PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

for the

KENT COUNTY
EMPLOYEE AND RETIREE BENEFITS PLAN

January 2024

INTRODUCTION

Kent County, a political subdivision of the state of Michigan (the "County" and "Plan Sponsor") has established the **Kent County Employee and Retiree Benefits Plan** ("Plan"). The Plan is an "umbrella plan" which includes various health and welfare benefits for employees of the County.

This document sets forth the terms of the Plan as of January 1, 2024. The County intends that this document serves as the Plan Document and as the Summary Plan Description, along with the documents supplied by the claim administrators, insurers, benefit providers and the County, for the health and welfare benefits under the Plan.

Certain health and welfare benefits under the Plan are provided on a self-funded basis. This means that these benefits will be paid by Plan Sponsor from its general assets rather than through a separate trust fund or an insurance company. The County has selected one or more claim administrators for the self-funded benefits under the Plan. These claim administrators will provide a summary plan description and other information to employees enrolled in the Plan. The claim administrators are not the insurers of the Plan and any and all references in the documents to the claim administrators should be interpreted accordingly.

Other health and welfare benefits under the Plan are provided on a fully-insured basis. Generally, the terms and conditions under which an employee may be eligible to receive these benefits are set forth in the terms of each applicable insurance policy. Because the fully-insured benefits under the Plan are provided solely through insurance companies, the County is not the insurer of these benefits.

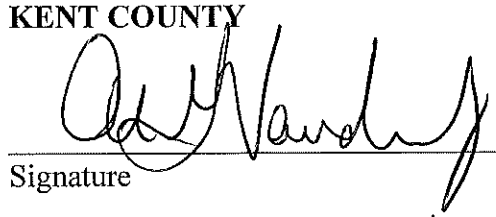
Finally, the County provides additional benefits which are technically not part of this Plan. However, these benefits are referred to in this document for informational purposes. Eligible employees will receive separate documentation describing these benefits.

The specific health and welfare benefits provided under the Plan and any additional benefits provided by the County are listed in the "EMPLOYEE AND RETIREE BENEFITS PLAN" section. This section also indicates whether the health and welfare benefits are self-funded or fully-insured.

The existence of the Plan does not grant employees any legal right to continue employment with the County or affect the right of the County to discharge employees. Questions about the Plan/Summary Plan Description should be directed to the Human Resources Department.

KENT COUNTY

Dated: Nov. 9, 2023



Signature

Alan C. Vanderberg, County Administrator/Controller

Printed Name and Title

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EMPLOYEE AND RETIREE BENEFITS PLAN

The Plan includes the following benefits:

HEALTH BENEFITS:	Self-Funded	Fully-Insured
Medical (includes PPO, HMO, and HDHP)	☑	☐
Prescription Drug	☑	☐
Dental	☑	☐
Vision	☐	☑
WELFARE BENEFITS:		
Group Term Life/Accidental Death and Dismemberment ("AD&D")	☐	☑
Sickness & Accident	☑	☐
Long-Term Disability	☑	☐
Long-Term Disability	☐	☑
ADDITIONAL BENEFITS:		
Medical and Dependent Care Flexible Spending Accounts (under the County's Flexible Benefits Plan)	☑	☐
Health Savings Accounts	☑	☐

Subsequent references throughout the document to "health benefits," "welfare benefits" and "additional benefits" mean the benefits described above.

Employees have received or will receive documentation describing each benefit in which they are enrolled. This Summary Plan Description is intended to supplement those materials. This document does not replace the provisions of the plan documents, summary plan descriptions, insurance applications, master plans, group insurance contracts and/or other documents for a benefit, including any applicable certificates and/or riders. (Note: The prescription drug benefit is described in detail in this document (see the "PRESCRIPTION DRUG BENEFIT" section)).

The other documentation for a benefit will contain the following information:

- A summary of benefits.
- With respect to health benefits:

- A description of any deductibles, coinsurance or copayment amounts.
- A description of any limits on benefits.
- Whether and under what circumstances preventive services are covered.
- Whether and under what circumstances prescription drugs are covered.
- Whether and under what circumstances coverage is provided for medical tests, devices and procedures.
- Provisions governing the use of network providers (if any). If there is a network, the booklet(s) or certificate will contain a general description of the provider network and participants will be entitled to obtain a list of providers in the network.
- Whether and under what circumstances coverage is provided for any out-of-network services.
- Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care.
- Any conditions or limits applicable to obtaining emergency medical care.
- Any provisions requiring preauthorization or utilization as a condition to obtaining a benefit.

- A description of the circumstances which may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery (e.g., by exercise of subrogation or reimbursement rights) of any benefits that the employee might otherwise reasonably expect the Plan to provide.

ELIGIBILITY AND PARTICIPATION

Employees

Each active regular full-time employee of the County who is regularly scheduled to work at least 80 hours per pay period will be eligible to receive all of the benefits under the Plan. A newly eligible employee is eligible to participate in the medical, prescription drug, dental, vision, and life/AD&D benefits and the Flexible Benefits Plan either on the employee's date of hire, provided it occurs on the first day of the month, or on the first day of the month following the employee's date of hire. Within select bargaining units, the employee is eligible to participate in the sickness & accident plan on the employee's date of hire, provided it occurs on the first day of the month, or on the first day of the month following the employee's date of hire.

Each active regular part-time employee regularly scheduled to work at least 40 hours per pay period will be eligible to receive certain benefits under the Plan (such as medical and prescription drug benefits and in some cases, the sickness & accident plan) and participate in the Flexible Benefits Plan. A newly eligible employee is eligible to participate in the medical and prescription drug benefits and the Flexible Benefits Plan either on the employee's date of hire, provided it occurs on the first day of the month, or on the first day of the month following the employee's date of hire. Certain part-time employees are eligible to participate in the sickness & accident plan and long-term disability plan on the employee's date of hire, provided it occurs on the first day of the month, or on the first day of the month following the employee's date of hire.

Health Care Reform

Despite the general rules set forth above, for purposes of the employer shared responsibility rules of Health Care Reform, additional employees shall also be eligible to participate in the medical and prescription drug benefits under the Plan in the following two circumstances:

- For **newly-hired employees** who are not otherwise eligible as described above, if the employee completes an initial measurement period beginning no later than the first day of the month after the employee's date of hire during which the employee is credited with an average of at least 30 hours per week, the employee shall be eligible to enroll in the medical and prescription drug benefits under the Plan for the stability period beginning immediately after the initial measurement period and any related administrative period ends.

- For **ongoing employees** who are not otherwise eligible as described above, for each plan year, there shall be a standard measurement period before the beginning of the plan year. If the employee is credited with an average of at least 30 hours per week during the standard measurement period, the employee shall be eligible to enroll in the medical and prescription drug benefits under the Plan for that plan year.

For each measurement period, the County shall notify otherwise ineligible employees if they satisfy the at least 30 hours per week average and are eligible for coverage for the subsequent, related stability period or plan year.

Notwithstanding the above, in the event the County employs independent contractors and leased employees, these individuals are not eligible for the Plan. If a leased employee is hired by the County, at least with respect to medical and prescription drug benefits, the leased employee's prior service with the leasing/temporary staffing agency on the County's behalf will be considered in applying the waiting period for coverage.

If an employee who is not otherwise eligible transfers to a position eligible for Plan benefits, the employee shall be eligible for benefits under the Plan on the first day of the month after the transfer.

If an eligible employee has a break-in-service (for example, due to termination of employment or the taking of a non-FMLA leave) during which the employee is not credited with any hours of service for at least 13 weeks the employee shall be treated as a new hire upon resumption of service. If the break is less than 13 weeks and the employee was enrolled in medical and prescription drug benefits and returns during the same stability period/plan year, the coverage shall be offered as soon as administratively practicable upon resumption of service (generally as of the first day of the month following return to work). Further, such an employee shall be treated as a continuing employee upon resumption of service for purposes of any applicable measurement periods.

Commissioners

County Commissioners will be eligible to participate in the medical, prescription drug, vision, dental and life/AD&D benefits and the Flexible Benefits Plan. Please refer to the applicable documentation provided by the insurers and/or claim administrators for details regarding when and how an eligible employee may become a participant in these benefits.

Employees Returning from Layoff

An employee who is recalled from a layoff to a job classification that is eligible to participate in the Plan is treated as a newly-hired employee and must make a new election of benefits under the Plan after satisfying the applicable service requirement. An employee who is classified as a Vision and Hearing Technician who returns to work following a summer layoff will have the employee's prior elections under the Plan reinstated on the date the employee returns to active employment.

Employees Returning from an FMLA Leave of Absence

An employee who goes on an FMLA leave may continue or revoke the employee's elections regarding group health coverage and/or medical spending account. Coverage for an employee who revokes the employee's elections and terminates participation may be reinstated when the employee returns from the FMLA leave. Reinstatement will occur immediately - no waiting period will apply.

If an employee terminates coverage in the medical spending account during the FMLA leave, the account cannot be used to reimburse expenses incurred during the FMLA leave. Also, the total benefits during the plan year may be reduced on a pro rata basis for the time period in which coverage was not in effect.

Dependents

An eligible employee's spouse and dependent children are eligible for certain coverages such as medical, prescription drug, dental and vision benefits.

Spouse

Your spouse is the person who is "legally married" to you. For purposes of this provision, a person is generally considered to be "legally married" to you if the

marriage is recognized as valid and enforceable under the laws of the state of Michigan. The term "spouse" does not include:

- A spouse who is divorced from the employee; or
- A spouse who is enrolled in the Plan as a full-time employee of the County.

Child

Your child is a person who meets one of the following requirements:

- Your natural child, legally adopted child, child placed with you for legal adoption, or step-child; or
- A child over whom you have a legal guardianship who resides with you and who relies on you for the majority of the child's financial support.

Notwithstanding the above, an eligible dependent child also includes a child for whom the employee is obligated to provide health care under a qualified medical child support order ("QMCSO"), as defined by applicable state and federal law. The Plan Administrator will maintain procedures governing the determination as to whether an order constitutes a QMCSO. Participants may obtain, without charge, a copy of the procedures from the Plan Administrator.

Ineligible Dependent Children

The following dependent children are not eligible to participate in the Plan:

- **Age.** A child will cease to be considered a dependent on the last day of the calendar month the dependent attains age 26. However, no age limit will apply to an unmarried dependent child who is totally disabled before age 26. Proof of the total disability must be provided before the end of the calendar year the child reaches the limiting age, or with the initial enrollment request if the dependent was not enrolled before reaching the limiting age, and subsequently at the request of the Plan Administrator.
- **Employee.** A dependent child who is a full-time employee of the County.

The County reserves the right to require proof of a dependent's eligibility.

For each fully-insured benefit, the insurance carrier is responsible for determining eligibility for, and the amount of, any benefits payable under its respective insurance policy.

RETIREE COVERAGE

Employees may be eligible for retiree health benefits in accordance with the County's policy for retiree health insurance. Please refer to Appendix A for the terms and conditions of the retiree group health insurance policy. Plan Sponsor reserves the right to amend or terminate the retiree group health insurance at any time.

ENROLLMENT RULES

When employees initially become eligible to participate in the Plan, they may make the following benefit elections:

Health Benefits

Eligible employees may elect to participate in the health benefits provided by the County by applying for coverage and agreeing to pay the required premium contributions, if applicable.

Welfare Benefits

Eligible employees will be automatically enrolled in the group term life/AD&D, sickness and accident and long-term disability benefits.

Additional Benefits

Eligible employees may elect to contribute to the medical and/or dependent care flexible spending accounts under the County's Flexible Benefits Plan upon initially becoming a participant.

After the employee makes elections upon initial enrollment, the elections may not be changed until the first day of the next plan year unless the employee experiences a change in status or other qualifying event (see the summary plan description for the County's Flexible Benefits Plan for details) or a special enrollment rights circumstance occurs as explained below.

ANNUAL AND SPECIAL ENROLLMENT PERIODS

Annual Enrollment

Before the beginning of each plan year, employees will be notified by the County of the dates for the open enrollment period, and otherwise ineligible employees will be notified if they are eligible for medical and prescription drug benefits for the plan year. During the open enrollment period, employees will have the opportunity to make benefit election changes. Benefit elections will remain in effect until the end of the plan year unless the employee requests an election change due to a change in status or other qualifying event (see the summary plan description for the County's Flexible Benefits Plan for details) or the employee has a special enrollment rights circumstance as explained below.

Special Enrollment

If an individual experiences a loss of health coverage, if an employee has a new dependent, or an individual loses or gains eligibility with respect to Medicaid or a State Children's Health Insurance Program ("CHIP"), an eligible employee and/or a dependent may have special enrollment rights to participate in medical, prescription drug, dental and vision benefits under the group health plan immediately without being required to wait until the next annual open enrollment period.

- A loss of other coverage may occur when COBRA has been exhausted, an individual becomes ineligible for coverage (for example, due to a change in status), employer contributions for the coverage have been terminated, the other coverage is an HMO and the individual no longer lives or works in the HMO service area, coverage is lost because the other plan no longer offers any benefits to a class of similarly-situated individuals (such as part-time employees), or a benefit package option is terminated unless the individual is provided a current right to enroll in alternative coverage. A loss of other coverage for this purpose does not include, however, termination due to the nonpayment of required contributions, for cause due to the filing of a fraudulent application or claim, or where the individual voluntarily terminates other coverage.

- The addition of a new dependent may occur due to marriage, birth, adoption or placement for adoption.

- If an individual's Medicaid or CHIP coverage is terminated as a result of a loss of eligibility or if the individual becomes eligible for a premium assistance subsidy under Medicaid or a CHIP, the individual has special enrollment rights.

Enrollment must generally be requested in a special enrollment rights situation within 30 days after the loss of other coverage or the addition of the new dependent, whichever is applicable. However, in the case of loss or gain of Medicaid or CHIP eligibility, a health plan must allow immediate enrollment if the individual submits a request within 60 days after the loss or gain of eligibility.

Coverage under the medical, prescription drug, dental and vision benefits for an eligible individual who enrolls under a special enrollment rights situation will be effective as of the following dates:

- If the special enrollment event is the addition of a new dependent child by birth, adoption or placement for adoption, coverage under the Plan will be effective as of the date of the birth, adoption or placement for adoption.

- If the special enrollment event is a loss of a dependent child's coverage due to aging out of other coverage, coverage under Plan will be effective as of the date that is the day after the effective date of the loss of other coverage.

- For all other special enrollment events, coverage under the Plan will be effective as of the first day of the month following the date that the eligible individual submits a request for enrollment to the County.

SOURCES OF CONTRIBUTIONS AND COST OF COVERAGE

The County may contribute to the cost of each benefit. In addition, employees may be required to contribute to the cost of one or more of the benefits, as periodically determined by the County. The County will notify employees of the required contribution, if applicable. Benefits are funded in the following manner:

Self-Funded

Benefits may be funded on a self-funded basis. The County will pay the self-funded benefits from its general assets. Any required participant contributions (if applicable) may be paid on a pre-tax basis under the County's Flexible Benefits Plan. Participant contributions toward the cost of a particular benefit will be used in their entirety prior to using County contributions to pay for the cost of such benefit. The County may establish a separate bank account for the payment of self-funded benefits. If a separate bank account is established, it will be for bookkeeping purposes only.

Fully-Insured

The County may purchase insurance to provide benefits on a fully-insured basis or, in the case of benefits funded on a self-funded basis, to protect the County from large individual and aggregate losses. Any required participant contributions (if applicable) may be paid on a pre-tax basis under the County's Flexible Benefits Plan or on a post-tax basis.

If participating employees become entitled to a refund in connection with any fully-insured benefit under the Plan (for example, due to a medical loss ratio rebate), the refund will be used for the exclusive benefit of participants within three months after the County receives the refund.

PRESCRIPTION DRUG BENEFIT

The prescription drug benefit is administered through Capital Rx and includes a retail pharmacy benefit and a mail order benefit.

Retail Pharmacy Benefit Option

- Copayments

Generic Prescription (medication and supplies) used for the treatment of diabetes and hypertension, and preventive Prescriptions required by Health Care Reform including generic	$0.00

contraceptive medications and devices, breast cancer drugs for women at increased risk for breast cancer and smoking cessation drugs	
Generic Prescription not listed above and Insulin on the Formulary (Preferred) list	$15.00 (up to a one-month supply)
Formulary (Preferred) Brand Name Prescription	$25.00 (up to a one-month supply)
Non-Formulary (Non-Preferred) Brand Name Prescription	$45.00 (up to a one-month supply)
Preferred Specialty	$100 (up to a one-month supply)

- Any one pharmacy prescription is limited to a 90-day supply. There is no maximum quantity supply.

- 75% of the supply must be consumed before a refill is authorized.

- For the PPO and HMO options, the prescription drug benefit is subject to a separate deductible and out-of-pocket maximum than the medical benefit.

- For the HDHP option, the deductible and out-of-pocket maximum for the prescription drug benefit is combined with the deductible and out-of-pocket maximum for the medical benefit. But the copayments listed above only apply once you have satisfied the applicable deductible under the HDHP option.

Mail Order Benefit Option

- Copayments

Generic Prescription (medication and supplies) used for the treatment of diabetes and hypertension, and preventive Prescriptions required by Health Care Reform including generic contraceptive medications and devices, breast cancer drugs for women at increased risk for breast cancer and smoking cessation drugs	$0.00
Generic Prescription not listed above, and Insulin on the Formulary (Preferred) list	$30.00 (up to a 90-day supply)
Formulary (Preferred) Brand Name Prescription	$50.00 (up to a 90-day supply)
Non-Formulary (Non-Preferred) Brand Name Prescription	$90.00 (up to a 90-day supply)

- Any one mail order prescription is limited to a 90-day supply. There is no maximum quantity supply.
- 50% of the supply must be consumed before a refill is authorized.
- For the PPO and HMO options, the prescription drug benefit is subject to a separate deductible and out-of-pocket maximum than the medical benefit.
- For the HDHP option, the deductible and out-of-pocket maximum for the prescription drug benefit is combined with the deductible and out-of-pocket maximum for the medical benefit. But the copayments listed above only apply once you have satisfied the applicable deductible under the HDHP option.

The Plan will direct the pharmacy to dispense generic drugs unless the participant's physician specifies a brand name drug or the participant requests a brand name drug. If a brand name drug is requested, the participant will pay the applicable brand copay.

Maximum Out-of-Pocket Limit

The prescription drug benefits are subject to an annual out-of-pocket maximum. Once the out-of-pocket maximum has been met for a plan year, 100% of otherwise eligible prescription drug expenses are payable by the Plan. The out-of-pocket maximum for prescription drug expenses varies depending on whether one or more of the employee's dependents are also enrolled.

For the PPO and HMO options, the maximum out-of-pocket limit for the prescription drug benefit is separate from the maximum out-of-pocket limit for the medical benefit. For the

HDHP option, the maximum out-of-pocket limit for the prescription drug benefit is combined with the maximum out-of-pocket limit for the medical benefit.

Eligible Expenses

To be eligible for payment, the prescription drug must meet the definition of a prescription drug. This means a drug which is ordered by a physician and which is dispensed by an individual or by an organization licensed to dispense drugs on the order of a physician. For this purpose, prescription drug includes a drug which under federal law is required to bear the legend "Caution: federal law prohibits dispensing without a prescription," a drug which under applicable state law may only be dispensed upon the prescription of a physician, or a compound medication which contains at least one ingredient which is the prescription legend drug.

Certain preventive care drugs are covered at 100% and are not subject to a prescription copayment amount. These preventive care drugs may include contraceptive medications and devices, aspirin, iron supplements, fluoride supplements, folic acid, tobacco cessation drugs and immunization vaccines as defined by the USPSTF, ACIP, HRSA or other sources in compliance with the provisions of Health Care Reform. In order for these preventive care drugs to be covered at 100%, the drugs must be prescription drugs but in certain circumstances over-the-counter versions of these drugs may be covered when specifically prescribed by a physician.

To find a complete list of covered prescription drugs visit: https://caprx.adaptiverx.com/webSearch/index?key=8F02B26A288102C27BAC82D14C006C6FC54D480F80409B68F7175D0DC1577226

Eligible prescription drugs specifically include:

- Medically necessary drugs and medicines requiring a physician's prescription under federal law (legend drugs).
- Disposable blood/urine glucose/acetone testing agents, disposable insulin needles/syringes, insulin, insulin devices, alcohol swabs, glucagon emergency injection kit, glucose tablets, ketone testing strips and lancets.
- ADD and Narcolepsy drugs.
- Anabolic steroids.
- Anorexients.
- Anti-rejection drugs (immunosuppressants).
- Smoking cessation drugs which are legend drugs.
- Topical acne medications (Retin-A, Differin, Altivac and Avita).

- Acne medication (Tazorac).
- Compounded medication of which at least one ingredient is a legend drug.
- Oral contraceptives, topical contraceptives, injectable contraceptives and contraceptive vaginal rings.
- Emergency allergic reaction kits (bee sting kits, Epi-pen, Ana-kit).
- Oral fertility drugs.
- Injectables, including IV injectables, unless otherwise noted.
- Migraine medications.
- Multiple Sclerosis medications.
- Multiple vitamins, prenatal vitamins and pediatric vitamins that are legend drugs requiring a physician's prescription.
- Allergy sera.
- Non-insulin needles and syringes.
- DESI drugs, unless otherwise noted.
- Controlled substance 5 (i.e., Robitussin AC syrup) where the medications may be considered a legend drug.
- Single entity vitamins which are used for the treatment of specific vitamin deficiency diseases.

Limits for Certain Medications

Certain medications may be subject to special copays and/or quantity limits. These restrictions are not intended to deny benefits, but help protect participants. They help ensure these medications are not utilized inappropriately or that recommended maximum dosages are not exceeded. They are based on FDA-approved dosing recommendations, pharmaceutical guidelines and have been reviewed and approved by licensed, clinical staff. These limits are reviewable through the appeals process. A letter of medical necessity and related clinical documentation must be provided to Capital Rx For further information, contact Capital Rx at (888) 832-2779.

Prior Authorization

Certain medications such as growth hormones, Botox, Soliris, Promacta, Somatuline, Myobloc, and Xenazine are subject to prior authorization. For further information, contact Capital Rx at (888) 832-2779.

If your prior authorization is denied, you have the right to request an appeal or file a grievance by completing the appropriate form and faxing it to Capital Rx's Appeals & Grievance Department at (833) 434-0563. To request the appropriate form, contact Capital Rx at (888) 832-2779.

Exclusions

The prescription drug benefit shall not pay for the following drugs, drug-related items, services and supplies:

- Abortifacient drugs, except to the extent classified by the federal government as a required preventive care drug to be offered by a non-grandfathered health plan.
- Impotency drugs.
- Non-prescription drugs, except as expressly provided.
- Cosmetic alteration drugs.
- Hair growth stimulants.
- Anti-wrinkle creams.
- Cosmetic drugs.
- Blood glucose testing monitors.
- Fertility injectables.
- Immunization agents and biological sera.
- Therapeutic devices or supplies, including support garments, ostomy supplies, durable medical equipment and non-medical substances regardless of intended use.
- Blood products, blood serum.
- Experimental drugs which do not have NDC numbers.
- Blood component.
- Surgical supply/medical device/ostomy.
- Any medications not FDA approved or not FDA approved for the treatment of the participant's condition.
- Miscellaneous biologicals.

- Allergenic extracts.
- Fluoride.
- Inhaler extender devices.
- Alodox convenience kit.
- Homeopathic medications.

See the "CLAIM" section for the claim and appeal procedures with respect to the prescription drug benefit.

Plan's Right to Reimbursement and Subrogation Right

If the Plan pays prescription drug benefits and another party (other than the participant or the Plan) is or may be liable for the expenses, the Plan has a right of reimbursement which entitles it to an equitable lien to be reimbursed from the participant or another party for 100% of the amount of benefits paid by the Plan to the participant or on the participant's behalf.

If the participant does not bring an action against the other party who caused the need for prescription drug benefits to be paid by the Plan within a reasonable period of time after the claim arises, the Plan will have the right to bring an action against the other party to enforce and protect its right to reimbursement. In this circumstance, the Plan will be responsible for its own attorneys' fees.

The participant will do whatever is necessary and will cooperate fully to secure the rights of the Plan. This includes assigning the participant's rights against any other party to the Plan and executing any other legal documents that may be required by the Plan.

TERMINATION OF COVERAGE

Generally, to remain eligible for benefits under the Plan, the employee must be actively working for the County on a regular basis. However, benefits under the Plan can be continued in the following situations:

- **FMLA Leave** All benefits under the Plan can be continued if the employee goes on a family or medical leave, as defined by the Family and Medical Leave Act of 1993 ("FMLA"). (See the "FAMILY AND MEDICAL LEAVE ACT" section.)
- **Paid Leave** Benefits under the Plan can be continued if the employee goes on an authorized paid leave of absence, generally for the duration of the authorized paid leave. The paid leave can occur concurrent with or following the end of an FMLA leave or may occur in a non-FMLA situation. See the County for details. The employee must pay the same premium amount for the coverage during the paid leave as actively-working employees. Please refer to the documentation for each

benefit (including the applicable collective bargaining agreement) for details concerning eligibility and the period of continued coverage during a paid leave situation. This continuation provision does not apply to unpaid leaves.

- **Layoff** Benefits under the Plan can be continued if the eligible employee is laid off. Please refer to the documentation for each benefit (including the applicable collective bargaining agreement) for details concerning eligibility and the period of continued coverage during a layoff situation.

Except for an FMLA leave, paid leave of absence or layoff, all health coverage of an eligible employee who quits or is terminated, or otherwise leaves active regular employment, terminates as of the last day of the month in which the employee's active regular employment ends. Other coverages (life/AD&D, sickness & accident plan and long-term disability) and participation in the Flexible Benefits Plan end on the last day of work.

Benefits under the Plan will also terminate on:

- The date an individual ceases to be eligible for coverage. However, if an employee has a reduction in hours so the employee is no longer eligible, the employee will become ineligible for all benefits under the Plan except medical and prescription drug benefits. In the case of medical and prescription drug benefits, if the employee was determined to be eligible for a stability period or plan year (based on the employee's job classification as "full-time" or the employee's credited hours during the immediately preceding measurement period) a reduction in hours will generally not cause the employee's medical and prescription drug benefits to terminate until the end of the applicable stability period or plan year.

- The first day any required participant contributions are not timely paid.

- The effective date of the individual's voluntary withdrawal from the Plan due to a change in status or during an open enrollment period.

- The date the Plan is discontinued as a whole or a particular benefit is discontinued.

- The date on which the participant's coverage is terminated for cause by the plan administrator. (Termination for cause means the participant is found to have misrepresented information in the application for participation or on a claim for benefits.)

In certain circumstances, the employee and/or the employee's eligible dependents may be eligible for COBRA continuation coverage and/or a conversion policy, as explained in the following sections.

CONTINUATION OF HEALTH COVERAGE UNDER COBRA AND USERRA

Continuation coverage is required under the Public Health Service Act, which is similar to the federal law known as COBRA (which applies to private sector employers). COBRA continuation

coverage allows eligible individuals to temporarily extend health coverage under the Plan in certain circumstances where health coverage would otherwise end. The federal law known as USERRA gives employees who cease to be eligible for health coverage due to service in the U.S. military additional rights regarding continuation of health coverage. This section provides information regarding extensions of coverage under these laws.

COBRA Continuation Coverage

COBRA continuation coverage allows the employee and/or the employee's dependents (including a child for whom the employee is required to provide health insurance coverage pursuant to a QMCSO) an opportunity to temporarily extend health insurance coverage under the Plan at group rates in certain instances where coverage would otherwise end. The employee may also have continuation coverage rights with respect to the employee's medical flexible spending account under the County's Flexible Benefits Plan. (See the summary plan description of that plan for details.)

The plan administrator may delegate some or all of its responsibilities with respect to COBRA to a third-party COBRA administrator. The employee and spouse (if any) will be informed if a COBRA administrator is appointed and which responsibilities the COBRA administrator has assumed, including whether notices required to be provided to the plan administrator should be sent to the COBRA administrator.

Eligibility

The employee and/or the employee's dependents who are eligible to purchase continuation coverage are "qualified beneficiaries." If a child is born to or adopted by or placed for adoption with the employee during a period of COBRA continuation coverage, the newborn or newly-adopted child will also be a qualified beneficiary. However, the newborn or newly-adopted child's maximum continuation period will be measured from the date of the initial qualifying event and not from the subsequent date of birth or adoption or placement for adoption.

The events which may entitle a qualified beneficiary to continuation coverage are "qualifying events." The qualifying events occur when health coverage is lost, even if The County pays the cost of continuation coverage for a certain period of time. The qualifying events, the qualified beneficiaries, and the maximum continuation period are described in the following chart:

Qualifying Event	Qualified Beneficiary	Continuation Period (Months)
Reduced hours[1] or termination of employment[2]	Employee and Dependents	18

[1] A reduction in hours due to a family or medical leave, as defined by the FMLA, will not cause an employee's participation to terminate, to the extent required by the FMLA. Thus, a reduction in hours pursuant to an FMLA leave will not constitute a qualifying event. However, if the employee does not return to work at the end of the FMLA leave, a qualifying event will occur as of the last day of the FMLA leave.

[2] Continuation coverage is not available if employment is terminated for gross misconduct.

Qualifying Event	Qualified Beneficiary	Continuation Period (Months)
Employee's death	Dependents	36
Employee's entitlement to Medicare	Dependents not entitled to Medicare	36
Dependent child becomes ineligible for coverage	Ineligible Dependent	36
Employee's divorce/legal separation[3]	Dependents	36
Commencement of Bankruptcy proceeding under Title 11 of the United States Code with respect to the County	Retiree and Dependents	For a qualified beneficiary who is the retiree - until the qualified beneficiary's death. For qualified beneficiaries who are the spouse, surviving spouse, or dependent children of the retiree upon the occurrence of the qualifying event - the earlier of the date of the qualified beneficiary's death or 36 months after the retiree's death.

Extension of Continuation Coverage

If the employee and/or the employee's dependents become entitled to continuation coverage as a result of the employee's termination of employment or reduction in hours, the 18-month continuation period may be extended for the employee and/or the employee's dependents in the three circumstances described below ("extension events").

Second Qualifying Event

If a second qualifying event that is a divorce, legal separation, the employee's death, or a dependent child's loss of eligibility for health coverage under the Plan occurs during the initial 18-month period (or 29 months, if there is a disability extension), the employee's dependents may be eligible to elect continuation coverage for a period of 36 months, beginning on the date of the employee's termination of employment or reduction in hours. ***Notice of this second qualifying event must be provided***

[3] Elimination of the employee's spouse's or dependent child's health insurance coverage under the Plan in anticipation of a divorce or legal separation (at open enrollment, for example), is not a qualifying event, but it also does not cause the subsequent divorce or legal separation to fail to be a qualifying event. However, COBRA continuation coverage is not required to be made available between the date coverage under the Plan is eliminated in anticipation of the divorce or legal separation and the date of the divorce or legal separation.

to the plan administrator within 60 days of the date of the second qualifying event.

Employee's Entitlement to Medicare

If the employee becomes entitled to Medicare benefits during the initial 18-month period, the employee's dependents may be eligible to elect continuation coverage for a period of 36 months, if, ignoring the original qualifying event, the employee's entitlement to Medicare would have been a qualifying event under the Plan. The 36-month continuation period begins on the date of the employee's termination of employment or reduction in hours. ***Notice of the employee's entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of the date on which the employee became entitled to Medicare.***

A special rule applies if the employee became entitled to Medicare before the employee's termination of employment or reduction in hours. In that situation, the maximum continuation period for the employee's dependents may be extended, and may end on the later of: 36 months after the date of the employee's Medicare entitlement or 18 months (or 29 months, if there is a disability extension) after the date of the employee's termination of employment or reduction in hours. ***Notice of the employee's entitlement to Medicare in this situation must be provided to the plan administrator within 60 days of the employee's termination of employment or reduction in hours.***

Social Security Disability Determination

If it is determined that the employee or one of the employee's dependents is entitled to Social Security disability benefits either before the employee's termination of employment or reduction in hours or within 60 days after the employee's termination of employment or reduction in hours, the disabled individual and the qualified beneficiaries who are the employee's family members will be entitled to an additional 11 months of continuation coverage (29 months total). ***Notice of the Social Security disability determination must be provided to the plan administrator within 60 days of the date of the disability determination (or within 60 days of the employee's termination of employment or reduction in hours, if later) and before the end of the 18-month continuation period.***

If there is a final determination that the disabled qualified beneficiary is no longer disabled, the disabled qualified beneficiary ***must notify the plan administrator of that determination within 30 days of the date of the final determination.*** In this event, continuation coverage for the additional 11-month period will terminate as of the first day of the month beginning more than 30 days after the date of the final determination or on the date continuation coverage would otherwise terminate, if earlier (see the "Termination" subsection below).

Plan Administrator's Notice Obligations

The plan administrator will provide the employee and the employee's spouse (if any) with certain information regarding their rights under COBRA in the following situations:

Notice of Eligibility to Elect COBRA

The plan administrator will generally notify qualified beneficiaries of their eligibility for continuation coverage within 44 days of a qualifying event.

However, a special rule applies where the qualified beneficiary is required to provide the plan administrator with notice of a qualifying event in order to trigger the qualified beneficiary's eligibility for continuation coverage (see the "Qualified Beneficiary's Notice Obligations" subsection below). In that situation, the plan administrator will notify the qualified beneficiary of the qualified beneficiary's eligibility for continuation coverage within 14 days of receiving notice of the qualifying event, but only if the notice of the qualifying event was timely submitted in accordance with the requirements described in the "Notice Procedures" subsection.

Notice of Unavailability of Continuation Coverage

The plan administrator will provide a notice of the unavailability of continuation coverage in the following situations:

- Where the plan administrator determines that continuation coverage is not available after receiving notice of a potential initial qualifying event that is a divorce, legal separation or a dependent child's loss of eligibility for health coverage under the Plan.

- Where the plan administrator determines that an extension of the continuation coverage period is not available after receiving notice of a potential extension event.

The determination that continuation coverage or an extension of continuation coverage is not available could be made because the plan administrator determines that no qualifying event or extension event occurred, or because the notice of the qualifying event or extension event was defective. A notice will be defective if it is not provided within the applicable time limit or is not provided in accordance with the requirements of the "Notice Procedures" subsection.

The plan administrator will provide the notice of unavailability of continuation coverage within 14 days of the date the plan administrator receives the notice of the potential qualifying event or extension event, or if later, the deadline for submission of additional information requested by the

plan administrator to supplement a defective notice. The notice of the unavailability of continuation coverage will be sent to the individual who submitted the notice of the qualifying event or extension event, and to all individuals for whom continuation coverage or an extension of continuation coverage was being requested.

Qualified Beneficiary's Notice Obligations

In some situations, the employee and/or the employee's dependents have the obligation to provide notice of a qualifying event or extension event to the plan administrator in order to trigger eligibility for continuation coverage or an extension of continuation coverage. The employee and/or the employee's dependents have this obligation in the following situations:

Notice of Certain Initial Qualifying Events

The employee, one of the employee's dependents, or an individual acting on behalf of the employee and/or the employee's dependents must inform the plan administrator of a qualifying event that is a divorce or legal separation, or of a child losing dependent status under the Plan within 60 days after the later of:

- The date of the qualifying event; or
- The date the qualified beneficiary loses health insurance coverage under the Plan on account of that qualifying event.

Notice of an Extension Event

In order to qualify for an extension of the continuation coverage period due to an extension event described in the "Extension of Continuation Coverage" subsection, the employee, one of the employee's dependents, or an individual acting on behalf of the employee and/or the employee's dependent must notify the plan administrator of the extension event within the time limits that apply to that extension event as described in the "Extension of Continuation Coverage" subsection.

These notices must be provided in accordance with the requirements of the "Notice Procedures" subsection. If notice is not provided within the applicable time limit or is not provided in accordance with the notice procedures, continuation coverage or an extension of the continuation period will not be available as a result of the qualifying event or extension event.

Notice Procedures

This subsection describes the procedures a qualified beneficiary must follow to notify the plan administrator of qualifying events and extension events.

The plan administrator has a form which may be used to provide the required notice. The form may be obtained by contacting the plan administrator at the address or telephone number listed at the end of this Summary Plan Description. While use of the notice form will help ensure that the qualified beneficiary provides all of the required information, use of the notice form is not required. Written notification that contains all of the following information will also be accepted:

- The name of the employee or former employee.
- The name of the individual(s) for whom continuation coverage is being requested (i.e., the qualified beneficiary(ies)).
- The current address of the individual(s) for whom continuation coverage or an extension of continuation coverage is being requested.
- The date of the qualifying event or extension event.
- The nature of the qualifying event or extension event (for example, a divorce).
- If the notice relates to a divorce, a copy of the judgment of divorce.
- If the notice relates to a legal separation, a copy of the judgment of separate maintenance.
- If the notice relates to the employee's entitlement to Medicare, a copy of the document(s) establishing the entitlement.
- If the notice relates to a determination that a qualified beneficiary is entitled to Social Security disability benefits, a copy of the disability determination.
- If the notice relates to a determination that a qualified beneficiary is no longer entitled to Social Security disability benefits, a copy of the determination.

Notice that is not furnished by the applicable deadline, is not made in writing and/or does not contain all of the required information is deemed to be defective and may be rejected. If a notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

If the plan administrator receives notice of a qualifying event or extension event that is defective because it is not in writing or does not contain all of the required information, the plan administrator will request the missing information. If the defective notice was provided by the representative of a qualified beneficiary or a potential qualified beneficiary, the plan administrator will send the request to the

representative and each individual who is a qualified beneficiary or a potential qualified beneficiary. If all of the requested information is not provided, in writing, within 30 days of the date the plan administrator requests the additional information, the notice may be rejected. If the notice is rejected, continuation coverage or an extension of continuation coverage will not be available with respect to that potential qualifying event or extension event.

The plan administrator may also request additional information or documentation that is deemed necessary to determine whether a qualifying event or extension event has occurred. If the plan administrator does not receive the requested information or documentation within 30 days of the date it is requested, continuation coverage or an extension of continuation coverage may not be available.

Qualified Beneficiary's Election of Continuation Coverage

If a qualified beneficiary chooses to purchase continuation coverage, the qualified beneficiary must notify the plan administrator within 60 days after the later of:

- The date the qualified beneficiary loses health coverage on account of the qualifying event; or

- The date on which the qualified beneficiary is sent notice of the qualified beneficiary's eligibility for continuation coverage.

Notification is made by timely returning the election form to the plan administrator at the address specified in the election notice. If the qualified beneficiary does not choose continuation coverage during the 60-day period, the qualified beneficiary's participation in the Plan will end as provided in the "Termination" subsection.

Coverage

If a qualifying event occurs, the qualified beneficiaries must be offered the opportunity to elect to receive the group health insurance coverage that is provided to similarly-situated non-qualified beneficiaries. Generally, this means that if the qualified beneficiaries purchase continuation coverage, it will be identical to the health coverage provided to them immediately before the qualifying event. Each qualified beneficiary has the right to make an independent election to receive continuation coverage. Alternatively, the qualified beneficiary may initially elect to purchase one or more of the medical, prescription drug, dental and vision coverages which are provided by the County pursuant to any separate group health plans and/or which may be separately elected pursuant to the County's Flexible Benefits Plan, if applicable. However, each coverage is initially available only if the qualified beneficiary was receiving coverage immediately before the qualifying event.

Qualified beneficiaries do not have to show that they are insurable in order to purchase continuation coverage. If coverage is subsequently modified for

similarly-situated participants, the same modifications will apply to the qualified beneficiary and the qualified beneficiary's dependents. Qualified beneficiaries who purchase continuation coverage will have the opportunity to elect different types of coverage during the annual enrollment period just as active employees.

Cost of Continuation Coverage

Generally, the qualified beneficiary must pay the total cost of continuation coverage. This cost will be up to 102% of the cost of identical coverage for similarly situated participants. However, for disabled qualified beneficiaries and their dependents who elect an additional 11 months of continuation coverage, the cost will be 150% of the cost of the identical coverage for similarly situated participants for the additional 11-month period (and for any longer continuation period for which the disabled qualified beneficiary is eligible, as permitted by law).

The initial premium must be paid within 45 days after the qualified beneficiary elects continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the qualified beneficiary initially elects continuation coverage.

Termination

Generally, continuation coverage terminates at the end of the initial 18- or 36-month continuation period or at the end of any additional 11- or 18-month continuation period for which the qualified beneficiary is entitled to elect continuation coverage. However, continuation coverage may end sooner for any of the following reasons:

Coverage Terminated

The County no longer offers a group health plan to any of its employees.

Unpaid Premium

The premium for continuation coverage is not timely paid, to the extent payment is required.

Other Coverage

A qualified beneficiary becomes covered under another group health plan. Continuation coverage will end as of the date on which the qualified beneficiary first becomes, after the date of the election of continuation coverage, covered under another group health plan. See below for more details regarding the impact of Medicare on COBRA continuation coverage.

Medicare

A qualified beneficiary becomes entitled to Medicare (Part A or Part B). Continuation coverage will end as of the date on which the qualified beneficiary first becomes, after the date of the election of continuation coverage, entitled to Medicare (Part A or Part B).

Cause

A qualified beneficiary's coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of similarly-situated non-qualified beneficiaries (e.g., for fraud or misrepresentation in a claim for benefits). Continuation coverage will end as of the date on which the qualified beneficiary's coverage is terminated for cause.

The plan administrator will notify the qualified beneficiary if continuation coverage terminates before the end of the initial 18- or 36-month continuation period or before the end of any additional 11- or 18-month continuation period for which the qualified beneficiary has elected continuation coverage. The notification will be provided as soon as practicable following the plan administrator's determination that continuation coverage will terminate.

COBRA Continuation and Medicare

COBRA Continuation Coverage and Medicare

In general, if an employee does not enroll in Medicare Part A or B when first eligible because they are is still employed, after the Medicare initial enrollment period, the employee has an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after the employee's employment ends; or
- The month after group health plan coverage based on current employment ends.

If the employee does not enroll in Medicare and elects COBRA continuation coverage instead, the employee may have to pay a Part B late enrollment penalty and have a gap in coverage if the employee wants Part B later. If the employee elects COBRA continuation coverage and later enrolls in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate COBRA continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if the employee enrolls in the other part of Medicare after the date of the election of COBRA coverage.

If the employee is enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation

coverage will pay second. Certain plans may pay as if secondary to Medicare, even if the employee is not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

Other Coverage Options

There may be other coverage options for you and your family through the Health Insurance Marketplace (also known as the exchange). In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premiums, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. For more information about health insurance options available through the Health Insurance Marketplace, visit www.healthcare.gov. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan) even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Questions

Employees and/or their dependents should contact the plan administrator at the address or telephone number listed at the end of this Summary Plan Description if they have questions regarding COBRA that are not answered in this Summary Plan Description. They may also visit the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") website at www.dol.gov/ebsa or call their toll-free number at (866) 444-3272.

Keep Plan Administrator Informed of Address Changes

To protect their rights under COBRA, it is important that the employee and the employee's dependents keep the plan administrator informed of any changes in address. They should also keep a copy, for their records, of any notices that are sent to the plan administrator.

Continuation of Health Coverage Upon Military Leave

If an employee ceases to be eligible for health coverage under the Plan due to service in the U.S. military, the employee and the employee's eligible dependents will be offered the opportunity to continue health coverage in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). The employee and the employee's dependents may also be entitled to elect to continue health coverage under COBRA if the employee ceases to be eligible for health coverage due to the employee's military service. Continuation coverage under USERRA runs concurrently with COBRA continuation coverage.

Length of USERRA Continuation Coverage

An employee may elect to continue health coverage under the Plan for the employee and the employee's eligible dependents for the period that is the lesser of:

- 24 months, beginning with the first day the employee is absent from work to perform military service; or

- The period beginning on the first day the employee is absent from work to perform military service and ending with the date the employee fails to return to employment or apply for reemployment as provided under USERRA.

Electing USERRA Continuation Coverage

If an employee gives the County advance notice of a period of military service that will be 30 days or less, the plan administrator will treat the employee's notice as an election to continue health coverage during the employee's military service unless the employee specifically informs the County, in writing, that the employee wants to cancel health coverage during the employee's military leave. The employee will have to pay the required premiums for the employee's health coverage, but the employee will not have to complete any additional forms or paperwork to continue health coverage during the employee's military service.

If an employee gives the County advance notice of a period of military service that will be 31 days or longer, the plan administrator will provide the employee with a notice of the employee's right to elect to continue health coverage pursuant to USERRA and a form for the employee to elect USERRA continuation coverage for the employee and the employee's eligible dependents. Unlike COBRA, the employee's dependents do not have a separate right to elect USERRA coverage. If the employee wants USERRA continuation coverage for any member of the employee's family, the employee must elect it for the employee and all of the employee's eligible dependents who are covered under the Plan when the employee's military service begins.

If an employee chooses USERRA continuation coverage, the employee must return the USERRA election form to the plan administrator within 60 days of the date it was provided to the employee. If the employee does not timely return the election form, USERRA continuation coverage will not be available to the employee and the employee's eligible dependents.

A special rule applies if the employee does not give the County advance notice of the employee's military service. In that case, the employee and the employee's eligible dependents will not be provided with USERRA continuation coverage during any portion of the employee's military service, but the employee can elect to reinstate health coverage (and the coverage of the employee's eligible dependents) retroactive to the first day the employee was absent from work for military service under the following circumstances:

- The employee is excused from providing advance notice of the employee's military service as provided under USERRA regulations (e.g., it was impossible or unreasonable for the employee to provide advance notice or the advance notice was precluded by military necessity);

- The employee affirmatively elects to reinstate the coverage; and

- The employee pays all unpaid premiums for the retroactive coverage.

Paying for USERRA Continuation Coverage

- **Paid Leave** To the extent the employee has paid time off to cover the period of military leave, the employee may continue coverage by paying the same premium as actively-working employees. After the paid leave is exhausted, if the employee continues on military leave, the payment rules are the same rules as the rules for an unpaid military leave. However, the paid leave will be counted toward the 30-day period described below. As a result, if the paid leave is 31 days or longer, the 102% premium cost will apply.

- **Unpaid Leave** For the first 30 days of military service, the employee's required contributions for health coverage will be the same as the required contributions for the identical coverage paid by similarly-situated active participants. If the employee's period of military service is more than 30 days, beginning on the 31st day of the employee's military service the employee's required contributions will be 102% of the cost of identical coverage for similarly-situated active participants.

USERRA continuation coverage will be cancelled if the employee does not timely pay any required premiums for health coverage. If the employee's USERRA continuation coverage is cancelled for non-payment of premiums, it will not be reinstated.

The initial premium must be paid within 45 days after the date the employee elects USERRA continuation coverage. Subsequent premiums must be paid monthly, as of the first day of the month, with a 30-day grace period for timely payment. However, no subsequent premium will be due within the first 45 days after the employee initially elects USERRA continuation coverage.

Coverage will be suspended if payment is not made by the first day of the month, but will be reinstated retroactively to the first of the month as long as payment for that month is made before the end of the grace period. Payment more than 30 days late will result in automatic termination of the employee's USERRA continuation coverage.

If the employee complies with USERRA upon returning to active employment after military service, the employee may re-enroll the employee and the employee's eligible

dependents in health coverage immediately upon returning to active employment, even if the employee and the employee's eligible dependents did not elect USERRA continuation coverage during the employee's military service. Reinstatement will occur without any waiting periods or pre-existing condition exclusions, except for illnesses or injuries connected to the military service.

CONVERSION PRIVILEGES

When the employee or one of the employee's dependents is no longer eligible under the Plan (either as an active participant, the eligible dependent of an active participant or as a qualified beneficiary receiving continuation coverage), the employee and/or the employee's dependents may be eligible to obtain an individual conversion policy for one or more fully-insured benefits. Conversion availability is set forth in the policy with each insurance carrier. See the County for details.

SPECIAL RULES REGARDING THE HEALTH BENEFITS

There are several special rules which apply to the health benefits under the Plan but do not apply to the welfare benefits. This section summarizes these special rules.

Qualified Medical Child Support Orders ("QMCSO")

Despite any contrary provision in any group health benefit under the Plan, an eligible dependent child may include a child for whom an employee is required to provide coverage pursuant to a QMCSO. Participants can obtain, without charge, a copy of the Plan's QMCSO procedures from the plan administrator.

Health Care Reform

The medical/prescription drug benefits under the Plan comply, and will continue to comply, with the patient protections of the Patient Protection and Affordable Care Act ("PPACA"), the Health Care and Education Reconciliation Act ("HCERA"), and the Consolidated Appropriations Act, 2021 ("CAA"). Collectively, the PPACA, HCERA, and CAA are known as Health Care Reform. The required changes include the following:

- Dependent children must be eligible to participate in the medical and prescription drug benefits under the Plan until at least the child's 26th birthday. However, the County has voluntarily extended coverage until the end of the month in which the child turns age 26.

  NOTE: The dental and vision benefits under the Plan are "excepted benefits" which are not subject to Health Care Reform. However, the County voluntarily amended the definition of dependent child for purposes of the dental and vision benefits to align with the definition under the medical and prescription drug benefits. In other words, the County also

voluntarily extended coverage under the dental and vision benefits until the end of the month in which a dependent child turns age 26.

- Lifetime limits on the dollar value of essential health benefits under the Plan no longer apply.

- Any annual limits on the dollar value of essential health benefits under the Plan no longer apply.

- Medical and prescription drug coverage may not be retroactively rescinded except as permitted by law, for example, in cases of fraud, intentional misrepresentation or failure to timely pay required premiums for coverage. Thirty days advance notice may be required before coverage may be retroactively terminated.

- Any pre-existing condition limitations or exclusions no longer apply.

- Where a participant is required to have a primary care physician (PCP), the participant may designate any participating PCP, including a pediatrician, as the PCP.

- The Plan may not require preauthorization or referral when a participant seeks coverage for obstetric or gynecological care from a participating OB-GYN.

- The Plan is not a grandfathered plan under PPACA and HCERA. Accordingly, the following patient protections under the PPACA and HCERA apply:

    - The Plan must provide certain preventive care items and services without required participant cost-sharing.

    - The Plan may not require preauthorization for emergency services.

    - Maximum out-of-pocket limits are restricted.

    - Certain routine patient costs associated with clinical trials are covered.

    - Participants must be afforded additional rights with respect to internal appeals under the Plan and must be provided with the opportunity to undergo an external review procedure.

- The following patient protections apply with respect to emergency services:

    - The Plan must cover emergency services without requiring you to get approval for emergency services in advance (prior authorization).

- The Plan must cover emergency services by out-of-network providers.

- The Plan must base what you owe the provider or facility (your cost-sharing) on the amount that you would pay an in-network provider or facility, and show that amount in the explanation of benefits.

- The Plan must count any amount you pay for emergency services toward your in-network deductible and out-of-pocket limit.

- The out-of-network provider or facility is not permitted to "balance bill" you for emergency services (see the "No Surprises Act" subsection for more information).

"Emergency services" generally means: (1) an appropriate medical screening that is within the capabilities of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate an "emergency medical condition;" and (2) further medical examination and treatment that is within the capabilities of the staff and facilities available at the hospital or independent freestanding emergency department, as applicable, to stabilize you (regardless of the department of the hospital in which such further examination or treatment is furnished).

An "emergency medical condition" generally means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to: (1) place the health of the individual (or, with respect to a pregnant individual, the health of the pregnant individual or the unborn child) in serious jeopardy; (2) result in serious impairment to bodily functions; or (3) result in serious dysfunction of any bodily organ or part.

- If you receive non-emergency services at an in-network hospital or ambulatory surgery center and you are treated by an out-of-network provider, the following patient protections apply (unless you waive these protections):

  - Your cost-sharing requirement for items or services provided by the out-of-network provider may not be greater than the cost-sharing requirement that would apply if the items or services were provided by an in-network provider. Additionally, the Plan generally must base the cost-sharing amount on the lesser of: (1) the amount billed by the out-of-network provider; and (2) the median of the Plan's (or the claim administrator's) contracted rates with in-network providers for the items or services in the same geographic region.

- The Plan must count any amount you pay for the items or services provided by the out-of-network provider toward your in-network deductible and out-of-pocket limit.

- The out-of-network provider is not permitted to "balance bill" you for these items or services (see the "No Surprises Act" subsection for more information).

NOTE: Providers of ancillary services are not permitted to ask you to waive these patient protections. Ancillary services currently include the following: (1) emergency medicine, anesthesiology, pathology, radiology, or neonatology (whether provided by a physician or non-physician practitioner); (2) assistant surgeons, hospitalists, and intensivists; (3) diagnostic services (including radiology and laboratory services); and (4) items and services provided by an out-of-network provider when there is no in-network provider available to furnish the items or services.

- If you receive air ambulance services (either by airplane or helicopter) from an out-of-network air ambulance provider, the following patient protections apply:

  - Your cost-sharing requirement for items or services provided by the out-of-network air ambulance provider may not be greater than the cost-sharing requirement that would apply if the items or services were provided by an in-network air ambulance provider. Additionally, the Plan generally must base the cost-sharing amount on the lesser of: (1) the amount billed by the out-of-network air ambulance provider; and (2) the median of the Plan's (or the claim administrator's) contracted rates with in-network air ambulance providers for the items or services in the same geographic region.

  - The Plan must count any amount you pay for the items or services provided by the out-of-network air ambulance provider toward your in-network deductible and out-of-pocket limit.

  - The out-of-network air ambulance provider is not permitted to "balance bill" you for its services.

- If you are a "continuing care patient," you will receive a notice from the Plan that you may elect "transitional care" if an in-network provider or facility that is providing you care leaves the Plan's network for reasons other than the provider's or facility's failure to meet applicable quality standards, or for fraud. If you timely notify the Plan (through the claim administrator) of your need for "transitional care," charges from the provider or facility that moved out-of-network will continue to be paid on an in-network basis, and will be subject to the same terms and conditions that apply in-network for a period of 90 days or, if shorter, the date that you

are no longer a "continuing care patient." This 90-day period begins on the date that you receive the notice from the Plan regarding the transitional care.

You are a "continuing care patient" if you: (1) are undergoing a course of treatment for a "serious and complex" condition; (2) are undergoing a course of institutional care or inpatient care; (3) are scheduled to undergo non-elective surgery, including receipt of postoperative care with respect to the non-elective surgery; (4) are pregnant and undergoing a course of treatment for the pregnancy; or (5) were determined to be "terminally ill" and are receiving treatment for the terminal illness.

- If you receive items or services from an out-of-network provider or at an out-of-network facility on the belief that the provider or facility was in-network after consulting the Plan's (or claim administrator's) provider directory (which includes a telephone or electronic, web-based, or internet-based response protocol), the following patient protections apply:

  - The Plan is required to limit your cost-sharing to an amount that is no greater than the cost-sharing that would apply under the Plan if the items or services were provided by an in-network provider or at an in-network facility.

  - The Plan must count any amount you pay for the items or services provided by the out-of-network provider or at an out-of-network facility toward your in-network deductible and out-of-pocket limit.

For more information concerning Health Care Reform or any of these required changes, please contact the plan administrator.

No Surprises Act

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than the Plan's copayments, coinsurance, and/or deductible.

What is "Balance Billing" (Sometimes Called "Surprise Billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in the Plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with the Plan (through the Plan's claim administrator) to provide services. Out-of-network providers may be allowed to bill you for the difference between what the

Plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward the Plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are Protected from Balance Billing for the Following Services:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is the Plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Additionally, under Michigan law, an out-of-network provider of emergency services may generally not charge you more than your in-network cost-sharing amounts that would apply to an in-network provider or facility.

Certain Services at an In-Network Hospital or Ambulatory Surgical Center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is the Plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balanced billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in the Plan's network.

Additionally, under Michigan law, an out-of-network provider may not charge you more than your in-network cost-sharing amounts that would apply to an in-network provider if the provider does not provide you with the required disclosure before the services are provided or when you don't have the opportunity to select and in-network provider.

When Balance Billing Isn't Allowed

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). The Plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, the Plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "**prior authorization**").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the Department of Health and Human Services at https://www.cms.gov/nosurprises/consumers or 1-800-985-3059. The Department of Health and Human Services will route your complaint to the Department of Labor's Employee Benefits Security Administration.

Visit dol.gov/agencies/ebsa for more information about your rights under federal law.

Michigan Department of Insurance and Financial Services ("DIFS") can also help you with health insurance questions and complaints and can provide general information about Michigan's Surprise Medical Billing law. Contact DIFS Monday through Friday from 8 a.m. to 5 p.m. at 877-999-6442 or visit the DIFS website to file a complaint at Michigan.gov/DIFScomplaints.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996, a federal law, provides certain rights to newborns and mothers. 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 the newborn's attending provider, after consulting with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998, a federal law, provides certain rights to participants. Group health plan expenses for a mastectomy include charges for the reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications relating to all stages of the mastectomy, including lymphedemas. Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996, a federal law known as HIPAA, requires group health plans and health insurance issuers to make sure that medical information identifying a participant is kept private, maintain and follow privacy policies and procedures and notify participants of the privacy policies and procedures. In addition, group health plans and health insurance issuers must conduct a written risk analysis and maintain and follow policies and procedures to ensure the security of protected health information maintained or transmitted in electronic form. Further, group health plans and health insurance issuers must comply with the changes made to the HIPAA privacy and security rules under the federal law known as HITECH, including, but not limited to, the new breach notification requirements. (See the "HIPAA PRIVACY AND SECURITY RULES" section for further details.)

Family and Medical Leave Act

An employee eligible for and on a family or medical leave, as defined by the Family and Medical Leave Act of 1993, as amended ("FMLA"), may continue the same level of benefits under the Plan for the employee and the employee's dependents as if the employee had continued in active employment continuously for the duration of the leave.

The employee must pay any required contributions in accordance with the County's FMLA policy. If the employee fails to pay any required contributions within the time requirements of the Plan, the employee's participation in the Plan may be suspended after receiving 15 days advance written notice in accordance with FMLA, subject to the right of immediate reinstatement of participation upon return to work from the FMLA family or medical leave.

If an employee takes an FMLA family or medical leave and does not return to active employment with the County at the end of the FMLA family or medical leave, the

employee will experience a qualifying event for purposes of COBRA on the last day of the FMLA family or medical leave.

If the participant fails to return to work from the FMLA family or medical leave for any reason other than the continuation, recurrence, or onset of a "serious health condition" as defined by FMLA or another circumstance considered by the Plan Administrator as beyond the control of the employee, the County may recover any County contribution paid to maintain coverage for the participant during the leave.

Other provisions regarding an FMLA family or medical leave are set forth in FMLA, the accompanying regulations and the County's FMLA policy.

HEALTH SAVINGS ACCOUNT ("HSA")

An employee who enrolls in the County's high deductible health plan ("HDHP") may be eligible to make contributions to an HSA. This section describes the rules concerning HSAs.

What is an HSA?

An HSA is a tax-favored IRA-type account established for an eligible individual. Contributions to an HSA are fully vested when made, and investment earnings are not taxable when earned. Distributions from the HSA are tax-free if they are used to pay qualified health care expenses. Unused benefits can be carried forward and used in future years.

Who is Eligible to Participate in an HSA?

Employees are eligible to establish and make contributions to an HSA upon satisfying two requirements:

- The employee participates in the County's HDHP (as that term is defined in the Internal Revenue Code) with an annual minimum deductible determined by law; and
- The employee does **not** participate in any health plan that is **not** an HDHP. The employee will **fail** to satisfy this requirement if:
    - The employee participates in a "traditional" health plan (for example, through the County or a spouse's employer); or
    - The employee participates in a medical flexible spending account (for example, through the County a spouse's employer) that permits reimbursement of all types of medical claims. If a spouse has a medical flexible spending account through the spouse's employer, the spouse should check with that employer regarding how the medical flexible spending account coordinates with the HDHP coverage.

Who Administers the Employee's HSA?

An HSA must be held by a trustee or custodian (such as a bank). Employer has selected Health Equity as the trustee or custodian. But Employer will inform you if it switches its selected trustee or custodian for the HSA. This arrangement will not prohibit the you from subsequently transferring you current HSA balance to another qualified trustee or custodian. But Employer will only forward your pre-tax HSA contributions made through the Flexible Benefits Plan and Employer HSA contributions to Health Equity.

If the you elect to contribute to an HSA, Employer will forward your contributions to the trustee or custodian, if you use Health Equity as your trustee or custodian. The money in the HSA will be held by the trustee or custodian. The trustee or custodian will provide the you with more information regarding how the HSA balance will be invested and any election opportunities the employee has with respect to the investments.

What are the Rules for Making HSA Contributions?

IRS rules govern who is eligible to make HSA contributions and the amount that can be contributed each calendar year.

Employees may begin to contribute to an HSA on the first day of the month on or after the date the employee becomes enrolled in the County's HDHP and is eligible to make HSA contributions.

Employees can make tax-deductible contributions directly to an HSA, or employees can elect to make pre-tax contributions to an HSA through the Flexible Benefits Plan, if applicable.

What are the Election Procedures for Making Pre-Tax HSA Contributions?

Employees must make an affirmative election in order to make pre-tax contributions to the HSA through the Flexible Benefits Plan. If the employee elects to make pre-tax contributions to an HSA through the Flexible Benefits Plan, the County will directly deposit the contributions with the trustee or custodian of the HSA, if the trustee or custodian is Health Equity.

If the employee does not make an affirmative election with the County before the required date (i.e., initial date of participation in the County's HDHP), no pre-tax pay reductions will be initially made to the HSA. However, pre-tax pay reductions to the HSA may be made starting as of a subsequent date based upon the procedures established by the County.

Employees can elect to increase, decrease, stop or begin pre-tax HSA contributions at least monthly, as of any prospective date, based upon the procedures established by the County.

The ability to make pre-tax contributions to the HSA ends on the date that the employee ceases to meet the eligibility requirements under the Flexible Benefits Plan.

Will the County Make Contributions to Employees' HSAs?

The County may make a County contribution to the employee's HSA. Any amount provided by the County will be based on a formula determined by the County that is permissible under the Internal Revenue Code and communicated to employees during the open enrollment period. No County contributions will be made to individuals who have terminated participation.

Is There a Limit on HSA Contributions?

The IRS limits the HSA contributions the employee may make each calendar year. The maximum amount depends on whether the employee is enrolled in single/employee-only or family coverage. The maximum may be adjusted each year for changes in the cost-of-living. The County will inform you what the specific maximum annual contribution amounts are for each calendar year.

If the employee will be at least age 55 by December 31, the maximum annual HSA contribution limit for that calendar year will be increased under a special catch-up rule. The additional catch-up contribution amount is $1,000, regardless of whether the employee is enrolled in single/employee-only or family coverage. This amount may be adjusted in future years for changes in the cost-of-living. The County will inform you if this catch-up contribution amount changes.

When Do Employees Lose Eligibility to Make HSA Contributions?

If the employee terminates employment, loses or drops coverage under the County's HDHP, or otherwise becomes ineligible to make HSA contributions (for example, by becoming covered by a medical flexible spending account that reimburses all types of medical claims), the employee will no longer be eligible to contribute to the HSA as of the last day of the month during which the employee terminates employment or otherwise becomes ineligible.

However, if the employee continues to participate in the County's HDHP (for example, by electing COBRA), the employee may still be eligible to make tax-deductible contributions directly to the HSA.

How Can the Employee Access the Employee's HSA Funds?

Once an HSA is established, it may be accessed by following the procedures established by the trustee or custodian. Typically, this will require the submission of a written reimbursement request form to the trustee or custodian. However, the trustee or custodian may issue you an employee a debit card to access the funds in the employee's HSA.

Amounts in the employee's HSA can be distributed to cover the deductible requirements under the HDHP. The employee can also use HSA money to pay for eligible health care expenses not covered by the HDHP. Amounts distributed for health care expenses are tax-free. The employee can also request a distribution for other purposes. For expenses other than eligible health care expenses, the amount distributed is taxable income and is also

subject to a 20% penalty tax. But in certain circumstances the 20% penalty tax may be waived (such as for individuals who are disabled or at least age 65).

What if the Employee Changes Jobs?

HSAs are permanent and portable. Employees can take their HSA with them to their next job. The dollars in the HSA account can continue to grow through investment or the employee can use the monies for eligible health care expenses. However, in order to actively continue to contribute to an HSA, the employee must be covered under a qualified HDHP either through the employee's new employer or through an individual policy.

What Happens to the HSA after the Employee Turns Age 65?

Employees that are enrolled in Medicare (e.g., are age 65 or older) are not eligible to make or receive contributions to the HSA. After the employee reaches age 65, the HSA can be used to pay eligible health care expenses and certain insurance premiums like Medicare Parts B and D. Monies cannot be used to purchase a Medigap policy. Distributions for eligible health care expenses are tax-free. Distributions for other expenses are taxable.

CLAIM AND APPEAL PROCEDURES

Each insurance carrier is responsible for prescribing the claims procedures to be followed with regard to the benefits provided pursuant to that carrier's policy. The summary plan description, insurance certificates or booklets from the third party administrators and the insurers for a benefit that are coupled with this Summary Plan Description contain a summary of the claims procedures. The claims procedures for the prescription drug benefit are as follows[4]:

Initial Decision

A claimant will be notified of a benefit determination as follows:

Urgent Care Health Claims

An urgent care health claim is a pre-service claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A claimant will be notified of a benefit determination regarding an urgent care health claim as soon as possible, consistent with the medical exigencies involved, but no later than 72 hours after the Plan's receipt of the claim unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the claimant will be notified within 24 hours

[4] The claims procedures for the medical benefit will provide claim and appeal rights comparable to the prescription drug benefit.

after the Plan's receipt of the claim of the information necessary to complete the claim. The claimant will be granted 48 hours to provide the information. The claimant will then be notified of the benefit determination within 48 hours after the earlier of the Plan's receipt of the information or the end of the period granted the claimant to provide the information.

Pre-Service Health Claims

A pre-service health claim is a claim for a benefit which is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining medical care. A claimant will be notified of a benefit determination regarding a pre-service health claim within 15 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of the extension will describe the required information and the claimant will be granted 45 days from receipt of the notice within which to provide the information. The Plan will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

Post-Service Health Claims

A post-service health claim is a claim for a health benefit which is not a pre-service claim or an urgent care claim. If a post-service health claim is denied, in whole or in part, the claimant will be notified of the adverse determination within 30 days after the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will be granted 45 days from the receipt of the notice within which to provide the information. The Plan will have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Plan may issue a denial of the claim within 15 days after the expiration of the 45-day period.

Concurrent Care Health Claims

If the Plan has approved an ongoing course of health treatment to be provided over a period of time or over a number of treatments, any reduction or termination by

the Plan of that course of treatment (other than by Plan amendment or termination), will constitute an adverse benefit determination. Notice will be provided in accordance with the "Benefit Determination Notice" subsection below and will be given at least 30 days before the course of treatment is reduced or terminated in order to give the claimant time to appeal the reduction or termination. However, special rules apply in the case of a course of treatment for urgent care. Any request to extend a course of treatment for urgent care will be decided as soon as possible and the claimant will be notified of the determination within 24 hours, provided the claim is made to the Plan at least 24 hours before the expiration of the prescribed course of treatment for urgent care.

Benefit Determination Notice

The claimant will be provided with a written or electronic notification of any adverse benefit determination. The notice will set forth the reason or reasons for the adverse determination, refer to the Plan provisions on which the determination is based, and describe any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. The notice will also describe the Plan's review procedures and related time limits.

If the adverse benefit determination was based upon an internal rule, guideline, protocol or other similar criterion, a statement will be included that such a rule, guideline, protocol or other similar criterion was relied upon and that a copy will be provided free of charge to the claimant upon request. If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will contain a statement that such an explanation will be provided free of charge to the claimant upon request.

Appeal of Denial

The claimant may request a review of an adverse benefit determination regarding a health or disability claim by submitting a written application to the Plan within 180 days following the denial of the claim. An adverse benefit determination includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. In addition, with respect to a non-grandfathered health plan subject to Health Care Reform, a rescission of coverage is considered an adverse benefit determination for this purpose. As a result, a claimant has the right to appeal a rescission of coverage under a non-grandfathered health plan subject to Health Care Reform. The claimant may submit written comments, documents, records and other information relating to the claim. The information will be considered without regard to whether it was submitted or considered in the initial benefit determination.

In filing the appeal, the claimant will be provided, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to the claimant's claim for benefits. For this purpose, a document, record or other information will be considered relevant if it was relied upon in making the benefit determination, was submitted, considered or generated in the course of making the benefit determination, or constitutes a statement of policy or guidance with respect to the Plan

concerning the denied treatment option or benefit. In connection with the appeal of an adverse benefit determination under a non-grandfathered health plan subject to Health Care Reform, the claimant must be provided, free of charge, with new or additional evidence considered, relied upon, or generated by the Plan in connection with a claim, as well as any new or additional rationale for the adverse benefit determination. Further, with respect to an appeal of an adverse benefit determination under a non-grandfathered health plan subject to Health Care Reform, the claimant must be provided with a reasonable opportunity to respond to the new or additional evidence or rationale.

The appeal procedure will provide for a review that does not rely on the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor is a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment including a determination with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involving the judgment. The health care professional engaged for purposes of reviewing the appeal will be an individual who is neither an individual who is consulted in connection with the initial adverse benefit determination nor a subordinate of such an individual. The Plan will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination without regard to whether the advice was relied upon. With respect to a claim under a non-grandfathered health plan subject to Health Care Reform, the Plan shall not base decisions regarding the hiring, compensation, termination or promotion of a claims adjudicator, medical expert or similar individual upon the likelihood that the individual will support the Plan's denial of benefits.

In the case of an appeal of an adverse benefit determination regarding an urgent care health claim, a request for an expedited appeal may be made orally or in writing and all necessary information including the Plan's determination on review may be transmitted between the Plan and the claimant by telephone, facsimile or any other available similarly expeditious method.

Final Decision

The Plan will make a decision regarding a request for review as follows:

Urgent Care Health Claims

The claimant will be notified of the Plan's determination on review regarding an urgent care health claim within 72 hours after the Plan's receipt of the claimant's request for a review of an adverse benefit determination.

Pre-Service Health Claims

There will be two levels of appeal for pre-service claims. Both levels of appeal will be conducted by the claim administrator (and the claim administrator will be a Plan fiduciary for this purpose). The claim administrator will notify the claimant of its

determination regarding a first level appeal within 15 days after receipt of the claimant's request for a review of an adverse benefit determination. A claimant whose first level of appeal is denied may submit a second level of appeal to the claim administrator within 60 days after receiving written notice of the denial of the first level appeal. If the claimant submits a second appeal, the claim administrator will notify the claimant of its determination regarding a second level appeal within 15 days after receipt of the claimant's request of a second level review of an adverse benefit determination.

Post-Service Health Claims

There will be two levels of appeal for post-service claims. Both levels of appeal will be conducted by the claim administrator (and the claim administrator will be a Plan fiduciary for this purpose). The claim administrator will notify the claimant of its determination regarding a first level appeal within 30 days after receipt of the claimant's request for a review of an adverse benefit determination. A claimant whose first level of appeal is denied may submit a second level of appeal to the claim administrator within 60 days after receiving written notice of the denial of the first level appeal. If the claimant submits a second appeal, the claim administrator will notify the claimant of its determination regarding a second level appeal within 30 days after receipt of the claimant's request of a second level review of an adverse benefit determination.

External Review

After a claimant has exhausted the internal appeals described above, the claimant may submit a request for an external review which satisfies U.S. Department of Labor regulations issued in connection with Health Care Reform. Additionally, if you think that the Plan has violated the patient protections under the No Surprises Act (see the "No Surprises Act" subsection), that determination may also be eligible for external review.

Legal Actions

No legal action may be brought to recover benefits under the Plan until the participant has exhausted the claim review procedure. Further, with respect to the self-funded benefits under the Plan, no legal action may be brought after the expiration of one year after the participant has been provided with a written notice denying the final level of Plan appeal concerning a claim. If the Plan fails to strictly adhere to the internal claim and appeal procedures described above with respect to a claim under a non-grandfathered health plan subject to Health Care Reform, the claimant will be deemed to have exhausted the internal claim and appeal procedures and as a result, may initiate an external review and/or file a legal proceeding. However, this rule shall not apply to minor, de minimis violations.

ADMINISTRATION

Plan Sponsor is the plan administrator. The plan administrator is the designated named fiduciary and is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan.

With respect to the self-funded benefits, Plan Sponsor, as the plan administrator, has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the Plan. However, the plan administrator may delegate claims administration for some or all of the self-funded benefits to a third party administrator. Such a third party administrator may be a named fiduciary for benefit appeals pursuant to the applicable benefit.

The fully-insured benefits are provided pursuant to an insurance policy and the insurer has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the policy. The insurers are the exclusive source of payment for the fully-insured benefits.

AMENDMENT OR TERMINATION

Although Plan Sponsor intends to maintain the Plan indefinitely, Plan Sponsor has the authority to amend or terminate the Plan or any benefit at any time. However, no amendment or termination can retroactively diminish a participant's right to obtain Plan benefits. Participants will be informed of any material amendment affecting their benefits or changing the operation of the Plan.

HIPAA PRIVACY AND SECURITY RULES

This section applies to the health benefits under the Plan and is required by the privacy and security rules of HIPAA.

Permitted and Required Uses and Disclosure of Protected Health Information ("PHI")

Subject to obtaining written certification (see below), the Plan may disclose PHI to Plan Sponsor, provided Plan Sponsor does not use or disclose such PHI except for the following purposes:

- Performing Plan Administrative Functions which Plan Sponsor performs for the Plan.
- Obtaining premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan; or
- Modifying, amending or terminating the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event will Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

Conditions of Disclosure

Plan Sponsor agrees that with respect to any PHI, it will:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.
- Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to Plan Sponsor with respect to PHI.
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Plan Sponsor.
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for which it becomes aware.
- Make available to a participant who requests access, the participant's PHI in accordance with 45 CFR §164.524.
- Make available to a participant the right to request an amendment to the participant's PHI and incorporate any amendments to the participant's PHI in accordance with 45 CFR §164.526.
- Make available to a participant who requests an accounting of disclosures of the participant's PHI, the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528.
- Make its internal practices, books, and records, relating to the use and disclosures of PHI received from the Plan, available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA privacy rules.
- If feasible, return or destroy all PHI received from the Plan that Plan Sponsor still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

- Ensure that the adequate separation between Plan and Plan Sponsor, required in 45 CFR §164.504(f)(2)(iii), is satisfied and that terms set forth below are followed.

- Plan Sponsor further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI and Plan Sponsor will ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. Plan Sponsor will report to the Plan any security incident of which it becomes aware.

Certification of Plan Sponsor

The Plan will disclose PHI to Plan Sponsor only upon the receipt of a certification by Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that Plan Sponsor agrees to the conditions of disclosure set forth above.

Permitted Uses and Disclosures of Summary Health Information

The Plan may disclose Summary Health Information to Plan Sponsor, provided such Summary Health Information is only used by Plan Sponsor for the purpose of:

- Obtaining premium bids from health plan providers for providing health coverage under the Plan; or

- Modifying, amending or terminating the Plan.

Adequate Separation Between Plan and Plan Sponsor

- The following employees, or classes of employees, will be given access to PHI:

    - Human Resources Director

    - Benefits and Compensation Manager

    - Employees with oversight responsibilities for claim administration

    - Payroll staff

    - Employees serving in Human Resources functions, who assist in the administration of Plan activities

- Employees in the finance area
- Employees in the audit area
- Employees in the IT area
- In-house legal employees
- Employees in the risk management area

- The access to and use of PHI by the individuals described above will be restricted to the Plan Administrative Functions that Plan Sponsor performs for the Plan.

- In the event any of the individuals described above do not comply with the provisions of the Plan relating to use and disclosure of PHI, the plan administrator will impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions will be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and will be imposed so that they are commensurate with the severity of the violation.

- To comply with the HIPAA security rules, Plan Sponsor will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the authorized employees or classes of employees have access to electronic PHI.

Disclosure of Certain Enrollment Information to Plan Sponsor

Pursuant to 45 CFR §164.504(f)(1)(iii), the Plan may disclose to Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from any health insurance issuer or health maintenance organization offered by the Plan.

Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

Plan Sponsor authorizes and directs the Plan, through the plan administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures will be made in accordance with the HIPAA privacy rules.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan will comply with the HIPAA privacy rules.

Definitions

For purposes of this section, the following terms have the following meanings:

- **"Business Associate"** means a person or entity who:

  - Performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration, data analysis, underwriting, etc.); or

  - Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.

- **"Plan Administrative Functions"** mean activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan administrative functions include quality assurance, employee assistance, claims processing, auditing, monitoring, and management of carve-out-plans–such as dental. PHI for these purposes may not be used by or between the Plan or business associates of the Plan in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Plan administrative functions specifically do not include any employment-related functions.

- **"Protected Health Information"** or **"PHI"** means information that is created or received by the Plan, or a business associate of the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant (whether living or deceased). The following components of a participant's information are considered to enable identification:

  - Names;

  - Street address, city, county, precinct, zip code;

  - Dates directly related to a participant's receipt of health care treatment, including birth date, health facility admission and discharge date, and date of death;

  - Telephone numbers, fax numbers and electronic mail addresses;

  - Social Security numbers;

  - Medical record numbers;

  - Health plan beneficiary numbers;

- Account numbers;
- Certificate/license numbers;
- Vehicle identifiers and serial numbers, including license plate numbers;
- Device identifiers and serial numbers;
- Web Universal Resource Locators (URLs);
- Biometric identifiers, including finger and voice prints;
- Full face photographic images and any comparable images; and
- Any other unique identifying number, characteristic or code.

- **"Summary Health Information"** means information that may be individually identifiable health information:
  - That summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the County has provided health benefits under a health plan; and
  - From which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

Fully-Insured Health Plans Administered Under "Hands Off" Approach

Pursuant to HIPAA, if a group health plan is fully-insured and only enrollment/ disenrollment information and Summary Health Information rather than Protected Health Information is disclosed to Plan Sponsor and Plan Sponsor only uses the Summary Health Information to obtain premium bids and/or to amend/terminate the Plan, then the responsibility to comply with the HIPAA privacy rules generally shifts from the Plan to the insurer. This is known as the "hands off" approach to administration. Any fully-insured health benefits under the Plan which are administered under the hands off approach shall not otherwise be subject to the HIPAA privacy and security rules set forth in this Article.

Hybrid Entity

To the extent the Plan provides any non-health benefits such as (but not limited to), disability benefits or group term life insurance benefits, those benefits shall be considered "non-covered functions." The Plan is a separate legal entity whose business activities include the functions covered by the HIPAA privacy and security rules and non-covered functions. As a result, the Plan is a hybrid entity, as that term is defined in HIPAA. The Plan's covered functions are its health benefits ("health care component"). All other

benefits are non-covered functions. Therefore, the Plan hereby designates that it shall only be a covered entity under the HIPAA privacy and security rules with respect to the health care component (the health benefits) of the Plan.

GOVERNING LAW

The Plan will be construed in accordance with the laws of the state of Michigan and applicable federal law, such as Health Care Reform.

OTHER BASIC INFORMATION ABOUT THE PLAN

Name of Plan:	Kent County Employee and Retiree Benefits Plan
Name, Address, Telephone Number and Taxpayer Identification Number of Plan Sponsor:	Kent County Administration 300 Monroe Avenue, N.W. Grand Rapids, MI 49503 (616) 632-7440 38-6004862
Type of Plan:	A group benefits plan providing medical, prescription drug, dental, vision, group term life/AD&D, sickness and accident, long-term disability, and medical and dependent care flexible spending accounts benefits.
Type of Administration:	The Plan is administered by the plan administrator. With respect to each self-funded benefit, the plan administrator may retain the services of a third party administrator to provide administrative services. With respect to each fully-insured benefit, the insurer provides administrative services.
Plan Administrator:	Plan Sponsor
Claim Administrator for the Prescription Drug Benefit:	Capital Rx
Claim Administrators, Third Party Administrators and Insurers for Other Benefits:	See the summary plan descriptions, insurance certificates and booklets for addresses and telephone numbers of claim administrators, third party administrators and insurers.
Plan Year for Fiscal Record Purposes:	January 1 through December 31 However, the Plan may maintain a different 12-month period for other purposes. For example, insurance policies may renew based on a different 12-month cycle, participants may make annual benefit elections on a different 12-month cycle and the period of coverage for deductibles, annual out-of-pocket limits and other annual benefit provisions may operate on a different 12-month period.

APPENDIX A – RETIREE INSURANCE COVERAGE

If you retire, your group health coverage as an active employee of Kent County, (the "County") continues until the last day of the month of your active employment. Thereafter, if you are an employee of the County who retires, you are eligible for retiree health insurance (medical, prescription drug, dental and vision) provided by the County, as further described below.

Retirees, and their spouses and dependent children are not vested in their rights to dental benefits under the retiree health insurance provided by the County. The County reserves its right to amend or terminate retiree dental benefits at any time.

All Retirees except Retired Judges

1. Retiree Eligibility You are eligible for retiree coverage on the first day of the month corresponding with your retirement if you are eligible for a pension benefit under the Kent County Employee's Retirement Plan upon your retirement and you meet the applicable criteria set forth in either (a), (b), (c) or (d) below.

    a. You are a member of one of the following employee groups: Kent County Deputy Sheriff's Association (hired before January 1, 2013), or Kent County Law Enforcement Association (POAM) and you retire from the County on or after the date you satisfy one of the following requirements:

        i. You complete 25 years of service regardless of age;

        ii. You complete 15 years of service and reach age 55; or

        iii. You complete 5 years of service and reach age 60.

    b. You were initially hired prior to January 1, 2011 and are a "grandfathered" member of one of the following employee groups: MPP, Elected Officials, Captains/Lieutenants, Court Reporters, UAW, Prosecuting Attorneys, Teamsters-PHN, or Technical, Professional and Office-Workers Association of Michigan (TPOAM) or you were initially hired prior to January 1, 2012 and are a "grandfathered" member of the Teamsters-Parks or Circuit Court Referees employee group, and you retire from the County on or after the date you satisfy one of the following requirements:

        i. You complete 25 years of service regardless of age;

        ii. You complete 15 years of service and reach age 55; or

        iii. You complete 5 years of service and reach age 60.

    c. You were initially hired on or after January 1, 2011 and are a member of one of the following employee groups: MPP, Elected Officials, Court Reporters, UAW, Prosecuting Attorneys, Teamsters-PHN, or Technical, Professional and Office-Workers Association of Michigan (TPOAM) or you were initially hired on or after January 1, 2012 and are a member of the Teamsters-Parks or Circuit Court Referees

employee group, and you retire from the County on or after the date you satisfy the following requirements:

i. You complete 5 years of service and reach age 62; or

ii. You complete 25 years of service and reach age 60.

d. You were initially hired on or after January 1, 2011 and are a member of the following employee group: Captains/Lieutenants, or you were initially hired on or after January 1, 2013 and are a member of the following employee group: Kent County Deputy Sheriff's Association, and you retire from the County on or after the date you satisfy the following requirements:

i. You complete 5 years of service and reach age 62; or

ii. You complete 25 years of service and reach age 55.

For this purpose, you will be credited with one year of service for each calendar year in which you have at least 1,800 hours of service with the County. If you have at least 500 hours of service during a calendar year but less than 1,800 hours, you will be credited with a pro-rated partial year.

2. Retiree Health Benefits

a. Medical and Prescription Drug Before you and your spouse become eligible for Medicare, you are generally eligible for the same medical and prescription drug benefits offered to actively-working employees and their dependents.

At the time you (or your spouse) become eligible for Medicare, you (or your spouse) have the following choices:

i. With respect to medical coverage:

(A) You may continue to participate in the pre-Medicare eligible medical benefit. The coverage will be provided on a secondary basis to Medicare Parts A and B. This is true even if you or your spouse fail to enroll in both Medicare Parts A and B; or

(B) Alternatively, the County makes available a fully-insured Medicare supplement. The supplement pays on a secondary basis to Medicare Parts A and B. As a result, it is important for you (or your spouse) to enroll in those benefits as soon as you become eligible.

ii. With respect to prescription drug coverage:

(A) You may continue to participate in the pre-Medicare eligible prescription drug benefit. The coverage will be provided on a secondary basis to Medicare Part D. This is true even if you or your spouse fail to enroll in Medicare Part D; or

(B) Alternatively, the County makes available prescription drug benefits which include Medicare Part D coverage. If you enroll in one of these alternatives, separate enrollment in Medicare Part D will not be required. See the County for details.

b. Vision Coverage All retirees (regardless if eligible for Medicare) and their dependents are eligible for a vision benefit. See the County for details.

Any dependent children are generally eligible on the same basis as a spouse (see Sections 3 and 4). See Section 5 for the rules on the cost of coverage.

3. Dependent Eligibility for Retiree Insurance Your spouse and dependent children, as those terms are defined in the County's group health plan for actively-working employees, are eligible.

4. Enrollment

a. Eligible retirees and their spouses and dependent children may enroll in retiree health insurance by contacting the County and completing the necessary application forms and also paying the required premium.

b. At the time of retirement an eligible retiring employee can elect retiree health insurance coverage. If coverage is to be effective upon retirement it must be elected within 30 days of the employee's retirement date. If you defer enrollment or have not previously elected retiree health insurance, coverage can only be subsequently elected if you experience a loss of other coverage or acquire a new dependent, or during an annual open enrollment period.

c. If retiree health coverage is dropped for you (or your spouse or your dependent child) it cannot be reinstated unless you experience a loss of other coverage or acquire a new dependent, or during an annual open enrollment period.

d. There will be an annual open enrollment period for retirees to make benefit election changes. The County will establish the choices available, if any, to retirees.

e. Spouses have independent election rights with respect to retiree health coverage. Any dependent children may enroll but their coverage elections are tied to the retiree's enrollment elections.

5. Cost and Payment of Retiree Insurance Retirees are required to contribute toward the cost of retiree health insurance for themselves and their spouses and dependent children. The cost may vary depending on your years of service, date of retirement, or collective bargaining agreement (see the management pay plan or applicable collective bargaining agreement for more information). Payment must be made in full by check or money order in advance of the first day of the month for that month's coverage. However, for convenience, the participant may elect to pay all or a portion of the payment for retiree health coverage otherwise due via the retiree's monthly pension payment. If the participant voluntarily elects for such a deduction to be made, it will be made from the monthly pension payment during that month for that month's retiree health benefit coverage.

6. Funding of Benefits County contributions made by the County for benefits under this Appendix are placed in a tax-exempt VEBA trust. The trust has been established for the exclusive purposes of providing benefits to eligible retirees and paying reasonable administrative expenses associated with the County's retiree insurance program. Each month County funding for retiree health benefits is forwarded to the Risk Management Fund which forwards payment to the claim administrators, third party administrators and insurers.

7. Termination of Retiree Insurance Participation in the retiree health insurance program will terminate on the earliest of the following dates:

   a. The end of the month following the date any required premium is due but not timely paid.

   b. The date as of which coverage is voluntarily cancelled for an individual (retiree, spouse and/or dependent child).

   c. For retirees, the last day of the month the individual no longer qualifies as an eligible retiree.

   d. For dependents, the date coverage would terminate for a dependent of an employee who became ineligible. For example, if a retiree and spouse divorce, the spouse will no longer be eligible for retiree coverage but may be eligible to elect COBRA continuation coverage. Similarly, if a dependent child reaches the limiting age, (the last day of the calendar month in which the dependent attains age 26 but, no age limit will apply to an unmarried dependent child who is totally disabled before age 26), the dependent child will no longer be eligible for retiree coverage but may be eligible to elect COBRA continuation coverage with proper notification.

   e. The date as of which the individual (retiree, spouse or dependent child) dies. In the event of death, the County must be notified as soon as possible. If the spouse or dependent child dies, the retiree remains eligible. Conversely, if the retiree dies, the continued eligibility of the spouse and any dependent children depend upon the form of benefit payment the retiree elected under the Retirement Plan. For example, if the retiree elected a single life annuity, benefits end for the spouse and any dependent children upon the retiree's death. (However, COBRA continuation coverage may then be elected with proper notification.) On the other hand, if the retiree elected a pension benefit with survivor coverage, the spouse and any dependent children may be eligible for continued retiree coverage. See the County for details.

   f. The date as of which coverage is terminated for cause. Termination for cause includes a termination for fraud or misrepresentation in an application for participation or in a claim for benefits.

   g. The date the County amends the Plan to eliminate coverage for the class of individuals to which the retiree or dependent belongs.

Except in the case of voluntary cancellation, if an individual's coverage terminates, the individual shall in no circumstances become subsequently eligible for any retiree health insurance offered by the County.

8. No Vested Rights Retirees and their spouses and dependent child(ren) are not vested in their rights to any retiree insurance offered by the County. The County reserves its right to amend or terminate retiree insurance coverage at any time.

Retired Judges

1. Retiree Eligibility You are eligible for retiree coverage on the first day of the month corresponding with your retirement if you are a retired judge who was initially hired, appointed, or elected on or after March 30, 1997, you leave the bench on or after January 1, 2021, and on your retirement you satisfy one of the following requirements:

   a. You complete 5 years of service and reach age 59½; or

   b. You complete 15 years of service and reach age 55.

2. Retiree Health Benefits

   a. Medical and Prescription Drug Before you and your spouse become eligible for Medicare, you are generally eligible for the same medical and prescription drug benefits offered to actively-working employees and their dependents.

      At the time you (or your spouse) become eligible for Medicare, you (or your spouse) must enroll in the County's group Medicare Advantage Prescription Drug Plan.

   b. Vision Coverage All retired judges (regardless if eligible for Medicare) and their dependents are eligible for a vision benefit. See the County for details.

   Any dependent children are generally eligible on the same basis as a spouse (see Sections 3 and 4). See Section 5 for the rules on the cost of coverage.

3. Dependent Eligibility for Retiree Insurance Your spouse and dependent children, as those terms are defined in the County's group health plan for actively-working employees, are eligible.

4. Enrollment

   a. Eligible retired judges, and their spouses and dependent children may enroll in retiree health insurance by contacting the County and completing the necessary application forms and also paying the required premium.

   b. At the time of retirement an eligible retiring employee can elect retiree health insurance coverage. If coverage is to be effective upon retirement it must be elected within 30 days of the employee's retirement date. If you defer enrollment or have not previously elected retiree health insurance, coverage can only be subsequently

elected if you experience a loss of other coverage or acquire a new dependent, or during an annual open enrollment period.

c. If retiree health coverage is dropped for you (or your spouse or your dependent child) it cannot be reinstated unless you experience a loss of other coverage or acquire a new dependent, or during an annual open enrollment period.

d. There will be an annual open enrollment period for retired judges to make benefit election changes. The County will establish the choices available, if any, to retired judges.

e. Generally, your spouse and dependent children may only enroll in the benefits (medical/prescription drug or vision) if you enroll in the benefit. There is an exception to this rule with respect to the medical and prescription drug benefits when you and/or your spouse are eligible for Medicare. In that case, if you or your spouse are eligible for Medicare, you or your spouse must enroll in the County's group Medicare Advantage Prescription Drug Plan. But if you or your spouse are not **also** eligible for Medicare, the non-Medicare eligible individual, including your dependent children, may enroll in the same medical and prescription drug benefits offered to actively-working employees and their dependent children.

5. Cost and Payment of Retiree Insurance Retired judges are required to contribute towards the cost of retiree health insurance for themselves and their spouses and dependent children. The cost may vary depending on whether the County provides you with a stipend towards the cost of retiree health insurance. If the County provides you with a stipend towards the cost of retiree health insurance, that stipend may only be used to offset the cost of **your** coverage (not coverage for your spouse or dependent children) under the **medical and prescription drug benefit** (not the vision benefit). If you retire from the County with less than 25 years of service, your stipend will be prorated.

Payment of the required contribution towards the cost of retiree health insurance must be made in full by check or money order in advance of the first day of the month for that month's coverage.

6. Funding of Benefits County contributions made by the County for benefits under this Appendix are placed in a tax-exempt VEBA trust. The trust has been established for the exclusive purposes of providing benefits to eligible retirees and paying reasonable administrative expenses associated with the County's retiree insurance program. Each month County funding for retiree health benefits is forwarded to the Risk Management Fund which forwards payment to the claim administrators, third party administrators and insurers.

7. Termination of Retiree Insurance Participation in the retiree health insurance program will terminate on the earliest of the following dates:

a. The end of the month following the date any required premium is due but not timely paid.

b. The date as of which coverage is voluntarily cancelled for an individual (retired judgge, spouse and/or dependent child).

c. For retired judges, the last day of the month the individual no longer qualifies as an eligible retired judge.

d. For dependents, the date coverage would terminate for a dependent of an employee who became ineligible. For example, if a retired judge and spouse divorce, the spouse will no longer be eligible for retiree coverage but may be eligible to elect COBRA continuation coverage. Similarly, if a dependent child reaches the limiting age (the last day of the calendar month in which the dependent attains age 26 but, no age limit will apply to an unmarried dependent child who is totally disabled before age 26), the dependent child will no longer be eligible for retiree coverage but may be eligible to elect COBRA continuation coverage with proper notification.

e. The date as of which the individual (retired judge, spouse or dependent child) dies. In the event of death, the County must be notified as soon as possible. If the spouse or dependent child dies, the retired judge remains eligible. Conversely, if the retired judge dies, the spouse and dependent children will cease to be eligible, but will be offered COBRA continuation coverage for any benefit in which the spouse or the dependent children were enrolled at the time of the retired judge's death. See the County for details.

f. The date as of which coverage is terminated for cause. Termination for cause includes a termination for fraud or misrepresentation in an application for participation or in a claim for benefits.

g. The date the County amends the Plan to eliminate coverage for the class of individuals to which the retired judge or dependent belongs.

Except in the case of voluntary cancellation, if an individual's coverage terminates, the individual shall in no circumstances become subsequently eligible for any retiree health insurance offered by the County.

8. No Vested Rights Retired judges and their spouses and dependent child(ren) are not vested in their rights to any retiree insurance offered by the County. The County reserves its right to amend or terminate retiree insurance coverage at any time.

This Policy Statement supersedes any prior descriptions of the County's retiree insurance program set forth in any Summary Plan Description or other documents.