included on the Health Plan Comparison Summary, available on the County Intranet.

Health Maintenance Organizations - HMOs

Both GHI HMO and MVP Health Plan are Health Maintenance Organizations, usually referred to as HMOs. You must select a doctor for yourself and each of your dependents from the applicable HMO list of participating providers; visits to participating specialists are by referrals. With a Health Maintenance Organization, you usually have little or no paperwork, no deductibles or co-insurance. Both of the HMOs offered by Orange County are premium plans.

GHI and MVP will not be mailing full enrollment packets to employees. If you are interested in switching to one of these HMOs, call the Benefits Unit at Risk Management.

The Empire Plan, NYSHIP (New York State Health Insurance Program)

The New York State Health Insurance Program (NYSHIP) provides health insurance through the Empire Plan. The Empire Plan is a specially designed health insurance program for public employees in New York State. NYSHIP Empire Plan is a comprehensive indemnity plan with some managed care features. The Empire Plan is a plan of the New York State Health Insurance Program; it is not an Empire Blue Cross Blue Shield Plan, although Blue Cross Blue Shield pays claims for the Empire Plan hospital component.

The Empire Plan does not mail informational packets to prospective enrollees during Option Transfer. For general information, copies of the current The Empire Plan At A Glance are available through Risk Management or OCCC Human Resources. The brochure helps explain the Empire Plan payer components. If you are thinking of leaving your HMO and enrolling in the Empire Plan, please contact the Benefits Unit with any questions, since there are differences in the way HMOs and the Empire Plan work.

You can keep your out of pocket expenses down if you select your providers from the Empire Plan Participating Provider Directory. When a doctor participates with the Plan, it means that he or she has a contract with the Empire Plan and has agreed on the amount he/she will be paid for the service. When you choose doctors or providers of services that participate with the Empire Plan, you will only have to pay the co-pay(s), and the doctor accepts what the Empire Plan pays as payment in full.

You can also choose to go to non-participating providers. When you use a non-participating provider, you must meet deductibles.
Before you **switch** your health plan, think about the following things:

If you or your dependent has a current medical condition, make sure you understand how the new plan will cover it. If there is a specialist involved, does he/she participate with the new plan?

If you take several medications, or new medications, you should make sure that you understand how the new plan will cover them.

If you need to cover a dependent that lives outside the HMO service area, you should not consider HMO coverage.

If you do not understand anything you have read about these benefits, please call or stop by Risk Management to talk to someone who can help you.

How will the changes you make affect any other coverage you and/or enrolled dependents may have?

**Coordination of Benefits** rules determine which plan pays first when an individual has coverage under more than one plan. Generally, this means that you must first use the coverage you have through your employer and your spouse must first use the coverage that he or she has through his or her employer before the other’s insurance can be used. When children have coverage under both parents, the primary coverage is usually the coverage of the parent whose birthday comes first in the year. Consider how upgrading or changing your coverage might affect your family. **Remember that each covered member must use the coverage that is primary for him/her.** There are many circumstances that affect the order of payment, including custody agreements, Medicare for end stage renal disease, and work status. If you do not know which plan should pay first, or if something has changed that might affect the order of payment for you or a family member, you should contact the Benefits Coordinator at Risk Management as soon as possible to discuss your particular situation.

**After thinking about your health plan choices, decide what you want to do for the coming year. If you want to:**

**Keep your Current Plan - Do Nothing.** Your coverage will continue as it is now.

**Keep your Current Plan, but Add or Delete Dependents for January 1 -** you must complete a change form from your plan. The New York State Health Insurance (NYSHIP) form is available on the County Intranet, or you can call the Benefits Unit for a form. Keep in mind that if you remove otherwise eligible dependents from your coverage during open enrollment, they will not be eligible for continuation coverage under COBRA. You may not be able to re-enroll them until next open enrollment. You must inform dependents that you are dropping them from your coverage. If the dependent lives at a different address, you must supply the Benefits Unit with that address so a HIPAA certificate of creditable health coverage can be issued to the dependent(s) losing medical coverage. If you are trying to remove a spouse to prevent him/her from being offered COBRA coverage when you divorce, RECONSIDER your request. There could be legal repercussions.

**Enroll in a Health Plan, are eligible but not currently enrolled -** you can enroll for coverage for the coming year by completing an enrollment form of the health plan you select.

**Change to a Different Health Plan -** You must complete an enrollment form for the new plan you want for the coming year, and provide all the necessary information on the new plan’s enrollment form. Risk Management will inform your old plan of your termination from its coverage. (See sentence above for enrollment form information.)
If you want to:

**Terminate Your Current Medical Health Insurance**, because you are eligible for and want to take advantage of the Annual Medical Health Insurance Buy-Out - you must complete a Request to Decline and Waive Medical Health Insurance Coverage. Risk Management will terminate your current health plan. (*If you are eligible for health coverage, but are not currently enrolled in an Orange County medical health plan option, you may still be able to sign up for the Buy-Out. For more Buy-Out information, see Page 11.)

**When completing enrollment/change forms**, make sure you provide the names and all requested information (first and last name, date of birth, Social Security number) for all eligible dependents you want covered. Remember that, for insurance purposes, your spouse (a husband or wife to whom you are legally married) is considered a dependent under your plan.

Please use proper names, not nicknames. Double check forms for accuracy!

**You Must Provide Proof** (copies of marriage certificate if enrolling spouse, birth certificates, Social Security cards, legal guardianship papers, etc.) FOR ALL DEPENDENTS BEING ADDED TO YOUR COVERAGE. These documents are to be attached to the enrollment or change form. Applications submitted without the required documentation will be returned to the employee.

If you want to switch to one of the HMOs, either GHI or MVP, you must make sure that each covered member has a primary care physician selected from the Plan’s list of primary care doctors, and that you have included this information on your enrollment application. It is your responsibility to make sure the doctor will accept new patients. **If your application is incomplete, or if it cannot be read, the application cannot be processed and will be returned to you. Please note that all dependents over age 18 must sign the MVP enrollment form.**

Providing false or misleading information to obtain benefits for ineligible dependents is considered fraud.

**IMPORTANT NOTICE:** Risk Management has not yet received health plan rates for the coming year. However, you should be aware that a provision in union contracts stipulates that in the event your HMO monthly premium is higher than the Empire Plan monthly premium, you will have to pay that difference, plus any required employee contribution. While it is not anticipated that this excess HMO premium situation will occur, your attention is called to this fact because Risk Management does not have final rates.

A **comparative summary** of the most used services can be found on the County Intranet.
Orange County Self-Insured Dental and Vision Plans

You make changes to your dental and vision coverage by using the combined dental/vision change form, but you can make separate choices. Make sure you mark the form correctly, and list all eligible dependents you want covered, including full names, dates of birth and Social Security numbers. Remember, if you are adding dependents for the first time, (or if documents for dependents are not currently on file at Risk Management) you must supply required proofs of eligibility.

Dental Coverage

Dental coverage is provided by the Orange County Self-Insured Dental Plan, and is available only to active benefits-eligible employees and their enrolled eligible dependents. The claims administrator is Fitzharris and Company, Farmingdale, NY.

Your dental benefit is funded by the premiums that you and/or your department pay. Your department pays the total cost of individual coverage for you, the employee. If you are not currently enrolled in the dental plan, you can enroll at this time. **An upgrade to, or continuation of, the Family dental benefit will require a payroll deduction of $19.38.**

If you do not submit a change form, your dental coverage will remain the same as it is now. You cannot upgrade or downgrade your coverage during the year, unless you qualify for such a change. (Contact Risk Management to discuss mid-year changes.)

Vision Coverage

Vision coverage is provided by the Orange County Self-Insured Vision Plan, and is available only to active benefits-eligible employees and their enrolled eligible dependents. The claims administrator is Fitzharris and Company, Inc., Farmingdale, NY.

Your vision benefit is funded by the premiums that you and/or your department pay. Your department pays the total cost of individual coverage for you. If you are not currently enrolled in the vision plan, you can enroll at this time. **An upgrade to Family vision coverage will require a payroll deduction of $1.56.**

If you do not submit a change form, your vision coverage will remain the same as it is now. You cannot upgrade or downgrade your coverage during the coming year unless you have a qualifying event. (Contact Risk Management to discuss mid-year changes.)

You must submit the appropriate application (**Orange County Self-Insured Dental/Vision Change Form**) if you want to upgrade or downgrade your coverage. If you are not currently enrolled in dental or vision coverage, you can enroll at this time by completing the **Orange County Self-Insured Dental/Vision Enrollment Form.**

If you want additional information on the Orange County Self-Funded Dental Plan or the Orange County Self-Funded Vision Plan, please contact Risk Management (291-2139).
MEDICAL HEALTH INSURANCE BUY-OUT OPTION

Employees who are eligible for medical coverage and are actively employed (at work) are eligible for the Medical Health Buy-Out Option.

If you are NOT currently participating in the Medical Health Insurance Buy-Out, but are interested:

If you choose to apply for the annual Medical Health Insurance Buy-Out option, it is effective from January 1 through December 31 of each year. As union contracts explain, you must apply for this Buy-Out Option by completing the Request to Decline and Waive Medical Health Insurance Coverage. This was not, and is not, an automatic benefit; it is your responsibility to apply for it for each year you want the Buy-Out option.

You must submit the form and a letter verifying your alternate medical coverage for the coming year. (The letter should state the holder of the plan, ID #, name of covered dependent(s), period of anticipated coverage Jan 1- Dec 31.) This letter has become necessary because most insurance cards do not specify periods of coverage, and some do not issue cards with employee’s name. (If you are requesting the Buy-Out based on coverage through your Orange County or OC Community College Spouse, note that information on the form and this Office will verify the information for you.)

For those employees currently participating in the Medical Health Plan Buy-Out, please take Note:

The Buy-Out option must be renewed during each Option Transfer. It is not renewed for you. If you are interested in continuing your medical health buy-out for next year, you must once again complete and submit the required form and proof of other health coverage during this Option Transfer period. The Request to Decline and Waive Medical Health Insurance Coverage that you signed in order to participate in the current plan year Buy-Out explained that you must renew your option annually. However, because a significant number of employees failed to follow these instructions and did not submit the required Buy-Out forms/verification, numerous employees were, by contract terms, needlessly enrolled in Empire Plan coverage they did not want. This year, for those employees currently enrolled in the Buy-Out option, Risk Management will mail a Request to Decline and Waive Medical Health Insurance Coverage to your home address. If you want to continue the Buy-Out option for the coming year, please complete the form and return, along with the letter verifying other coverage, to Risk Management before the October 29, 2004 deadline. If you want to re-apply for medical coverage, complete an enrollment form for the medical plan of your choice, and return it, to Risk Management before the October 29, 2004 deadline.

You will not be able to re-enter a medical health plan during the year unless you experience a qualifying event. (It would not be a qualifying event if you find that your alternate coverage is not as good as the coverage you instructed this office to terminate. However, if your spouse loses his/her job and health coverage, that would be a qualifying event that would allow you to enroll in coverage for yourself and your dependents.) If you experience an involuntary loss of coverage during the period of the Buy-Out, you must contact the Risk Management Benefits Unit (or OCCC Human Resources) immediately to discuss re-entry into a health plan, and to complete the required Request to Resume Medical Health Insurance Coverage. (You must also be able to supply acceptable supporting documentation.)

Each Annual Option Transfer, you will be able to re-enroll in a medical health plan for the following year.

If you want the Buy-Out option but are also planning to retire during the coming year, contact the Benefits Coordinator to discuss your situation.

Buy-Out payments are issued by the Orange County Payroll Department in the month following the end of each quarter.