MACOMB COUNTY
EMPLOYEE HEALTHCARE
RESOURCE GUIDE
2019

Provided by: TMR & Associates
Macomb County strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you’re getting the most out of our benefits—that’s why we’ve put together this guide.

Open enrollment is a short period each year when you can make changes to your benefits.

This guide will outline all of the different benefits Macomb County offers, so you can identify which offerings are best for you and your family.

Elections you make during open enrollment will become effective on January 1, 2019. If you have questions about any of the benefits mentioned in this guide, please don’t hesitate to reach out to Human Resources and Labor Relations (HRLR).

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WHO IS ELIGIBLE?
If you are a full-time employee at Macomb County, you’re eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work 30 or more hours per week. In addition, the following family members are eligible for medical, dental and vision coverage:

- Spouse
- Legal dependents and children

HOW TO ENROLL
Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes. Once all your information is up to date, it’s time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

WHEN TO ENROLL
Open Enrollment begins on 10/29/2018 and runs through 11/16/2018. The benefits you choose during open enrollment will become effective on January 1, 2019.

HOW TO MAKE CHANGES
Unless you experience a qualifying event, you cannot make changes to your benefits until the next open enrollment period. Qualifying events include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child’s dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan
HEALTH INSURANCE
Macomb County is pleased to offer a variety of options for our employees when it comes to health care. For 2019, we will offer employees the opportunity to participate in a High Deductible Health Plan with a Health Savings Account (HDHP/HSA). We will still continue to offer the same PPO and HMO options. The addition of the HDHP/HSA plan design provides more flexibility to our employees.

For further information please visit www.macombgov.org/humanresources

Side-by-side Comparison
The chart below compares PPOs, HMOs and HDHPs side-by-side

<table>
<thead>
<tr>
<th></th>
<th>PPO</th>
<th>HMO</th>
<th>HDHP/HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFINITION</td>
<td>A network of providers who enter into an agreement with insurance companies to offer substantially discounted fees for covered health care services. If you choose a provider who is in the PPO network, your copayments and deductibles will also be lower.</td>
<td>A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. A copayment is due for each office and hospital visit. HMO’s generally won’t cover out-of-network care except in the event of an emergency.</td>
<td>A health plan that has a high deductible HSAs are tax-advantaged accounts that can be used to pay for qualified out-of-pocket medical expenses.</td>
</tr>
<tr>
<td>PRIMARY CARE PHYSICIAN (PCP)</td>
<td>Not typically required. Some PPO vendors offer incentives for employees to visit a PCP to coordinate medical care.</td>
<td>Required; the PCP coordinates all medical care and must make referrals to specialty providers for employees.</td>
<td>Not required</td>
</tr>
<tr>
<td>NETWORK OF PROVIDERS</td>
<td>There is a network, and the plan allows for use of out-of-network providers with greater cost-sharing by employees.</td>
<td>Services by out-of-network providers are not typically covered under the plan.</td>
<td>Not required</td>
</tr>
<tr>
<td>REFERRALS</td>
<td>May not be required.</td>
<td>Required for BCN Open network for HAP PCP coordinates all medical care.</td>
<td>Not required</td>
</tr>
<tr>
<td>DEDUCTIBLES, COINSURANCE, COPAYMENTS AND CLAIM FORMS</td>
<td>Coinsurance, deductibles and copays are the standard; usually lower when using in-network providers.</td>
<td>May require employee cost-sharing through deductibles, copays or coinsurance.</td>
<td>Typically, low or no coinsurance after deductible is met. Deductibles are substantially higher than other plans.</td>
</tr>
<tr>
<td>HSA ELIGIBLE?</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The following chart compares the different medical plans available effective January 1, 2019

<table>
<thead>
<tr>
<th>Services</th>
<th>BCN HMO In-Network</th>
<th>HAP HMO In-Network</th>
<th>BCBS PPO In-Network</th>
<th>BCBSM HDHP/HSA In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible (Individual/Family)</td>
<td>$0</td>
<td>$0</td>
<td>$1,500 Individual $3,000 Family</td>
<td>$2,000 Individual $4,000 Family</td>
</tr>
<tr>
<td>Physician Visit Copay</td>
<td>$20/Primary $30/Specialist</td>
<td>$25/Primary $40/Specialist</td>
<td>$40/Primary $40/Specialist</td>
<td>100% covered after in-network deductible met</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>No charge – In Network</td>
<td>No charge – In Network</td>
<td>Covered up to 80% out of pocket maximum</td>
<td>100% covered after In-Network Deductible met</td>
</tr>
<tr>
<td>Preventative Care</td>
<td>No charge – In Network</td>
<td>No charge – In Network</td>
<td>No charge - In Network</td>
<td>No charge - In Network</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$100 Copay*</td>
<td>$200 Copay*</td>
<td>$250 Copay*</td>
<td>100% covered after in-network deductible</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (Individual/Family)</td>
<td>$6,350/Individual $12,700/Family</td>
<td>$6,600/Individual $13,200/Family</td>
<td>$6,350/Individual $12,700/Family</td>
<td>$3,000/Individual $6,000/Family</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>2x’s the co-pay</td>
<td>2x’s the co-pay</td>
<td>2x’s the co-pay</td>
<td>2x’s the co-pay</td>
</tr>
<tr>
<td>90 day Retail/Mail Order</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$10.00</td>
<td>$20.00</td>
<td>$7.00</td>
<td>$10.00</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$25.00</td>
<td>$40.00</td>
<td>$35.00</td>
<td>$40.00</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>$50.00</td>
<td>$60.00</td>
<td>$70.00</td>
<td>$80.00</td>
</tr>
</tbody>
</table>

*Waived if admitted

**YOUR COST**

Macomb County is pleased to announce that we will not surpass the PA 152 Hard-Cap and there will be no premium increase to any current cost-share.
The following chart compares the differences between a Health Savings and a Flexible Spending Account

<table>
<thead>
<tr>
<th>Who owns the account?</th>
<th>Health Savings Account (HSA)</th>
<th>Medical FSA</th>
<th>Dependent FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible individual</td>
<td>Individuals &amp; families covered by a qualified high deductible health plan (HDHP) and no other health plan(s) that covers the same benefits. Individuals are not eligible if they can be claimed as a dependent on another person’s tax return.</td>
<td>Current employees whose employers offer such a plan.</td>
<td></td>
</tr>
<tr>
<td>Eligibility of spouse or dependents</td>
<td>Spouse &amp; dependents are eligible to use employee’s account.</td>
<td>Spouse &amp; dependents are eligible to use employee's account</td>
<td></td>
</tr>
<tr>
<td>Who may fund the account?</td>
<td>Anyone can make contributions to an individual’s HSA, including employer/employee.</td>
<td>Employee</td>
<td>Employee</td>
</tr>
<tr>
<td>What plans may be offered with the tax-advantaged account?</td>
<td>A high deductible health plan (HDHP) that satisfies minimum annual deductible and maximum annual out-of-pocket expense requirements.</td>
<td>FSA’s must qualify as excepted benefits to satisfy ACA reforms. To qualify as an excepted benefit, the FSA must meet a maximum benefit requirement and other group health plan coverage must be offered by the employer.</td>
<td>N/A</td>
</tr>
<tr>
<td>Is there a limit on the amount that can be contributed per year?</td>
<td>$3,500 for self-only HDHP coverage/$7,000 for family HDHP coverage. Catch-up contributions of $1,000 per year are permitted for individuals who are age 55 by the end of the tax year.</td>
<td>$2,650 Annually</td>
<td>$5,000 per year/per household &amp; $2,500 for married individuals filing a separate tax return.</td>
</tr>
<tr>
<td>Can unused funds be rolled over from year to year?</td>
<td>Yes</td>
<td>No; however, unused amounts may be used for expenses incurred during a grace period of 2 1/2 months after the end of the plan year.</td>
<td>No</td>
</tr>
<tr>
<td>Must claims submitted for reimbursement be substantiated?</td>
<td>No; however, IRS may require payment documentation.</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Federal tax treatment of employee contributions</td>
<td>Tax-deductible for individual, even if he or she does not itemize, provided contributions do not exceed the individual’s annual contribution limit. If an employee contributes to his or her HSA through salary reduction, the contributions are tax-free and are not subject to FICA and other employment taxes.</td>
<td>If an employee contributes to an FSA through salary reductions, the contributions are tax-free and are not subject to FICA and other employment taxes.</td>
<td></td>
</tr>
</tbody>
</table>
HEALTH SAVINGS ACCOUNTS
AVAILABLE WITH HDHP PLAN

Health savings accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHP’s).

WHAT ARE THE BENEFITS OF AN HSA?

- It is portable. The money in your HSA is carried over from year to year and is yours to keep, even if you leave the company.
- It is a tax-saver—HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you’ll pay less in taxes.

The maximum amount that you can contribute to an HSA in 2019 is $3,500 for individual coverage and $7,000 for family coverage.

Additionally, if you are age 55 or older, you may make an additional “catch-up” contribution of $1,000. You may change your contribution amount at any time throughout the year as long as you don’t exceed the annual maximum.

HSA CASE STUDY

Justin is a healthy 28-year-old single man who contributes $1,000 each year to his HSA. His plan’s annual deductible is $2,000 for individual coverage. Here is a look at the first two years of Justin’s HSA plan, assuming the use of in-network providers. (This example only includes HSA contribution amounts and does not reflect any investment earnings.)

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSA Balance</td>
<td>$1,000</td>
</tr>
<tr>
<td>Total Expenses:</td>
<td></td>
</tr>
<tr>
<td>- Prescription drugs: $150</td>
<td>(-$150)</td>
</tr>
<tr>
<td>Preventive care services: $0 (100% covered by insurance)</td>
<td></td>
</tr>
<tr>
<td>HSARollover to Year 2</td>
<td>$850</td>
</tr>
<tr>
<td>HSA Rollover to Year 3</td>
<td>$1,550</td>
</tr>
</tbody>
</table>

Since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.

Once again, since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.
FLEXIBLE SPENDING ACCOUNTS

Macomb County offers an employer-sponsored flexible spending account (FSA). Employees may not have both an FSA and HSA.

WHAT ARE THE BENEFITS OF AN FSA?

It saves you money. It allows you to put aside money tax-free that can be used for qualified medical expenses & qualified dependent care expenses.

- Your taxable income is decreased by your contributions.
- Flexible. You can use your FSA funds at any time, even if it’s the beginning of the year.

If you do not use it, you lose it. You should only contribute the amount of money you expect to pay out of pocket that year.

WHAT IS A MEDICAL FSA?

A Medical FSA allows you to contribute pre-tax dollars to qualified medical expenses as defined by IRS Section 213(d). The maximum amount you may contribute each year is $2,650.

WHAT IS A DEPENDENT CARE FSA?

A Dependent Care FSA allows you to contribute pre-tax dollars to qualified dependent care. The maximum amount you may contribute each year is $5,000 (or $2,500 if married and filing separately).

HOW DO I ENROLL?

You must fill out the FSA Enrollment Form during Open Enrollment. Even if you signed up last year, you must re-enroll for 2019.

FSA CASE STUDY

FSAs provide you with an important tax advantage that can help you pay for health care expenses on a pre-tax basis. Due to the personal tax savings you incur, your spendable income will increase. The example that follows illustrates how an FSA can save money.

Bob and Jane have a combined annual gross income of $45,000. They are married and file their income taxes jointly. Since Bob and Jane expect to spend $3,000 in eligible medical expenses in the next plan year, they decide to direct a total of $2,650 (the maximum allowed amount per individual, for that taxable year) into their FSAs. The table below demonstrates their savings:

<table>
<thead>
<tr>
<th></th>
<th>Without FSA</th>
<th>With FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross income</td>
<td>$45,000</td>
<td>$45,000</td>
</tr>
<tr>
<td>FSA contributions</td>
<td>$0</td>
<td>(-$2,650)</td>
</tr>
<tr>
<td>Gross income</td>
<td>$45,000</td>
<td>$42,400</td>
</tr>
<tr>
<td>Estimated taxes</td>
<td>(-$5,532)</td>
<td>(-$4,999)</td>
</tr>
<tr>
<td>After-tax earnings</td>
<td>$39,468</td>
<td>$37,401</td>
</tr>
<tr>
<td>Eligible out-of-pocket expenses</td>
<td>(-$3,000)</td>
<td>(-$400)</td>
</tr>
<tr>
<td>Remaining spendable income</td>
<td>$36,468</td>
<td>$37,001</td>
</tr>
<tr>
<td>Spendable income increase</td>
<td></td>
<td>$533</td>
</tr>
</tbody>
</table>
There are no changes to your dental benefits for 2019. The following chart outlines the dental plans Macomb County offers:

- **DELTA DENTAL PPO PLAN**
- **GOLDEN DENTAL DMO PLAN**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Definition</th>
<th>Primary Care Dentist</th>
<th>Network of Providers</th>
<th>Referrals</th>
<th>Deductibles, Coinsurance, Copayments, Claim Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delta Dental Preferred Provider Organization (PPO)</td>
<td>Patients select a dentist from a list of providers (network) who have agreed to discount their fees.</td>
<td>Not Required</td>
<td>Services provided by out-of-network providers may generate greater cost sharing for employee.</td>
<td>Not Required</td>
<td>No Deductible/Co-Insurance may apply on services other than Basic &amp; Preventive.</td>
</tr>
<tr>
<td>Golden Dental Maintenance Organization (DMO)</td>
<td>Patients are required to select a dentist from a specific list and indicate a primary dentist.</td>
<td>Required</td>
<td>Services by out-of-network providers are not typically covered under the plan.</td>
<td>Required</td>
<td>No Deductible/Co-Insurance may apply on services other than Basic &amp; Preventive $5 Office Visit Co-Pay.</td>
</tr>
</tbody>
</table>

There are no changes to your Vision benefits for 2019. The following vision plans are available to employees.

- **SVS VISION**
- **HAP VISION (FOR EMPLOYEES ENROLLED IN HAP MEDICAL)**

**BASIC LIFE INSURANCE**

Macomb County provides full-time employees a $50,000 group term life insurance policy with, The Standard Insurance Company. Macomb County pays for the full cost of this benefit, you are not responsible for paying any monthly premiums. Contact Human Resources and Labor Relations at (586) 469-5650, if you would like to update your beneficiary information.

Additional Supplemental Life Insurance for yourself, your spouse and child(ren) is offered in the month of June during our Voluntary Benefit Open Enrollment.
WHAT CHANGES ARE EFFECTIVE JANUARY 1, 2019?
The addition of a High Deductible Health Plan and Health Savings Account

IF I DO NOT WANT TO MAKE ANY CHANGES, WHAT FORMS MUST BE COMPLETED?
Fill out the Flexible Spending Account Enrollment Form for the new plan year.

IF I DO WANT TO MAKE CHANGES, WHAT FORMS MUST BE COMPLETED?
You must complete the Open Enrollment Form to change plans or individual/dependent coverage levels

WHERE DO I FIND THESE FORMS?
Contact HRLR at (586) 469-5650 or visit www.macombgov.org/humanresources

WHEN ARE THE FORMS DUE AND WHERE DO I RETURN THEM?
All forms must be returned to HRLR by Friday, November 16, 2018

OTHER INFORMATION:
If you do not make changes to your current insurance plans, those elections will remain in-force for 2019

ARE THERE EDUCATIONAL OPPORTUNITIES AVAILABLE?
Yes. To learn more about Macomb County’s benefits offerings for the next plan year, please attend an open enrollment meeting.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday, October 30th</td>
<td>9 am – 4 pm</td>
<td>Administration Building – Main Lobby 1 South Main St., Mt. Clemens</td>
</tr>
<tr>
<td>Thursday, November 1st</td>
<td>9 am – 4 pm</td>
<td>Verkuilen Building Conference &amp; Training Room - 21885 Dunham Road, Clinton Twp.</td>
</tr>
<tr>
<td>Monday, November 5th</td>
<td>9 am – 4 pm</td>
<td>Verkuilen Building Conference &amp; Training Room - 21885 Dunham Road, Clinton Twp.</td>
</tr>
<tr>
<td>Thursday, November 8th</td>
<td>9 am – 4 pm</td>
<td>Administration Building – Main Lobby 1 South Main St., Mt. Clemens</td>
</tr>
</tbody>
</table>
INTRODUCTION
You are receiving this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

READ THIS NOTICE CAREFULLY TO HELP UNDERSTAND YOUR COBRA RIGHTS.
Keep in mind that when you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice does not fully describe COBRA continuation coverage or other rights under the Plan. For additional and more complete information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

YOU MAY HAVE OTHER OPTIONS AVAILABLE TO YOU WHEN YOU LOSE GROUP HEALTH COVERAGE.
For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally does not accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage.

EMPLOYEE
If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either of the following qualifying events happens:
Your hours of employment are reduced, or
Your employment ends for any reason other than your gross misconduct.
SPouse
If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse. In the event your spouse, who is the employee, reduces or terminates your coverage under the Plan in anticipation of a divorce or legal separation that later occurs, the divorce or legal separation may be considered a qualifying event even though the coverage was reduced or terminated before the divorce or separation.

Dependent children
Your dependent children (including any child born to or placed for adoption with you during the period of COBRA coverage who is properly enrolled in the Plan and any child of yours who is receiving benefits under the Plan pursuant to a qualified medical child support order) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

Retiree coverage
Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is Cobra coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
• Death of the employee;
• Commencement of a proceeding in bankruptcy with respect to the Company or
• The employee’s becoming entitled to Medicare benefits (under Part A, Part B or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Macomb County HRLR. The Plan procedures for this notice, including a description of any required information or documentation, can be found by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, you will lose your right to elect COBRA continuation coverage.

HOW IS COBRA COVERAGE PROVIDED?
Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If COBRA continuation coverage is not elected within the 60-day election period, a qualified beneficiary will lose the right to elect COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage.
• When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of 36 months.
• When the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Also, when the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).
DISABILITY EXTENSION
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee’s termination of employment or reduction of hours, there will be no disability extension of COBRA continuation coverage. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

SECOND QUALIFYING EVENT EXTENSION
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both) or gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, there will be no extension of COBRA continuation coverage due to a second qualifying event.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.
IF YOU HAVE QUESTIONS
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.healthcare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES
To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION
Macomb County Human Resources/Labor Relations Department
1 South Main Street, 6th Floor
Mt. Clemens, MI 48043
(586) 469-5280
MACOMB COUNTY
HUMAN RESOURCES POLICY

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Health related medical information is primarily maintained by insurance carriers and contracted third party providers that provide medical plan coverage and administrative services to County employees and retirees. Macomb County does maintain limited protected health information (PHI) that relates to enrollment and health insurance premium costs.

The County will use or disclose your health information only as permitted by law, policy or contract. The County will only use or disclose health information for another purpose, when specifically authorized by an employee or retiree.

County employees and retirees have several rights regarding health information that the County maintains, outlined as follows:

The right to inspect and copy your health information:
Employees and retirees have the right to inspect and copy health information maintained by the County. Requested copies of information may incur a reasonable charge to cover expenses associated with the request. Any denial of a request will be explained in writing.

The right to amend incorrect or incomplete health information:
Employees and retirees may request a correction of health information, in writing with the reason for the correction. If the request for correction is authorized, the County will take reasonable steps to inform others of the correction. Any denial of a request will be explained in writing.

The right to an accounting of disclosures:
Employees and retirees may request an accounting of disclosures. This is a list of certain disclosures of your health information that the County has made to third parties. The request should specify a time period of no longer than six (6) years and may not include dates before April 14, 2003. The County will provide one list per twelve (12) month period free of charge. There may be a charge for additional lists.

POLICY: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
The right to request restrictions on uses and disclosures:
Employees and retirees have the right to request a restriction on how the County uses or discloses health information to third parties for medical treatment, payment of medical claims, or management of health care operations. The County is not required to agree to such restrictions.
The right to a paper copy of this notice:

Employees and retirees may obtain a copy of this Policy.

The County is required by HIPAA to do the following:

- To maintain the privacy and security of your PHI.
- To notify you if a breach occurs that may have compromised the privacy or security of your PHI.
- To provide you a copy of this Policy.
- To not use or share your PHI other than as described here unless you tell us we can in writing.

Change to this Policy
This Policy may be amended at any time and any new Policy provisions will be effective for all health information that are maintained.

Complaints
Employees and retirees may file a complaint if there is an allegation that privacy rights have been violated. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to, 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. The County will not retaliate against any employee or retiree in any way for filing a complaint.

You may also file a complaint or request information in writing to either:

Human Resources and Labor Relations
1 S. Main Street, 6th Floor
Mount Clemens, MI 48043

Corporation Counsel
1 S. Main Street, 8th Floor
Mount Clemens, MI 48043

Office of County Executive Approved: September 26, 2016
Enrollment Notice
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: Please see appropriate SBC for your plan benefits (BCBS/BCN or HAP). If you would like more information on WHCRA benefits, call your plan administrator at (586) 469-5280.

Annual Notice
Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at (586) 469-5280 for more information.

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).