Calhoun County

Benefit Enrollment Guide

Effective 1/1/2020

JUST RIGHT FOR YOU

Finding the Health Plan that Fits

BETTER CARE

Doesn't Have to be Expensive

Table of Contents

This Benefit Guide contains only a brief summary of your benefits. We have tried to ensure the accuracy of these materials, but if there is any discrepancy between the benefits discussed in these materials and the official plan documents, the official plan documents will rule. Actual benefits will be paid in accordance with the carrier contracts and any amendments to those contracts in place at the time of the claim. Please refer to the carrier booklets for details regarding your coverage, including benefit limitations and exclusions. Calhoun County reserves the right to amend, modify or terminate any plan at any time and in any manner. In addition, please be aware that the information contained in these materials is based on our current understanding of the federal health care reform legislation, signed into law in March 2010. Our interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. government. Therefore, we defer to the actual carrier contracts, processes, and the law itself as the governing documents.

Your 2020 Benefit Enrollment Guide

Your annual employee benefits open enrollment period is here. Open enrollment is the one time a year you have the opportunity to change your benefit elections outside of a life changing event. During this time, you will have the chance to add, delete, or change your benefits as well as add or delete your spouse or children from the plan.

Benefits are an important part of your total compensation and they provide valuable protection for you and your family. Please take the time to review all of the open enrollment materials provided to you. Should you have any questions, contact Human Resources at extension 0980. Following are a few highlights:

What's Staying the Same on January 1, 2020?

- **CareHere:** The CareHere Health & Wellness Center benefit continues to be available to employees on the medical plans. All preventative care office visits and preventative prescriptions continue to be free of charge. The mail order service will also continue to be available. Employees opting-out of the medical plans can still access the CareHere Connections on-line portal and receive a free Health Risk Assessment.

- **Ancillary Benefits:** There are no changes to the core Dental, Vision, Life, and Disability plan designs.

- **Dental Buy-Up Option:** The Dental Buy-Up option through Delta Dental will continue for 2020. Please review the Dental section of this Enrollment Guide for more information.

- **Voluntary Benefits:** Cigna will continue to be the provider for Voluntary Life, AD&D, LTD, Accident and/or Critical Illness coverage. For the Accident & Critical illness plans, Cigna is also allowing employees to enroll without answering medical questions during the open enrollment period.

- **Opt-Out Incentive:** The incentive for opting-out of the medical plans is $100 per pay period for full-time employees.

- **Medical Plans:** The Community Blue (CB3) Flexible Blue (FB3) and the Simply Blue (SB3) plans will still be available in 2020. Refer to pages 6 and 7 for plan design features.

- **County Health Savings Account (HSA) Contributions:** For the Flexible Blue (FB3) plan, the employer HSA contribution will be $750 for an individual and $1,500 family. For the Simply Blue (SB3) plan, the employer HSA contribution will be $1,500 for an individual and $3,000 family.

- **Flexible Spending Accounts (FSA):** For those on the Community Blue (CB3) plan, both the medical and the dependent care FSA plans will continue to be available; however, the employee can now contribute up to $2,650 towards the FSA medical

- **CareHere & HSA:** For those with a HSA Plan, the IRS requires that the County charge fair market value for non-preventative services. For 2020, the cost remains at $50 for office visits and $5 for prescriptions. All preventative office visits and prescriptions continue to be completely free to employees on all three medical plans.

What's Changing on January 1, 2020?

- **Employee HSA Contributions:** The maximum amount that you can contribute to a Health Savings Account has increased from $3,500 to $3,550 as a single and from $7,000 to $7,100 as a family. The employer contribution to your HSA must be included towards the maximum amounts allowed. If you are age 55-64, you can also contribute an additional $1,000.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 22 and 23 for more details.

Making Mid-Year Changes

The benefit elections you make during the annual open enrollment period are effective throughout the next plan year (January 1 through December 31) – so choose wisely! Each fall, you make new selections for the next plan year. You have the flexibility to re-evaluate your benefit needs each year, allowing you to change your coverage as you wish.

Between annual enrollments, you can change your benefit coverage decisions only if you have a qualified change in status. Qualified change in status events include:

- Birth, placement for adoption or adoption of a child, or being subject to a Qualified Medical Child Support Order, which orders you to provide medical coverage for a child
- Marriage, legal separation, annulment, or divorce
- Death of a spouse or covered dependent
- Change in the job status of employee or spouse
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan
- Spouse's loss or gain of equivalent coverage through his/her employer

Under IRS regulations, the change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. Or if your spouse's employment terminates and s/he loses coverage through their employer, you may add your spouse to your coverage. However, the change must be requested within 31 days of the event. If you do not notify Human Resources within 31 days, you must wait until the next annual benefit enrollment period to make a change.

Children's Health Insurance Program Reauthorization Act of 2009 adds the following two special enrollment opportunities.

- The employee or dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

It is your responsibility to notify Human Resources within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined.

Eligible Dependents

You may enroll the following dependents in the medical, prescription, dental, and vision plans:

Eligible SPOUSE:

- Your legally married spouse.

Eligible CHILDREN:

- Medical, Prescription, Vision: You or your spouse's natural child, stepchild, legally adopted child, a child placed with you for adoption, a child for whom you are required to provide health insurance by a Qualified Medical Child Support Order, or a child for whom you or your spouse have legal guardianship. Covered through the end of the year in which they turn 26.
- Dental: Dependent children to the end of the calendar year in which they turn 19 and dependent unmarried children to the end of the calendar year in which they turn 25, provided they are a full time student or IRS dependent.

Eligible DISABLED DEPENDENTS:

- A dependent 26 years of age or older who depends on you or your spouse for support as they are unable to support themselves due to a mental or physical condition. The child must depend on you or your spouse for financial support. The disability must have occurred by the end of the year in which the dependent reaches the limiting age.

Medical Plan Options

Medical coverage is one of the most important benefits employees choose. Calhoun County understands that each employee and family is unique and as a result, different plan options are provided through Blue Cross Blue Shield of Michigan (BCBSM) to help meet varying needs.

1) Community Blue (CB3)

Community Blue is a traditional PPO insurance plan that operates with deductibles, copays and co-insurance for services.

- PPO stands for "Preferred Provider Organization". Quite simply, a PPO is a network of doctors and hospitals that work under one umbrella to provide medical services at a discount to its membership. BCBSM's PPO is one of the largest in the country. To see what providers are in the BCBSM PPO network, refer to the BCBSM Website at www.bcbsm.com.

- Prescription drugs are covered through Express Scripts with copays of $10 generic/$20 brand/$40 non-formulary.

2) Flexible Blue (FB3) with Health Savings Account

Flexible Blue is also part of the BCBS PPO network. It is a Consumer Driven Heath Plan that has a higher deductible than a traditional plan, but is paired with a Health Savings Account (HSA) that you get to manage based on your individual or family needs:

- The HSA is an interest bearing, tax-favored account that is owned by you and is portable from employer to employer. It allows you to save money through pre-tax payroll deductions to help you pay for your out-of-pocket medical expenses, such as the deductible and coinsurance. The deductible for this plan is $2,000 for an individual and $4,000 for 2-person or family.

- **Calhoun County will also contribute $750 per single and $1,500 per 2-person or family annually into your HSA for this plan.** This, in turn, will also reduce your annual deductible. The money will roll over each year, and you may have investment options depending on the size of your account. The HSA offers a way to begin saving for current and future medical expenses on a tax-free basis.

- Prescription drugs are covered by Express Scripts and are subject to the deductible and coinsurance under this plan.

3) Simply Blue (SB3) with Health Savings Account

Simply Blue plan is also part of the BCBS PPO network. It is a Consumer Driven Heath Plan that has a higher deductible than a traditional plan, but is paired with a Health Savings Account (HSA) that you get to manage based on your individual or family needs:

- The HSA is an interest bearing, tax-favored account that is owned by you and is portable from employer to employer. It allows you to save money through pre-tax payroll deductions to help you pay for your out-of-pocket medical expenses, such as the deductible and coinsurance. The deductible for this plan is $3,500 for an individual and $7,000 for 2-person or family.

- **Calhoun County will also continue to contribute $1,500 per single and $3,000 per 2-person or family annually into your HSA for this plan.** This, in turn, will also reduce your annual deductible. The money will roll over each year, and you may have investment options depending on the size of your account. The HSA offers a way to begin saving for current and future medical expenses on a tax-free basis.

- Prescription drugs are covered by Express Scripts and are subject to the deductible and coinsurance under this plan.

It is important to plan carefully when choosing which Medical Plan option is right for you.

Medical Plan Comparison

	Community Blue (CB3)	Flexible Blue (FB3)	Simply Blue (SB3)
Medical Coverage - BCBS	In-Network	In-Network	In-Network
Employer HSA Contribution	N/A	$750 Single $1,500 Family	$1,500 Single $3,000 Family
Deductible	$250 Single $500 Family*	$2,000 Single $4,000 Family	$3,500 Single $7,000Family
Coinsurance	80% after deductible	80% after deductible	80% after deductible
Coinsurance Maximum ***("In-Network Maximum")***	$1,000 Single $2,000 Family	Not Applicable	Not Applicable
Preventive Care	100%	100%	100%
Office Visit Copay	$25	80% after deductible	80% after deductible
Emergency Room Copay	$150	80% after deductible	80% after deductible
ACA Out-of-Pocket Limit ***(includes deductible, coinsurance, copays - office, ER, & RX)***	$3,000 Single $6,000 Family**	$3,000 Single $6,000 Family	$5,000 Single $10,000 Family
Prescription Drug Coverage – Express Scripts			
Generic	$10 Copay	80% after deductible	80% after deductible
Brand Formulary	$20 Copay	80% after deductible	80% after deductible
Brand Non-Formulary	$40 Copay	80% after deductible	80% after deductible

* If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

** If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

How Do the Plans Compare?

Low Utilizer

(Assumes: Single, Full-time Employee Using In-Network Services)

	Community Blue (CB3)	Flexible Blue (FB3 w-HSA)	Simply Blue (SB3 w-HSA)
Employer Contribution	N/A	$750	$1,500
Deductible *(your portion)*	Not Utilized	$470	$470
Coinsurance Maximum *(your portion)*	$1,000	N/A	N/A
Copays Office Visits - 3 ER Visit - 0 Brand Rx* - 2	 $25 x 3 = $75 $100 x 0 = $0 $40 x 2 = $80	 $120 x 3 = $360 $500 x 0 = $0 $55 x 2 = $110	 $120 x 3 = $360 $100 x 0 = $0 $55 x 2 = $110
Annual EE Premium Contribution	$66.37 x 26 = $1,725.88	$36.96 x 26 = $960.96	$29.00 x 26 = $754.00
Total Out-Of-Pocket Cost	**$1,880.88**	**$960.96**	**$754.00**

High Utilizer

(Assumes: Single, Full-time Employee Using In-Network Services)

	Community Blue (CB3)	Flexible Blue (FB3 w-HSA)	Simply Blue (SB3 w-HSA)
Employer Contribution	N/A	$750	$1,500
Deductible *(your portion)*	Not Utilized	$2,000	$3,260
Coinsurance Maximum *(your portion)*	$1,000	N/A	N/A
Copays/Deductible Cost Office Visits - 12 ER Visit - 1 Brand Rx* - 24	 $25 x 12 = $300 $150 x 1 = $150 $20 x 24 = $480	 $120 x 12 = $1,440 $500 x 1 = $500 $55 x 24 = $1,320 (deductible met)	 $120 x 12 = $1,440 $500 x 1 = $500 $55 x 24 = $1,320
Annual EE Premium Contribution	$66.38 x 26 = $1,725.88	$36.96 x 26 = $960.96	$29.00 x 26 = $754.00
Total Out-Of-Pocket Cost	**$2,655.88**	**$2,462.96**	**$2,514.00**

**Assuming $120 per office visit, $500 per ER visit, $55 per brand RX*

Employees that enroll in the County medical plans will automatically be eligible to participate in all CareHere Health & Wellness Center benefits for 2020. The CareHere Health & Wellness Center provides medical plan participants with a primary health care option that is high-quality, convenient, inexpensive, and confidential.

FREE Preventative Care **FREE Preventative Medications** **FREE Health Coaching**

FREE Health Risk Assessment **FREE Lab Work**

High QUALITY Services **Easy Mail Order Options**

24/7 NURSE HOTLINE **EASY Scheduling, On-line or Phone**

No Long Wait (average 5 minutes) **On-Line Services – CareHere Connect**

CONVENIENT Appointment Times for Employees, Including EVENING & WEEKEND HOURS

Note: Employees on the Flexible Blue or Simply Blue plans that have a HSA, receive FREE preventative services and medications through CareHere. However, the IRS requires that a nominal contribution or "fair market value" be charged for non-preventative items. For 2020, the fees are $50 for non-preventative services, and $5 for non-preventative medications.

For employees that already have a primary care physician, please remember you can still use the center for lab work, preventative meds, free coaching (registered dietitian, smoking cessation, behavioral health, diabetes, etc…), as well as all of the CareHere Connect on-line tools.

Non-medical plan participants are also eligible to access the CareHere Connect on-line portal and participate in the annual Health Risk Assessment free of charge.

Register with CareHere
on-line at www.CareHere.com or by calling 877.423.1330

Identify yourself as:

Calhoun County CB3 Access Code: CCTY1
Calhoun County HSA (FB3 & SB3 Plans) Access Code: CCHSA
Calhoun County Opt Out Access Code: CCOPT

2020 Benefit Costs and Cost Sharing

As you may know, the Publicly Funded Health Insurance Act (Public Act 152) was approved by the Governor on September 24, 2011. This Act limits the amount public employers, including the County, can contribute toward employee health care plans. For 2020, Calhoun County is compliant with the hard-cap limits prescribed under PA 152.

The total costs (illustrated rates) of the health care plans for 2020 are provided below, along with the Employer portion of the rates. The Employee rates associated with each plan will appear on the E-Benefits on-line portal when you access the system to make your open enrollment elections. The Employer rates you see displayed on the E-Benefits system will be higher than the rates below because they include additional costs for budgeting purposes, such as the Wellness Program, HelpNet, Flex Spending Administration, CareHere, etc…

2020 Total Monthly Costs and Cost Sharing					
Plan	**Option**	**2020 Total Monthly Costs**	**Employer Monthly Cost**	**Employee Monthly Cost**	**Employee Cost Per Pay Period**
Community Blue (CB3): The Employer pays 80% of the Standard Plan and the Employee Pays 20%					
Standard Plan	Single	$734.67	$587.74	$146.93	$67.81
	Dual	$1,469.32	$1,175.46	$293.86	$135.62
	Family	$2,005.63	$1,604.50	$401.13	$185.15
Flexible Blue (FB3): The Employer pays 86% of the FB3 Plan and the Employee Pays 14%					
Figures do not include HSA funding of $750 Single, $1,500 Family	Single	$584.30	$502.50	$81.80	$37.77
	Dual	$1,168.62	$1,005.01	$163.61	$75.50
	Family	$1,595.16	$1,371.84	$223.32	$103.08
Simply Blue (SB3): The Employer pays 88% of the FB3 Plan and the Employee Pays 12%					
Figures do not include HSA funding of $1,500 Single, $3,000 Family	Single	$535.15	$470.93	$64.22	$29.65
	Dual	$1,070.31	$941.87	$128.44	$59.27
	Family	$1,460.98	$1,285.66	$175.32	$80.92

******Elected Officials must pay 20% on all plans.***

Dental Coverage

Delta Dental of Michigan continues to be the provider for 2020 and this benefit is provided by the County with no premium charge for you and your family for basic coverage. Calhoun County also offers a Buy-Up option, which provides coverage at a higher percentage, as well as a higher lifetime maximum for Orthodontia. You are responsible for the cost difference between the Core and Buy-Up plan if you chose to elect this benefit.

Under these plans, you are free to select any dentist; however, it would be most cost-effective to choose a dentist who participates in one of Delta Dental's two networks:

- **Delta PPO**
- **Delta Premier**

If you choose a **Delta Premier** dentist, the dentist has agreed to accept Delta Dental's fee schedule and file claims on your behalf.

If you choose a **Delta PPO** dentist, the dentist has agreed to discounted services. This is the lowest cost option.

To find a network dentist, go to www.deltadentalmi.com.

If you choose an out-of-network dentist, Delta will cover up to the usual and customary amount for the services provided. Your dentist may balance bill.

No matter which dentist you choose, the plan covers:

	Delta Dental Core	Delta Dental Buy-Up
Annual Deductible	None	None
Annual Maximum per person	$1,000 per person Classes II and III services combined*	$1,000 per person Classes II and III services combined*
Class I *Diagnostic and Preventive Services, Cleanings, Exams & Fluoride treatments*	Covered at 100%	Covered at 100%
Class II *Basic and Restorative Services, Oral Surgery, Fillings, Root Canals, Bridge and Denture Repair*	Covered at 50%	Covered at 80%
Class III *Prosthodontic Services, Bridges and Dentures*	Covered at 50%	Covered at 80%
Class IV *Orthodontia Services (up to age 19)*	Covered at 50%, ($1,000 Lifetime Maximum per dependent)	Covered at 50%, ($2,000 Lifetime Maximum per dependent)

Delta Dental Plan Limits	
Covered Services	**Benefit Frequency (Core and Buy-Up)**
Oral Exams	Twice per calendar year
Prophylaxes (cleanings)	Twice per calendar year
Fluoride Treatments	Once per calendar year (up to age 19)
Bitewing X-rays	Once per calendar year (under age 15); Once per two-year period (ages 15+)
Full Mouth X-rays	Once in any seven-year period

Vision Coverage

Vision coverage is provided by BCBSM through Vision Service Plan (VSP) using the VSP provider network. Your vision plan is designed to provide you with the highest level of benefit and the least amount of out-of-pocket costs when you choose a participating provider. Participating providers have signed agreements to accept the approved amount, less your copay, as payment in full for covered services.

Blue Vision-VSP		
	VSP Provider	**Non-Participating Provider**
Vision Examination (once per calendar year)	Covered 100% after $5 copay	Up to $35, less a $5 copay (member responsible for any difference)
Lenses and Standard Frames (once per calendar year)	Covered 100% after $10 copay for lenses and standard frames	Up to a predetermined amount for lenses and up to $45 for frames, less a $10 copay (member responsible for any difference)
Elective Contact Lenses (once per calendar year)	$130 Allowance for lenses and exam	$105 Allowance for lenses and exam
Please Note: Benefits are payable for either eyeglass lenses or contact lenses, but not both.		

Flexible Spending Accounts

Flexible Spending Accounts (FSA) are a great way to set aside pre-tax monies to fund eligible medical, dental and vision expenses. A complete list of qualified medical expenses can be found at the IRS website: www.irs.gov. Employees can also use FSA funds to pay for dependent care expenses such as day care. You can contribute the following:

Flexible Spending Account	Annual Contribution	
	Minimum	**Maximum**
Health Care Spending *(medical, dental, vision)*	$130	$2,650
Dependent Care	$130	$5,000*

**$2,550 if married and filing separately*

How Do You Save Money with a Flexible Spending Account?

	Without Flex	With Flex
Annual Salary	**$30,000**	**$30,000**
Health Care FSA	$0	$1,000
Dependent Care FSA	$0	$5,000
Taxable Salary (W-2 Income)	**$30,000**	**$24,000**
Federal Tax (15%)	$4,500	$3,600
State Tax (4%)	$1,200	$960
Social Security Tax (7.65%)	$2,295	$1,836
Total Annual Taxes	**$7,995**	**$6,396**
After-tax Out-of-Pocket Medical	$1,000	$0
After-tax Dependent Care	$5,000	$0
Annual Take-Home Pay	**$16,005**	**$17,604**
Annual Tax Savings with Flex		**$1,599**

This employee saved approximately $1,599 annually by participating in the FSA Plan!

Other Benefits

Short Term Disability (STD), Basic Life and AD&D Plans

Calhoun County provides Short Term Disability and Basic Life and AD&D benefits at no cost to you. Eligibility and coverage levels for these benefits vary. Please refer to the County policy or your union contract for details. Life benefits reduce for employees age 65 and older.

Optional Life and AD&D Plans

Choosing the right amount of Life and Accidental Death & Dismemberment Insurance is something only you and your family can decide based on your needs. The Optional Life and AD&D plan allows you to purchase additional coverage for you, your spouse and/or your dependent child(ren). In order to purchase coverage for your spouse or child(ren), you must first elect optional coverage for yourself. Coverage effective dates and increases in coverage may be delayed if you or your dependents are disabled on the date coverage is scheduled to take effect. You will be required to provide Evidence of Insurability if you or your spouse does not elect optional life and AD&D insurance when initially eligible but later elect it or if you elect an amount of coverage in excess of $150,000 for yourself or $25,000 for your spouse. Life benefits reduce for employees age 65 and older. The full cost of the optional coverage is deducted from your paycheck on an after tax basis.

- **Employee Optional Life and AD&D**
  Employees may purchase optional life and AD&D insurance in increments of $10,000. The minimum amount is $10,000 and the maximum is the lesser of 8 times your annual earnings or $500,000.

- **Spouse Optional Life**
  You may purchase coverage for your spouse in increments of $5,000 to the lesser of 50% of your optional life insurance or $50,000.

- **Child Optional Life**
  You may purchase Optional Life insurance for your children. Coverage for children live birth to 6 months is $500; coverage for children aged 6 months to 23 years (25 years if full time student) is $10,000.

Optional Long Term Disability Plan

The Optional Long Term Disability Plan (LTD) provides a stable source of income should you become disabled and are unable to work for an extended period of time or indefinitely. The LTD benefit is equal to 60% of your monthly income to a maximum benefit of $3,000. Monthly income is defined as total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. LTD benefits are payable after 180 days of disability for employees with 26 weeks of STD and after 360 days of disability for employees with 52 weeks of STD. LTD benefits may continue until you reach age 65, or longer in some instances.

If you do not elect optional Long Term Disability when initially eligible and you wish to elect this coverage during a subsequent annual enrollment period, you will be required to provide proof of insurability. Your coverage effective date may be delayed if you are not actively at work on the date coverage is scheduled to take effect. No benefits are payable for disability due to a pre-existing condition, unless the disability starts after you complete one day of active work after the date you are insured under this plan for 24 months in a row. The full cost of this optional coverage is deducted from your paycheck on a post-tax basis and benefits would be paid on a pre-tax basis. *Premiums are based on employee age and salary.

Group Critical Illness Insurance

Cigna's group critical illness insurance can help protect your finances from the expense of a serious health problem, such as a stroke or heart attack. Cancer coverage is also available. This plan pays a lump-sum benefit directly to you – not to a doctor or health care provider – at the first diagnosis of a covered condition. Employees can choose $5,000, $10,000, or $20,000 in coverage and reduced amounts are available for spouses and dependent children.

**This year, you have the opportunity to elect Critical Illness without answering any medical questions – even if you declined this coverage in previous open enrollments.

The following specified critical illnesses are covered under the base plan and pre-existing condition limitations apply. Please refer to the policy for complete details about these covered conditions.

- Heart attack
- Blindness
- Stroke
- Cancer
- Major organ transplant
- Wellness benefit included
- End-stage renal (kidney) failure
- Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- Coronary artery disease (pays 25% of lump-sum benefit)
- Carcinoma in situ (pays 25% of the lump-sum benefit)
- Permanent paralysis as a result of a covered accident

Group Accident Insurance

Cigna's group accident insurance can pay lump-sum benefits based on the injury you receive and the treatment you need, including emergency room care and related surgery. The benefit can help offset the out-of-pocket expenses that medical insurance does not pay, including deductibles and co-pays. A wellness benefit will provide an annual pay-out for preventive care. Group accident insurance can be purchased for you, your spouse, and your child(ren).

What is covered?

Covered Injury	Benefit Amount
Fractures (open or closed)	Up to $2,000
Dislocations (open or closed)	Up to $2,000
Burns	Up to $300
Concussion	$100
Coma due to covered injury	$5,000
Laceration	Up to $100
Eye injury	$200
Paralysis	Up to $2,000
Covered Expense	**Benefit Amount**
Emergency room treatment	$100
Physician follow up visit	$50 (up to 10 per accident)
Hospitalization	$500 for admission $100 per day for hospital stay (up to 365 days) $200 per day for ICU stay (up to 365 days)
Follow up physical therapy	$25 (up to 10 per accident)
Ambulance	$100 ground, air

See the schedule of benefits for a full list of covered injuries and expenses.

*All Accident benefits are paid when a covered injury results, directly and independently of all other causes, from a covered accident. Cigna does not consider pregnancy an accident.
**This year, you have the opportunity to elect Accident without answering any medical questions – even if you declined this coverage in previous open enrollments.

Action Steps and Enrollment Instructions

Read your enrollment information carefully to determine what benefits you want to elect for the 2020 plan year. Additional information on each health care plan is provided in the BCBSM Summary of Benefits and Coverage documents (SBC's) that are available in the Human Resources Department, the E-Benefit Portal, Road Department Admin, and the County Website/HR.

- Attend an employee Open Enrollment meeting. The meetings have been scheduled for November 13, 14, 18, and 19th at the various County buildings. Individual appointments are available upon request (x0982).
- Complete your enrollment by November 29, 2019. Failure to enroll by the deadline will result in automatic enrollment into the FB3 plan as single coverage for 2020.
- If you have any questions, please contact the Human Resources Department at 781-0980 (x0980 internally).

E-Benefits Online Enrollment Instructions

Miscellaneous Reminders:

- If you have not yet enrolled your dependents into the E-Suite system, please make sure you do this step before beginning the benefit selection process; otherwise, the dependents will not be added to your plan for 2020. To add dependents, go to the "My HR" tab, select "Dependents," follow the remainder of the on-screen instructions and then select "Submit Changes." HR will need to verify the dependent and will then approve the change. If you are adding a new dependent, you will need to complete a Dependent Affidavit form that can be found on the County Website/HR.
- Part-Time employees are eligible for the medical benefit plans and are required to make a selection or "Decline."
- To Opt-Out, please select the "Decline" button on the applicable benefit screens.

Accessing the System:

To access the system from the County network, go to https://hrportal.calhouncountymi.gov/ which will take you to the login screen. If you are accessing the system from outside the County network, please go to the County website at www.calhouncountymi.gov and select the Employees Only tab at the bottom of the home page. If you are a first time user or have forgotten your password, just follow the instructions on the login screen. All the 2020 Open Enrollment related documents are available in both the E-Benefit Portal and the County Website under HR Department – Employee Benefits.

PLEASE NOTE THAT YOU NEED TO USE GOOGLE CHROME TO ACCESS THE SYSTEM.

How to Enroll in Coverage:

1) The first step in the E-Benefit Enrollment process is to log-in to the E-Suite HR Portal. Then select the "Benefit Enrollment" tab. This will take you to the main page of the E-Benefit module.

2) Select the "Continue to Enrollment" button and it will take you to the main health care plan election screen. Make your election by clicking on the circle next to the benefit choice you want to elect. When finished, select "Save and Continue." Make sure you "Save and Continue" at each page.

3) If you made a benefit selection in item #2, then you will be routed to a "Dependent" Screen. Your dependents should appear and you can select which dependents you want to include on your 2020 benefit plan. If your dependents do not appear, please see the very first bullet point above.

4) The Vision election is on the next screen, followed by the Dental screen. Make your selections on each screen and remember to select "Save and Continue" at each page.

5) Continue to the Optional LTD and Life Insurance screens to select the option you prefer or decline.

6) At the Flexible Spending Account screens, enter the amount you want to contribute for the year. Contributions cannot exceed $2,650 for medical / $5,000 for dependent care, and you are not eligible for medical FSA if you are participating in the HSA. There are separate selection screens for medical care and dependent care accounts.

7) The Health Savings Account page is only required for those employees electing the FB3 or the SB3 High Deductible Health Care Plans. Enter the amount you wish to contribute on an annual basis.

8) The final page is a summary of your benefit elections. Please review this information very carefully to make sure all of your desired benefits have been selected. When you are confident the information is correct, select "Submit."

9) If you wish to enroll in the 401(k) or to make changes to your current contributions, the forms can be found on the County Website/HR. For 457 Plan changes, please contact HR.

To enroll in **Voluntary Life, Critical Illness or Accident** for the first time**,** or to make changes to your benefit amount, enrollment forms and Evidence of Insurability forms will be available at the open enrollment meetings. If you would like to enroll in or make changes to your **Voluntary Long Term Disability** benefit, please log on to the County's online enrollment system.

Where to Go for Help

Human Resources 781-0980

Vendor	Coverage	Contact Number	Website
Blue Cross Blue Shield of Michigan	Medical	(800) 972-9797	www.bcbsm.com
		To find providers: (800) 810-2583	www.bluecares.com
Express Scripts	Prescription Drugs	(800) 282-2881	www.express-scripts.com
Delta Dental	Dental	(800) 482-8915	www.deltadentalmi.com
Blue Cross Blue Shield of Michigan/VSP	Vision	(800) 877-7195	www.bcbsm.com
Discovery Benefits	Flexible Spending Accounts Health Savings Account	(866) 451-3399	www.discoverybenefits.com
Cigna	Short Term Disability Life/AD&D Voluntary Life Voluntary Long Term Disability Critical Illness & Group Accident	Disability Claims Intake: (800) 362-4462 Elective Benefits Claims Intake: (800) 754-3207	www.cigna.com

Legal Notices

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

Under Federal law, Group Health Plans and health insurance issuers providing benefits for mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

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

These services must be provided in a manner determined in consultation between the attending Physician and the patient.

Call your HR Department for more information.

Your HIPAA Privacy Rights

Keeping your personal health information private is your right. That's why the U.S. government passed the "Privacy Rule" – part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rule, passed in 2003, protects your health information and makes it illegal for health care providers to reveal information about your health without your permission unless needed to treat your condition. It also prevents the improper use of health information by health care benefit insurers and administrators. Doctors' offices and health care facilities are required by law to obtain your written permission to appropriately reveal information about your health.

A copy of our Notice of Privacy Practices is available upon your request.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30-days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30-days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("SCHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60-days from the occurrence of one of these events to notify the company and enroll in the plan.

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

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30-days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30-days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("SCHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60-days from the occurrence of one of these events to notify the company and enroll in the plan.

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)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid	NEVADA – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
RHODE ISLAND – Medicaid	**VIRGINIA – Medicaid and CHIP**

Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH CAROLINA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
TEXAS – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
UTAH – Medicaid and CHIP	**WYOMING – Medicaid**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VERMONT– Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since July 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

Patient Protection Model Disclosure

BCBSM generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BCBSM.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from BCBSM or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact BCBSM.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31- days, your Plan participation will not be interrupted. If the absence is for more than 31-days and not more than 12-weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31-days, or if you revoke a prior election to continue to participate for up to 12-weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

GINA Notice

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Discrimination is Against the Law

Calhoun County complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Calhoun County does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Calhoun County:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Kim Archambault

If you believe that Calhoun County has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Kim Archambault, 315 W. Green St Marshall, MI 49068, 269-781-0992, karchambault@calhouncountymi.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kim Archambault is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-269-781-0992.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-269-781-0992。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-26-781-0992.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-269-781-0992.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-269-781-0992.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-269-781-0992.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-269-781-0992.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-269-781-0992.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-269-781-0992.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-269-781-0992.

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-269-781-0992.

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-269-781-0992.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-269-781-0992.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-269-781-0992.

Important Notice from Calhoun County About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Calhoun County** 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:

1. 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.

2. Calhoun County has determined that the prescription drug coverage offered by the Calhoun County 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 and drop your Calhoun County prescription drug coverage, be aware that **your current prescription drug coverage is part of your medical coverage from Calhoun County. You cannot drop your Calhoun County prescription drug coverage unless you also drop your Calhoun County medical coverage.** If you enroll in a Medicare Part D plan and drop your creditable coverage with Calhoun County , you may not be able to return to the same plan through Calhoun County until the next enrollment period.

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

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

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

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

Contact the person listed below for further information or call your local Human Resources Department. **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 Calhoun County changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	November 7, 2019
Name of Entity/Sender:	Calhoun County
Contact--Position/Office:	Brandie Aldrich
Address:	315 W. Green St Marshall, MI 49068
Phone Number:	269-781-0982

Calhoun County Group Health Plan Procedures for Handling Medical Child Support Orders

1. The plan administrator will designate a responsible individual, by name, title or both, to receive all medical child support orders (MCSOs) delivered to Calhoun County.

2. Employees who could receive the MCSOs will be instructed to deliver any medical child support order, and any domestic relations order which purports to be a medical child support order, to the individual designated for this purpose. The immediate delivery of any such order to the designated individual is absolutely necessary in order to minimize potential fiduciary liabilities for failing to act prudently as required by ERISA, including liabilities for uncovered medical expenses.

3. Upon receipt of a MCSO, the designated individual will:

   (a) Forward a copy of the MCSO and related correspondence to the plan administrator or its designated representative to determine if the MCSO is a qualified MCSO ("QMCSO"); and

   (b) Promptly notify the effected employee and each alternate recipient of (1) the receipt of the MCSO, (2) the plan's procedures for determining whether the MCSO is a QMCSO, and (3) the alternate recipient's right to designate a representative for the receipt of copies of notices to be sent to the alternate recipient with respect to the MCSO. If the alternate recipient is a minor, the notice will be sent in care of the custodial parent or legal guardian identified in the order.

4. If the MCSO is a National Medical Support Notice (as defined in ERISA Section 609(a)(5)(c)), the designated individual will notify the issuing agency, within 20 business days of the date of the notice, if the employee is not eligible for coverage under the plan or if state or federal withholding limitations prevent the withholding from the employee's income of the amount required to obtain coverage under the terms of the plan. (In which case, no coverage will be provided to the proposed alternate recipient).

5. Within a reasonable time after receipt of the MCSO, the designated individual, or legal counsel on his or her behalf, will review the MCSO and make a determination as to whether the MCSO meets all of the requirements for a QMCSO under ERISA. (See the Plan Administrator's QMCSO Determination Checklist for the factors to be used to determine the MCSO's status).

6. If the MCSO is a National Medical Support Notice, the notice will be deemed to be a QMCSO if it contains the name of the issuing agency, the name and mailing address of an employee who is participating under the plan, the name and mailing address of the alternate recipient(s) (or name and address of the official or agency which has been substituted for the mailing address of the alternate recipients) and identifies an underlying child support order. The designated individual, or legal counsel on his or her behalf, will determine whether the notice complies with the requirements of this paragraph.

7. The responsible individual, or legal counsel on his or her behalf, will notify the employee and each alternate recipient (or his/her designated representative or the issuing agency), in writing, of the determination as to the qualification of the MCSO as a QMCSO within a reasonable period of time after receipt of the order but not later than 40 business days after the date of the notice with respect to a National Medical Support Notice.

8. If the MCSO fails to meet the requirement for a QMCSO, the notice described in 7 above will include an explanation of the deficiency. If the MCSO is a National Medical Support Notice, the designated individual will complete item 5 of the plan administrator response, sign the response and send it to the issuing agency.

9. If the MCSO is, or ultimately becomes, a QMCSO, the designated individual will (1) determine the coverage and benefit options available, if any, to the alternate recipient in accordance with these procedures, and (2) deliver applicable enrollment forms, plus filing instructions, a copy of the plan's current summary plan description, including any applicable summary of material modifications and benefit booklets or other benefit descriptions not included in the summary plan description or summary of material modifications, to each alternate recipient identified in the QMCSO or to his/her designated representative or the issuing agency.

10. If the QMCSO is a National Medical Support Notice, the plan administrator will notify the issuing agency, within 40 business days of the date of the notice, of the alternate recipient's eligibility for coverage, the effective date of coverage and, if necessary, the steps to be taken by the custodial parent or agency to obtain coverage for the alternate recipient. If the custodial parent must take any steps to obtain coverage, the plan administrator will provide a

copy of the plan's current summary plan description, applicable enrollment forms and filing instructions to the custodial parent.

11. Coverage will be offered to the alternate recipient in accordance with the plan's terms as follows:

    (a) If the employee is covered under the plan with family coverage, the alternate recipient will only be offered coverage in that same coverage option. However, the plan administrator should have the alternate recipient complete the plan's enrollment form. The enrollment form should be sent to the alternate recipient with the coverage option box selected and a cover letter should also be sent explaining that the alternate recipient may only receive coverage under the employee's existing coverage option, but that the other portions of the enrollment form need to be completed before the alternate recipient is covered under the plan.

    (b) If the employee is receiving coverage under the plan, but the alternate recipient lives outside the network or HMO coverage area of the employee's coverage option, the plan administrator will allow the employee to elect a different option that will cover the alternate recipient. If the employee does not make a timely election, the custodial parent (or authorized issuing agency) may elect the coverage option and the employee's coverage will be changed to the option so elected.

    (c) If the employee is not receiving coverage under the plan, the plan administrator will allow the employee to elect the coverage option that will apply to both the employee and the alternate recipient. If the employee does not elect a coverage option in a timely fashion, the alternate recipient's custodial parent (or issuing agency, in the case of a national medical support notice) may elect the coverage option. The employee will be required to be covered under the plan when the alternate recipient's coverage begins. **If the plan administrator does not hear from the alternate recipient's custodial parent or authorized issuing agency within 20 business days of the date the notice is sent to the alternate recipient's custodial parent or the issuing agency, the alternate recipient (and employee) will be enrolled in BCBSM.**

12. Upon receipt of fully completed enrollment forms, the plan administrator will enroll each alternate recipient as an eligible dependent of the employee in the plan in the coverage option available to the alternate recipient as determined in paragraph 11. The alternate recipient's coverage will be effective on the first day of the calendar month coincident with or following the receipt by the plan administrator of such fully completed enrollment forms. The alternate recipient is not entitled to coverage or any type or form of benefit, or any option, not otherwise offered by the plan. However, the alternate recipient is entitled to options such as dental and vision, if offered by the plan, even though the employee only has major medical coverage, if the employee is eligible for such coverage, and if the QMCSO states the alternate recipient is to have such coverage.

13. Effective as of the date the alternate recipient's coverage commences under the plan, the plan administrator may take any necessary steps to collect any applicable premium for the alternate recipient's coverage which the employee is required to pay pursuant either to the terms and conditions of the QMCSO or the terms and conditions of the plan. The means of collection may include, but is not limited to, pre-tax or post-tax payroll deductions.

14. Any claims submitted to the plan administrator for medical expenses incurred prior to the effective date of the alternate recipient's coverage under the plan will <u>not</u> be considered as eligible expenses and no payment or other reimbursements will be made for such expenses by the plan.

15. Any payment of plan benefits in reimbursement of eligible expenses paid by an alternate recipient, or by an alternate recipient's custodial parent or legal guardian on his/her behalf, will be made to the alternate recipient or the applicable custodial parent or legal guardian.