OUC EMPLOYEE SUMMARY

EMPLOYEE*benefits*

BENEFITS EDITION

2019 OPEN ENROLLMENT

OCTOBER 29 — NOVEMBER 16, 2018

Open Enrollment is your one time a year opportunity to add, change, or remove benefit enrollment elections that will take effect on January 1, 2019. Outside the open enrollment period, employees must make changes to their benefits elections within 31 days of a qualifying status/life event change.

You WILL BE automatically re-enrolled in your current Health (Core, HRA, Premium) Plan and/or Aetna Vision Preferred coverage, if you do NOT make any health insurance changes.

If ADDING dependents, copies of applicable documentations are required to validate the enrollment.

Required documentations must be turned in by **December 31, 2018**, to enroll new dependents in your plan.

You must ACT to participate in 2019 Flexible Spending (FSA) health care and/or dependent care reimbursement account.

All medical plan changes and FSA enrollments/ re-enrollments must be submitted through Employee Self-Service (ESS) by **Friday, November 16, 2018**.

SNACK & CHAT with HR/Benefits*

RELIABLE – WEDNESDAY, OCTOBER 31
11– 1 p.m. | OUCafé

GARDENIA – THURSDAY, NOVEMBER 1
11 – 3:30 p.m. | Atrium

STANTON – TUESDAY, NOVEMBER 6
1 p.m. – 3:30 p.m. | 1st Floor Lobby

PERSHING – THURSDAY, NOVEMBER 8
11 – 3:30 p.m. | Atrium

HR OPEN HOUSE – FLU SHOTS & INFO
RELIABLE PLAZA – SATURDAY, NOVEMBER 10
10 a.m. – 1 p.m. | 1st Floor

HR 3RD THURSDAY ON NOVEMBER 15

*ADDITIONAL PRESENTATIONS MAY OCCUR AT QUARTERLY SAFETY MEETINGS.

2019 HIGHLIGHTS

- HRA Plan subsidy increase to $1,200
- Teladoc with $0 copay

Again at $0 copay, Teladoc offers members the ability to consult with US board-certified family practitioners, pediatricians, and internists to diagnose, recommend treatment, and write short-term (non-DEA prescriptions) when necessary.

REVIEW YOUR OPTIONS WITH ALEX!

ALEX® walks you through the process of picking your best benefits and provides easy-to-understand explanations for any questions you might have along the way.

Prepare to make the best benefits decisions with ALEX at **https://www.myalex.com/ouc/2019**.

ENROLL OR MAKE YOUR CHANGES ONLINE

You can make enrollment changes and/or elections between Monday, October 29 and Friday, November 16.

Employee Self-Service (ESS) is your online tool to make health and vision insurance changes and enroll/re-enroll in 2019 Flexible Spending Account (FSA) health care and/or dependent care account. Access ESS from work/VPN (**http://enterpriseone/**) or home (**https://ess.ouc.com**). For assistance logging in, please contact IT Support Center at 407.434.5500 or ext. 20010.

Go to the Employee Self Service tab and look for "My OPEN ENROLLMENT" column. Then click on "Begin Your Enrollment." You can also quickly access ALEX (**https://www.myalex.com/ouc/2019**) in ESS.

EMPLOYEE SELF SERVICE (ESS) allows you to:

- View your current benefits
- Calculate your retirement benefit
- Update your address and phone number
- Update your emergency contacts
- Update your beneficiaries
- Make changes if you have a life event
- View your pay stub
- Update your direct deposit
- View your paid time off balances
- Update your W4
- Change your deferred compensation (Nationwide or Voya) contribution

2019 EMPLOYEE RATES

OUC is proud to offer competitive benefits to our employees and retirees. To assist employees with costs in 2019, OUC will be responsible for the largest share, but there will be a small increase in premiums for dependents, which we believe are offset by significant enhancements to benefits.

THE FOLLOWING WILL TAKE EFFECT JANUARY 1, 2019:

2019 EMPLOYEE Weekly Medical, Prescription and Dental Insurance Premiums*

Medical, Dental & Prescription Options	Core Plan ($1,000 Deductible)	Health Reimbursement (HRA) Plan ($3,000 Deductible)	Premium Plan ($300 Deductible)
Employee	$ 0.00	$ 0.00	$ 23.31
Employee + one Dependent	$ 65.99	$ 42.93	$ 111.62
Employee + Family	$ 129.18	$ 84.05	$ 196.57

2019 EMPLOYEE Weekly Aetna Vision Preferred Eyewear Insurance Premiums*	
Employee	$ 1.06
Employee + one Dependent	$ 2.02
Employee + Family	$ 2.96

**This coverage is a pre-tax plan and is subject to IRS rules and qualifying status change.*

OUC PAYS THE FOLLOWING
2019 OUC Monthly Group Medical, Prescription and Dental Insurance Premiums

2019 Medical, Dental & Prescription Options	Core Plan ($1,000 Deductible)	Health Reimbursement (HRA) Plan ($3,000 Deductible)**	Premium Plan ($300 Deductible)
Employee	$ 845.81	$ 742.39	$ 845.81
Employee + one Dependent	$1,376.90	$1,273.49	$1,376.90
Employee + Family	$1,885.39	$1,781.98	$1,885.39

***Plus the $1,200 HRA Contribution*

Health Benefits Choices .... At a Glance

Choose your plan based on your needs!

Medical, Prescription and Dental Plan Design

2019 Medical & Prescription Options (In-Network Only)	Core Plan ($1,000 Deductible)	Health Reimbursement (HRA) Plan ($3,000 Deductible)	Premium Plan ($300 Deductible)
Routine Adult Physical	100%	100%	100%
Routine Well Child	100%	100%	100%
Preventive Women	100%	100%	100%
Routine Eye Exam	100%	100%	100%
Teladoc	100%	100%	100%
Primary Care Office Visit	$25 co-pay	$50 co-pay	$20 co-pay
Specialist Office Visit	$45 co-pay	$65 co-pay	$35 co-pay
Urgent Care, Guidewell	$45 co-pay	$65 co-pay	$35 co-pay
Convenience Clinics (Take Care Clinic, Minute Clinic)	$25 co-pay	$50 co-pay	$20 co-pay
Diagnostic/Lab & X-ray	100%; deductible waived	100%; deductible waived	100%; deductible waived
Outpatient Surgery (surgery and facility)	80%; after deductible	80%; after deductible	80%; after deductible
Emergency Room	80%; after deductible	80%; after deductible	80%; after deductible
Annual Deductible	$1,000 Individual $3,000 Family	$3,000 Individual $9,000 Family	$300 Individual $900 Family
Combined Medical and Prescription Calendar Year Out-of-Pocket Payment Limit (Individual/Family)	$6,600/$13,200* (Individual/Family)	$6,600/$13,200* (Individual/Family)	$4,500/$9,000* (Individual/Family)
Diagnostic X-ray Complex Imaging Services (MRI & CT Scan)	80% after deductible – Precertification required	80% after deductible – Precertification required	80% after deductible – Precertification required
Inpatient Hospital	80% after deductible	80% after deductible	80% after deductible
Non-Emergency Care in Emergency Room	50% after deductible	50% after deductible	50% after deductible
Durable Medical Equipment	80% after deductible	80% after deductible	80% after deductible
Aetna Specialty Pharmacy	80%; deductible waived max. co-insurance $200	80%; deductible waived max. co-insurance $200	80%; deductible waived max. co-insurance $200
Aetna Prescription Drugs	Retail: $10/$50/$75 Mail Order: $20/$100/$150	Retail: $10/$50/$75 Mail Order: $20/$100/$150	Retail: $10/$30/$45 Mail Order: $20/$60/$90
Annual Health Reimbursement Account	n/a	$1,200	n/a

* Only in-network medical deductible, medical and prescription copayments and coinsurance expenses will apply towards the calendar year out-of-pocket payment limit.

AETNA PPO DENTAL PLAN

BENEFITS	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
Deductible (Individual/Family)	$50 / $100	$50 / $100
Preventive Services	100%	100%
Basic Services	90%	80%
Major Services	60%	50%
Calendar Year Max	$1,500	$1,500
Orthodontia Lifetime Maximum	60% up to $1,500	60% up to $1,500

FLEXIBLE SPENDING ACCOUNT (FSA)

The IRS has not released the 2019 Flexible Spending Account limits. If the IRS increases the limit for 2019, OUC will increase the limit as well. At this time OUC will use:

FSA Health Care $2,650.
FSA Dependent Care $5,000.

FSA is an annual enrollment process, go to your ESS to enroll or re-enroll.

OUC will again add the benefit of allowing employees to carryover up to $500 of unused 2018 funds from your health care FSA to your 2019 FSA. You can use this roll over amount to request for 2019 eligible claims payment. Any unused balance greater than the $500 carryover limit is forfeited after March 31, 2018. This carryover option will again happen for the 2019 health care FSA to the 2020 health care FSA. Employees will still need to be mindful of their allocation and ensure they are saving appropriately. The carryover does not apply to Dependent Care FSA.

2018 FSA DEADLINE REMINDER: December 31, 2018: **Deadline to utilize your account balance**

March 31, 2019: **Deadline to file 2018 claims**

WELLBEING: POWER TO THRIVE

THE WELLBEING TEAM IS EXCITED TO ANNOUNCE A NEW WELLBEING YEAR!

OUC is proud to offer its employees, retirees, and dependents a comprehensive and award winning workplace wellness program! Eligible members may register at **oucwellbeing.com** and begin earning incentives immediately. Visit the website and click REGISTER in the upper right corner of the screen to begin.

MORE WATTS EARN BRIGHTER REWARDS

How bright can you be? Your Watts will accumulate throughout the year to determine your annual incentive level. Rewards will be distributed at the end of the Wellbeing Year.

INCENTIVE LEVELS				
LEVEL	GLOWING	BRIGHT	BEAMING	RADIANT
Annual Number of Watts	75 Watts	150 Watts	225 Watts	300 Watts

INCENTIVE PROGRAM: 9/1/2018 through 8/31/2019

WHO IS ELIGIBLE TO PARTICIPATE? OUC employees, spouses, dependents and retirees on OUC's medical plan who create an account at OUCWellbeing.com are eligible.

INCENTIVE AMOUNT AND DISTRIBUTION DATE: Maximum $300 per participant. Payments will be made at the end of the incentive program period. Participants will receive a reward for reaching each incentive level. Participants must complete a Health Risk Assessment (HRA) and biometric screening to receive an incentive.

The OUC Wellbeing structure is a participation-based program. Start participating, start earning! All questions can be directed to the OUC Wellbeing team at **wellbeing@ouc.com**.

STAY ON THE LOOKOUT FOR THE ICONS BELOW TO START EARNING WATTS!

PREVENTIVE CHALLENGES EDUCATION COMMUNITY PHYSICAL JOURNEY

Visit The Wellbeing site (oucwellbeing.com) for upcoming 2019 events.

EYEWEAR MATERIALS (FRAMES AND LENSES) COVERAGE

This coverage is a great way to save money on contact lenses, frames, lenses and even LASIK surgery. The Aetna network includes chains such as Pearl Vision, LensCrafters, JCPenney Optical, Target Optical and Sears Optical, along with many other neighborhood eye doctors and optical shops. Discover what the Plan covers and find an eye care provider by visiting **www.aetnavision.com**. The following is a short summary of coverage (for more information visit **www.ouc.com/enrollment**):

Eyeglass Lenses/Lens Options	In Network
Use your Lens coverage once every calendar year to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses.	
Single, Bifocal, Trifocal, & Lenticular Vision lenses	$25 Copay
Standard Progressive Vision lenses	$90 Copay

Contact Lenses	In Network
Use your Contact Lens coverage once every calendar year to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses.	
Conventional contact lenses	$130 Allowance, Additional 20% off balance over the Allowance

Frames	In Network
Use your Frame coverage once every 2 calendar years.	
Any Frame, including frame for prescription sunglasses	$130 Allowance, Additional 20% off balance over the Allowance

ALLSTATE: VOLUNTARY SUPPLEMENTAL INSURANCE

The following Allstate Supplemental Insurance Plans are being offered:
• Group Accident • Group Hospital • Group Critical Illness (now includes Cancer)

Visit the OUC Open Enrollment website (www.ouc.com/enrollment) to view the Allstate brochures and weekly rates. You may enroll/add/drop/cancel by contacting All-state at 877.750.0468 prior to **Friday, November 16**.

Reminder: OUC's supplemental insurance plans (Allstate & Aflac) will be paid on a post-tax basis. Employee may cancel/drop dependent coverage during the year. Life Event is still required to add coverage.

RELIANCE VOLUNTARY TERM LIFE INSURANCE

Additional information, refer to the Reliance Voluntary Group Term Reliance Brochure in the Open Enrollment site.	
Employee Voluntary Term Life Insurance Benefit Amount	During open enrollment, employees may be eligible for a guaranteed issue of $10,000 coverage per year with a maximum cumulative amount of $100,000 without medical evidence as long as you are under the age of 60 and have not been previously declined for insurance coverage by Reliance Standard, terminated coverage or withdrawn an application. Any amount over $10,000 evidence of insurability is required.
Dependent Voluntary Term Life Insurance Benefit Amount	**Spouse:** Anytime during the year, you may elect spouse insurance from a minimum of $10,000 up to a maximum of $500,000. Evidence of insurability is required.
	Unmarried Dependent Child: $5,000 or $10,000 (age 6 months to 26 years old), $2,000 (age 14 days to 6 months) **Note:** In order to insure a dependent child(ren), you or your spouse must have current coverage.

REMINDER: If your dependent is no longer eligible, it is your responsibility to contact HR/Benefits to cancel coverage. You can cancel and/or make changes to this policy at any time during the Plan Year.

2019 LIMIT FOR NATIONWIDE & VOYA DEFERRED COMPENSATION 457 (B) PLANS

Currently, the elective deferral (contribution) annual limit is $18,500. The IRS has not posted the amount for 2019 calendar year. If you would like to change your contribution, go to your ESS. Current contributions will continue into 2019 unless a change is requested. Don't forget your Roth option which allows for post-tax contributions, but earnings are not taxable if held for at least five years.

REMINDER: The deferred compensation program allows employees age 50+ a catch-up contribution of an additional $6,000 annually and Special 457(b) for participants up to a total of $37,000 annually. For more details, contact Nationwide or Voya.

LIFE EVENT / STATUS CHANGE

Choose your options carefully. The election you make for 2019 will be for the entire year. IRS rules will not allow you to add or drop your dependent(s) during the Plan Year unless you experience a "qualifying life event/status change." You are responsible to inform HR/Benefits within 31 days of the qualifying life event. The qualifying life event/status changes are:

- Marriage
- Divorce
- Birth or adoption of a child or change in custody of your child
- Medicare eligible
- Termination of employment of your eligible dependent(s) that results in a change of benefits
- Change in employment status that results in a change to benefits
- Significant change in coverage due to your spouse's health care coverage attributable to your spouse's employment
- Loss or gain of dependent eligibility
- Death of spouse or other dependent

DEPENDENT ELIGIBILITY & VERIFICATION

Please review the eligible dependent definition to ensure that the dependent(s) you wish to cover will continue to meet 2019 eligibility requirements. If you are eligible and you elect a health plan (medical, prescription and dental) and/or vision for yourself, you may elect to cover your eligible dependents.

Eligible dependents include:

- Your legal spouse (opposite-sex or same-sex)
- Children under age 26 who:
  - ✓ Are your biological children; or
  - ✓ Are your stepchildren; or
  - ✓ Are your legally adopted children; or
  - ✓ Are your foster children; or
  - ✓ Is a child for whom the employee/retiree is the court-ordered legal guardian; or
  - ✓ Live with you and whose parent is your child and the parent is covered as a dependent under the plan.

Your unmarried children age 26 or older:

- Your unmarried child(ren) age 26 or older if fully handicapped:
  - ✓ He or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
  - ✓ He or she depends on you for support, maintenance and must live with you.

You are required to provide documentation for their eligible dependents. If employee/retiree fails to provide requested documentation, your dependent may lose coverage. If your dependent is ineligible for any OUC benefits, it is your responsibility to contact HR/Benefits and/or appropriate provider to remove coverage.

HEALTH CARE NOTICES

- Summary of Material Modification
- Women's Health and Cancer Rights Act Notice
- Statement of Rights under the Newborns' and Mothers' Health Protection Act
- Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law
- Creditable Coverage Notice About Your Prescription Drug Coverage and Medicare
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- Wellness Program - "Reasonable Alternative Standard" Disclaimer

SUMMARY OF MATERIAL MODIFICATION (SMM)

Orlando Utilities Commission Effective January 1, 2019

This Summary of Material Modification (SMM) provides a recap of 2019 changes to the OUC Flexible Benefits (Medical) Plan and other pertinent notifications. This document should be retained with your other benefits information. The summary plan descriptions are being revised to reflect these changes and will be posted on the OUCWeb/Forms & Documents/Human Resources.

BENEFIT	CORE PLAN	HRA PLAN	PREMIUM PLAN
Health Reimbursement Account (HRA)	N/A	2018: $1,150 2019: $1,200	N/A

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

all stages of reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, **http://www.cms.gov/home/regsguidance.asp**, and this U.S. Department of Labor website, **http://www.dol.gov/ebsa/consumer_info_health.html**.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

CONTINUATION OF COVERAGE DURING AN APPROVED LEAVE OF ABSENCE GRANTED TO COMPLY WITH FEDERAL LAW

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request FMLA leave, you must agree to make any contributions required by your Employer to continue coverage.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

The date you are required to make any contribution and you fail to do so.

The date your Employer determines your approved FMLA leave is terminated.

The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date.

If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

CREDITABLE COVERAGE NOTICE ABOUT YOUR OUC PRESCRIPTION DRUG COVERAGE AND MEDICARE

Notice for employees, retirees, eligible dependents and COBRA participants whom may be approaching 65 years of age or has just become disabled and will be eligible for Medicare enrollment.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with OUC 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.
- OUC has determined that the prescription drug coverage offered by the OUC Group Health 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.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current OUC coverage will not be affected. If you elect Part D, this plan will coordinate with Part D coverage. To understand how Medicare will coordinate, review the Medicare's "Who Pays First" guide (http://www.medicare.gov/publications/ pubs/pdf/02179.pdf). See CMS Disclosure of Creditable Coverage To Medicare Part D Guidance (**http://www.cms.hhs.gov/creditablecoverage**), which outlines the prescription drug plan that Medicare eligible individuals may have available when they become eligible for Medicare Part D.

OUC PRESCRIPTION PLAN CO-PAYS

Prescription Plan Options	30-Day Supply – Retail Pharmacy Generic/Formulary/Non-Formulary	90-Day Supply – Home Delivery Generic/Formulary/Non-Formulary	Specialty Pharmacy
Core Plan	$10/$50/$75	$20/$100/$150	20% co-insurance, max co-insurance $200/script
HRA Plan	$10/$50/$75	$20/$100/$150	20% co-insurance, max co-insurance $200/script
Premium Plan	$10/$30/$45	$20/$60/$90	20% co-insurance, max co-insurance $200/script

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 coverage with OUC 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 cover- age. 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 person listed below 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 OUC 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).

Contact-Position/Office: *Wendy Reynolds, Manager, Benefits & HRIS* *Phone Number: 407.434.2284*
Name of Entity/Sender & Address: *Orlando Utilities Commission, 100 W Anderson Street, Orlando, Florida 32801* *10/1/2018*

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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).

You may be eligible for assistance paying your employer health plan premiums. For more information on eligibility contact:

FLORIDA - MEDICAID

Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

To see if any other states premium assistance program since July 31, 2018 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)

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. 61565

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.

WELLNESS PROGRAM "REASONABLE ALTERNATIVE STANDARD" DISCLAIMER

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you may be unable to meet a standard for a reward under this wellness program, you may qualify for an opportunity to earn the same reward through different means. Contact **Wellbeing@ouc.com** or call 407-434-2003 to find a solution that will work for you.

NOTICE REGARDING WELLNESS PROGRAM

The Wellbeing Program is a voluntary wellness program available to all employees, spouses, and dependents (ages 18 - 26) on the OUC medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs seeking to improve population health and prevent disease. This includes the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment (HRA) which asks a series of questions about your health-related activities, behaviors, and medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for total cholesterol, HDL, Triglycerides, LDL, and glucose. You are not required to complete the HRA or to participate in the blood test or other medical examinations. Although you are not required to complete the HRA or participate in the biometric screening, completion of these two activities will earn your entry into the incentive structure. It's important to understand that without those two items, you will earn Watts, but no monetary value for your participation. Additional incentives may be available for employees who participate in health solutions or behavior change programs. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Kate Powers at 407-434-2003. The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as the YMCA's Diabetes Prevention Program, or Florida Hospital's Thrive or New Day, New Weigh Program. You also are encouraged to share results with your primary care physician.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and OUC may use aggregate information to design a program based on identified health risks in the workplace, OUC Wellbeing will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation, or as expressly permitted by law. Medical information that personally identifies you and is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. Any individual(s) who receive your personally identifiable health information will be vetted and used only as a way to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Kate Powers at 407-434-2003.

KEY CONTACTS FOR OUC HR/BENEFITS

Human Resources/Benefits	407.434.2284 or ext. 42284
100 W Anderson St, Orlando, FL 32801	**benefits@ouc.com**
Human Resources/Benefits	Fax 407.434.2211 or ext. 42211
OUC Employees Self Service (ESS)	**https://ess.ouc.com**
OUC Wellbeing	**http://oucwellbeing.com - Wellbeing@ouc.com**
OUC Open Enrollment Site	**www.ouc.com/enrollment**

CONTACT LIST OF BENEFIT PROVIDERS

Aetna Medical Choice POS II Aetna Dental – PPO Aetna Member Site	855.281.8858 877.238.6200 **www.aetna.com**
Aetna Teladoc	855.Teladoc (855.835.2368) **www.teladoc.com/aetna**
Aetna Pharmacy Management	888.792.3862
Aetna Prescription Home Delivery (mail-order)	888.792.3862
Aetna Specialty Pharmacy (ASRx)	866.782.2779 **www.AetnaSpecialtyPharmacy.com**
Aetna Vision Preferred Plan	877.973.3238 **www.aetnavision.com**
Aetna/PayFlex Flexible Spending Account (FSA)	888.238.6226 **www.payflex.com**
Aetna Hearing Discount Program	888.432.7464
P & A Group Health Reimbursement Account (HRA)	800.688.2611 **www.padmin.com**
Allstate Supplemental Benefits	800.521.3535 **www.allstateatwork.com/mybenefits**
Aflac Supplemental Benefits	800.433.3036 **www.aflacgroupinsurance.com**
Aetna Resources for Living Employee Assistance Program (EAP) **Log On:** ouc **Password:** ouc	800.272.7252 **www.resourcesforliving.com**
Matrix (FMLA and/or Short-Term Disability)	866.533.3438 **www.matrixeservices.com**
Reliance Voluntary Term Life (VG001624)	800.644.1103
Fidelity Investment Defined Contribution (DC) Plan or Supplemental Retirement Plan	800.430.2363 **www.fidelity.com/atwork**
Nationwide Retirement Solution	407.446.8669 - Roberto Rodriguez **rodrr1@nationwide.com** I **www.nrsforu.com**
Voya Financial Partners	407.252.3151 or 1.800.215.1918 **Pat Tierney** - **pat@gaboragency.com** **https://voyaretirement.voya.com**
OUC Micro Computer Support	407.434.5500 or ext. 20010 **itsupport@ouc.com**

REMINDERS!

- If your dependent is ineligible for any OUC benefits, it is your responsibility to contact HR/Benefits and/or appropriate provider to remove them from the plan.
- Create your login with your Aetna Member site (**www.aetna.com**). Your member site puts all of your Health/Vision Plan information and cost-saving tools in one place.
- You have 2 years from your date of hire to enroll in the optional 1-2% pre-tax contribution to your OUC Fidelity Defined Contribution 401(a) Pension Plan. After 2 years, the pre-tax contribution option expires. You are always eligible to enroll in the post-tax contribution option.
- **2018 Flexible Spending Account Deadlines:**
  ◊ **December 31, 2018:** Deadline to utilize your account balance ◊ **March 31, 2019:** Deadline to file 2018 claims.
- You should review all enrollment materials and visit the OUC Open Enrollment Website (**https://www.ouc.com/enrollment**) and ALEX (**https://www.myalex.com/ouc/2019**) in order to make the most informed decision.

ORLANDO UTILITIES COMMISSION
HUMAN RESOURCES/BENEFITS
100 West Anderson Street
Orlando, Florida 32801
www.ouc.com/enrollment
Phone: 407-434-2284 or Email: benefits@ouc.com