MONTGOMERY COUNTY, MARYLAND

MEDICAL INDEMNITY PLAN
for
RETIRED EMPLOYEES AND ELIGIBLE DEPENDENTS

Summary Description

Effective January 1, 2016

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PURPOSE OF THE PLAN

This Summary Description describes the Montgomery County Medical Indemnity Plan for Retired Employees and Dependents ("Plan"). This Summary Description only highlights the benefits and procedures contained in the Plan, the official Plan document and benefit booklet will control, even when conflicts arise between the Summary Description and the Plan document and benefit booklet. A copy of the Plan document may be obtained upon written request to the OHR Health Insurance Team. A reasonable charge may be made for copying this document.

The following is a summary of the Plan. The information presented reflects ***current benefits and provisions*** only. They are applicable to individuals who were participating in the indemnity medical option as of December 31, 2013 and who continued to participate in the Plan since that date. Before January 1, 2014, this Plan was a part of the County's Group Insurance Plan and as of January 1, 2014, this Plan became a separate plan. This is a closed plan and only retirees participating in the Plan as of December 31, 2015 may participate in the Plan.

The County expects to continue the Plan, but it is the County's position that there is no implied contract between participants and the County to do so. Subject to any express contract entered into by the County, including any collective bargaining agreements, the County reserves the right at any time and for any lawful reason to amend this Plan.

The Plan may also be amended by the County at any time, either prospectively or retroactively, to comply with the Internal Revenue Code or other applicable law.

BENEFITS AVAILABLE

If you currently participate in the indemnity medical option of the County's Group Insurance Plan, you may continue participation in this Plan. The benefits available under the Plan are administered through CareFirst. These rules are explained in a separate benefit booklet, available from the OHR Health Insurance Team. Details are also available in the Addendum.

ELIGIBIILTY

If you are a retiree participating in the Plan on December 31, 2015, you and your eligible dependents may continue to participate in the Plan. If you are not participating in the Plan on December 31, 2015, you are not eligible to participate in the Plan.

If you discontinue participation in the Plan, you may not re-enter the Plan at a later date.

Rehired Retirees

Participation in the Plan ends if you return to work for the County or a participating agency in a position eligible for active County group insurance coverage. You may not re-enter the Plan upon subsequent termination of employment.

Dependent Coverage

Your eligible dependents may participate in the Plan if they remain eligible dependents. Eligible dependents are:

- Your spouse or eligible domestic partner (please refer to the separate *Domestic Partner Benefits* Affidavit document for complete eligibility requirements and tax implications).

- Your children (including the children of your eligible domestic partner) until the day of their 26th birthday. The term "children" includes any biological children, any adopted children, and any stepchildren.

- An eligible dependent includes a child for whom you have legal guardianship. The child's coverage may continue until his/her 26th birthday if, before his/her 18th birthday, you had legal guardianship of the child and the child was covered under a County Government health plan.

- An unmarried child (including an unmarried child of your eligible domestic partner) age 26 and older who is incapable of self-support because of a mental or physical disability and who depends on you for support. The child's coverage may continue if the disability began before the day of their 26th birthday and the child was covered under a County Government health plan before age 26.

  Coverage will continue as long as the disabled child is incapacitated and financially dependent upon you; however, coverage may be otherwise terminated in accordance with the terms of the Plan.

You are responsible for notifying the OHR Health Insurance Team when your dependents are no longer eligible for coverage. If you do not do so, you will be responsible for 100% of any claims incurred.

Domestic Partner Benefits

County law requires that any employment benefit the County provides for the spouse of a County employee or the spouse's eligible dependents must be provided for the domestic partner of a County employee and the partner's eligible dependents.

What are the requirements for domestic partnership?

You and your partner must continue to meet the following requirements:

1) be the same sex;
   - share a close personal relationship and be responsible for each other's welfare;
   - have shared the same legal residence for at least 12 months;
   - be at least 18 years old;
   - have voluntarily consented to the relationship, without fraud or duress;
   - not be married to, or in a domestic partnership with, any other person;
   - not be related by blood or affinity in a way that would disqualify them from marriage under State law if the employee and partner were opposite sexes;
   - be legally competent to contract; and
   - share sufficient financial and legal obligations (described below in the section on *Required Evidence*) *or*,

2) legally register the domestic partnership, if:

- a domestic partnership registration system exists in the jurisdiction where the employee resides; and
- the OHR Health Insurance Team determines that the legal requirements for registration are substantially similar to the requirements listed under 1) on page 3.

What are the tax implications?

If you cover dependents who do not qualify as tax dependents under the Internal Revenue Code, the value of the County's contribution toward that coverage is considered taxable wages and will be reported as taxable income. This is *imputed income*. The County assumes that neither your domestic partner nor your partner's eligible dependents qualify as tax dependents, unless you provide acceptable documentation. For more information, contact the OHR Health Insurance Team.

What if my domestic partnership ends?

Should your relationship with your domestic partner end, or you no longer meet the domestic partnership requirements, the domestic partner and the partner's eligible dependents are no longer eligible for coverage under the Plan. You must notify the OHR Health Insurance Team (on an approved Statement of Dissolution of Domestic Partnership form) within 60 days of the termination event. Termination in the Plan will occur and the domestic partner and the partner's eligible dependents may be able to continue their health coverage under COBRA.

Same Sex Spouse

If you are legally married to your spouse, you will be treated for tax purposes in the same manner as if your spouse were the opposite sex.

In the Event of Death

If you die while participating in the Plan, your surviving spouse or eligible domestic partner and/or other dependents (who were eligible at the time of death, including an unborn child) remains eligible for coverage under the Plan. A surviving spouse or eligible domestic partner may only continue to cover other dependents who were participating in the Plan at the time of your death. A non-spouse or non-eligible domestic partner dependent remains eligible for coverage for as long as the individual meets the definition of dependent and may only elect individual coverage if not covered by the surviving spouse or eligible domestic partner.

ELECTING BENEFITS

If you are currently participating in the Plan, you may continue participation in the Plan.

During each annual Open Enrollment, you may change your medical option by electing not to participate in the Plan, but once you end participation in the Plan, you may not re-enter. If you fail to elect to continue participating in the Plan during the annual open enrollment, your participation in the Plan will end and you will not have any medical coverage.

QUALIFIED STATUS CHANGE

You may elect new benefits each year. Keep in mind that your choices are in effect for the entire calendar year, and can only be changed during the year if you have a *qualified status change*. Also remember this is a closed plan so that if you elect to discontinue participation in the Plan, you may not re-enter at a later date, even if you have a qualified status change.

Qualified status changes include:

Legal marital status. Events that change your legal marital status such as marriage, the death of a spouse, divorce and annulment.

Domestic partnership. Entering into or dissolving a domestic partnership.

Number of dependents. Events that change the number of your dependents such as birth, death, adoption and placement for adoption of a child.

Employment status. The following events that change your, your spouse's or dependent's employment status:

- A termination or commencement of employment;
- A strike or lockout;
- A commencement of or return from an unpaid leave of absence; or
- A change in a worksite.

This category also includes a change in your employment status or the employment status of a dependent, in which you or your dependent become (or cease to be) eligible for coverage under a plan.

Dependent's eligibility for coverage. Events that cause your dependent to satisfy or cease to satisfy eligibility requirements for coverage such as attainment of a certain age, change in dependent status or change in employment.

Residence. A change in your, your spouse's or dependent's residence.

Special rule for court-ordered health coverage of child. A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) that requires you to provide coverage for your child. You may also cancel coverage for the child if the order requires your spouse, former spouse or another individual to provide coverage for the child.

Special rule for Medicare or Medicaid entitlement. You may be able to make a prospective election change to cancel or reduce coverage under the Plan if you, your spouse or dependent who is enrolled in the Plan becomes entitled to Medicare or Medicaid coverage or if you lose premium assistance from your State under the Children's Health Insurance Program. Conversely, if you, your spouse, or dependent loses eligibility for Medicare or Medicaid coverage or become eligible for premium assistance from your state under the Children's Health Insurance Program, you may make a prospective election to commence or increase coverage under the Plan.

The occurrence of a special enrollment period under HIPAA. For example, you may change your election if you lose coverage under another plan.

Other special circumstances. Other special circumstances that may permit you to change your elections include cost and coverage changes to a health plan, such as a significant change in your health coverage or your spouse's coverage. You may also elect changes to correspond with your spouse's open enrollment period.

If you have a qualified status change or experience one of the circumstances described above, you must submit the proper forms and supporting documentation to verify the event to the OHR Health Insurance Team within 60 days of the event. If the qualified status change is the birth, adoption or placement for adoption of a child, any election to add your dependent will be retroactive to the child's date of birth, date of placement for adoption or date of adoption. If you submit the completed forms and supporting documentation for the birth, adoption or placement for adoption of a newborn (6 months of age or less) outside the 60 day time frame, the effective date of coverage will be the date the completed forms and supporting documentation are submitted. If the child is older than 6 months and you are outside the 60 day time frame, you must wait until the next enrollment period. Other qualified status change elections will be effective on the first day of the month following submission to the OHR Health Insurance Team provided the submission is received and processed by the 10th day of the month (or the last business day before the 10th of the month if the 10th falls on a weekend or holiday). If OHR Health Insurance Team receives the forms after the 10th of the month, the effective date of the qualified status change will start on the first day of the second month.

Any adjustments to your premiums applicable to your qualified status change will commence on the effective date of the qualified status change (e.g., the first day of the month following notification if proper notice given before the 10th day of the month). If you do not make the proper notification within 60 days, you must wait until the next open enrollment period to make any election changes.

It is recommended that you notify OHR Health Insurance Team promptly as a qualified status change could change your level of enrollment and your monthly premium.

COST SHARING

If your most recent date of hire as a permanent full-time or part-time employee was after December 31, 1986, you are eligible for the following cost sharing arrangement. If you were an FOP member hired before December 31, 1986, this method also applies to you.

"Years" refers to years of eligibility under the County's group insurance plan; it does not include any transferred or purchased service, or any sick leave converted to credited service for ERS purposes.

	County Share	**Retiree Share ***
15 or more years…….	70%	30%
10 years……..	60%	40%
5 years……..	50%	50%

For each year between 5 and 15 years, the County's share increases 2%.

If your most recent date of hire as a permanent full-time or part-time employee was prior to January 1, 1987, your cost sharing arrangement is as follows. You must have been an unrepresented employee, a member of IAFF or MCGEO to have this option.

"Years" refers to years of eligibility under the County's group insurance plan; it does not include any transferred or purchased service, or any sick leave converted to credited service for ERS purposes.

	County Share	**Retiree Share**
For the period of time equal to the number of years of your eligibility under the group insurance plan, beginning from your retirement date [/1]…….	80%	20%
After that period……	0%	100%

[/1] ***Please note that this cost sharing period is not affected by any times during which, as a retiree, you elected no coverage for the benefits available to you.***

At retirement, you may have elected the cost sharing arrangement available to employees whose most recent date of hire as a permanent full-time or part-time employee was after December 31, 1986. This choice was available to members of MCGEO, IAFF and unrepresented employees. You may not change your cost sharing arrangement.

"Years" refers to years of eligibility under the County's group insurance plan; it does not include any transferred or purchased service, or any sick leave converted to credited service for ERS purposes.

Also, if you retired on a service-connected disability either under the ERS, EOP or RSP, 5 years is added to your years of eligibility under the Plan for cost sharing purposes.

CONTINUATION OF THE PLAN

The County expects to continue the Plan, but it is the County's position that there is no implied contract between employees and the County to do so, and reserves the right at any time and for any reason to amend or terminate the Plan, subject to the County's collective bargaining agreements.

The Plan may also be amended by the County at any time, either prospectively or retroactively, to conform to the Internal Revenue Code or applicable law.

CLAIMS AND APPEALS

In general, any denial of a claim for benefits must be in writing to you and must state the reason for the denial. You will be provided a reasonable opportunity to file a written request for a review of the decision denying the claim. The Plan has its own procedures for making claims and for appealing denied claims. The procedures contain important information regarding time limits for requesting a review. If you do not request a review in a timely manner, your claim will remain denied. These procedures are described in detail in the individual benefit booklet available from the OHR Health Insurance Team.

You must submit any claims for services received within fifteen (15) months following the date of service.

PLAN TERMINATION

Should the Plan ever be terminated, the County will pay benefits payable on the date of termination.

ADDENDUM

BENEFIT SUMMARY

The CareFirst BlueCross BlueShield Indemnity Plan covers most of your health care needs and allows you to choose where to receive services, either from a participating provider who contracts with CareFirst to provide services at a fixed cost, or from any other covered provider that CareFirst recognizes as an eligible provider of medical services (Non-Participating Provider). You must submit any claims for services received by out of networker providers within fifteen (15) months following the date of service.

The CareFirst BlueCross BlueShield Indemnity Plan includes prescription drug coverage. If you (and/or your dependents) are eligible for Medicare (including due to disability) you (and/or your dependents) will automatically be enrolled in Medicare Part D. The prescription benefits coordinate around Medicare to provide prescription drug coverage. Silverscript administers the program for the County. Medicare requires that you have a 21 day period to opt out of Medicare part D coverage. However, if you opt out, **you (and your dependnets, if applicable) will not have any prescription drug coverage through the County's Plan.** Under Medicare, if you pay an income based adjusted premium, you will also pay an additional amount for Part D.

Under the coordination with Medicare, all aspects of the benefits provided are as described below, For example, you will pay the applicable copayment and the Prescription Plan's formulary will apply.

Coverage for maintenance medications
A maintenance medication is a medicine taken regularly for chronic conditions or long-term therapy, such as prescriptions for high blood pressure, asthma or diabetes. For the price of one copayment for up to a 90- to 102-day supply, you and your covered dependents have the choice of purchasing your maintenance medications via a participating retail pharmacy or Caremark's Mail Service Pharmacy.

Coverage for brand name medications that have generic equivalents
Caremark participating retail pharmacies and the Caremark Mail Service Pharmacy automatically fill prescriptions with generic equivalents. If your doctor includes "dispense as written" instructions on your prescription, Caremark may contact your doctor to request consideration of a less expensive but equivalent drug.

Prescription Benefits *At-a-Glance*

	Short-Term Medications	Maintenance Medications
Supply amount	➢ Up to a 30-day supply	➢ Up to a 3-month (90-day) supply
Where / how	To purchase up to a 30-day supply, use your Caremark Discount Card at over 64,000 participating retail pharmacies nationwide (e.g., a CVS, Target, Giant, Safeway, Walgreens or Walmart pharmacy).	To purchase a 3-month supply, use Caremark's Mail Service Pharmacy or your Caremark Discount Card at over 64,000 participating retail pharmacies nationwide (e.g., a CVS, Target, Giant, Safeway, Walgreens or Walmart pharmacy).
Copayment	You pay 20% of the discounted price	You pay 20% of the discounted price

The coverage described in the chart is how the Plan pays when it is your primary coverage. Generally, if you are also covered under Medicare and are retired from the workforce, Medicare is your primary coverage and your County plan is secondary. This may change the copays and charges listed in the medical comparison chart. The Plan *coordinates* with Medicare so that the benefits payable under the Plan will generally be reduced by the benefits payable under Medicare, regardless of whether you are actually enrolled in Medicare. However, as described above, you (and/or your dependents) must be enrolled in Medicare Part D in order to receive prescription drug benefits under the Plan. If you (and/or your eligible dependents) are not enrolled in opt out of Medicare Part D, you will no longer participate in the Plan and will be enrolled in United Healthcare medical plan.

Benefit Type	Health Plan
(Assumes Primary Coverage)	**Indemnity Plan (closed to new members)**
Allergy Testing	80% after deductible.
Deductible	$200 individual deductible; $400 family deductible.
Diagnostic/Lab/X-Ray	100% up to $500 for services related to an illness in a calendar year (there is a separate limit of $500 for services related to an accident in a calendar year); 80% for services in excess of the $500 limit for either an illness or an accident in a calendar year.
Dr. Office Visits	80% after deductible.
Emergency Room	Covered in full if life-threatening or accidental injury; 80% after deductible for illness.
Hearing Aids	For minor children. One hearing aid for each hearing impaired ear once every 36 months. Up to $1,400 for each ear.
Hearing Screening	Not covered.
Home Health Care Services	Covered in full; 40 visits maximum/calendar year.
Hospice	Covered in full; $5,000 maximum.
Hospital	Covered in full; 180 day maximum per confinement.
Immunizations	Maximum $15 per immunization ($45 per calendar year maximum per member); balance paid at 80% after deductible.
In vitro Fertilization	Limited to 3 attempts per live birth. Lifetime maximum of $100,000.
Mammography - Preventive Screening Schedule	Age 35-39: one baseline mammogram; Age 40-49; One mammogram every two calendar years; Age 50+ One mammogram per calendar year.
Maternity	100% up to amount allowed by plan.
Maximum Lifetime Benefit	Individual: Unlimited Maximum for major medical services.
Out-of-Pocket Annual Maximum	Individual: $1,000 plus the annual deductible; Family: $2,000 plus the annual deductible.
Physical	Up to $75/exam every 2 years - employee and spouse only; balance is paid at 80% after deductible.
Prescriptions	80% after deductible. Prescription discount program included with mail order feature.
Rehabilitation Services	80% after deductible.
Skilled Nursing Facility	$30/day, up to 360 days per calendar year; $10,800 calendar year maximum.
Specialists	80% after deductible.
Substance Abuse/Mental Health	Inpatient- 100% to 180 days (lifetime maximum does not apply); Outpatient-80% after deductible.
Surgery	100% up to amount allowed by plan.
Vision (Routine)	None.
Well Child Care	100% for child wellness (including related lab tests and Xrays) up to age 18.

Note: This summary of benefits is to be used as a guide only and not as the benefits offered. Consult the individual plan booklets for complete information.

MEDICARE

Medical Coverage

Generally, you become eligible for Medicare at age 65 or if awarded Social Security disability prior to age 65. Medicare becomes your primary medical insurance and the Plan becomes your secondary medical insurance effective the date you become eligible for Medicare. You must enroll in Medicare Part A and Part B at that time, if you fail to do so, your out of pocket expenses may become higher.

The Plan *coordinates* with Medicare. This means that the benefits payable under the Plan will generally work together with Medicare to ensure that you receive as complete a coverage as possible (but not a duplication of coverage). Generally, your retiree medical premiums reduce and your prescription premiums increase when you become Medicare-eligible.

What happens if you do not enroll in Medicare Part B?

If you do not enroll in Medicare Part B, your out-of-pocket expenses may be significantly higher. Why? Because the Plan pays as if you had enrolled in Medicare Part B – even if you did not.

> **Example:** Let's say that, before age 65, the Plan covered a certain benefit ("Benefit X") at $200. When you turn age 65, Benefit X is classified as a Medicare Part B benefit that is covered by Medicare Part B for $120. The Plan, being your *secondary* insurance that coordinates with Medicare, covers Benefit X at $80. Regardless of whether or not you have enrolled in Medicare Part B, the Plan covers Benefit X at $80 (not $200). That means that if you are not enrolled in Medicare Part B, you would be responsible for paying the amount not covered by the Plan ($120).

Services not covered by Medicare are not covered under the Plan.

What about your County medical plan premiums?
When either you or your spouse/eligible domestic partner becomes eligible for Medicare at age 65, your premium will also change. When someone first becomes Medicare-eligible, the premium paid will decrease from the Non-Medicare rate to a lower split rate. When you and all your dependents become eligible for Medicare, the rate paid will decrease to the Medicare rate.

Important Note: If you (and/or your dependents) are eligible for Medicare (including due to disability) you (and/or your dependents) must participate in Medicare Part D in order to receive prescription drug benefits under the Plan.

What happens if you do not enroll in Medicare Part D?
If you (and/or your eligible dependents) do not enroll in Medicare Part D, you (and your eligible dependents) are not eligible to participate in the Plan and will terminate participation in the Plan. You (and your eligible dependents) will be enrolled in United Healthcare medical plan and will not receive any County provided prescription drug coverage.

For more information:

- Visit www.medicare.gov.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

CONTINUATION OF COVERAGE (COBRA)

Introduction

COBRA continuation coverage is a temporary extension of coverage under the Plan. **The following information generally explains COBRA continuation coverage, when it may become available to your family, and what you need to do to protect the right to receive it. You do not have a right to COBRA under this Plan, only your spouse and/or your eligible dependents have a right to COBRA under this Plan.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). When an individual becomes eligible for COBRA, he or she may also become eligible for other coverage options that may cost less than COBRA continuation coverage. COBRA continuation coverage can become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage under the Plan.

An individual may have other options available when losing group health coverage. For example, an individual may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the individual may qualify for lower costs on monthly premiums and have lower out-of-pocket costs. Additionally, an individual may qualify for a 30-day special enrollment period for another group health plan for which he or she is eligible, even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Your spouse (including an eligible domestic partner), and your dependent children (including the eligible children of your domestic partner) could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

A spouse of a retiree becomes a qualified beneficiary if he or she loses your coverage under the Plan if he or she becomes divorced or legally separated from the spouse.

Dependent children will become qualified beneficiaries if they lose coverage under the Plan if the child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

You must give notice of some qualifying events.
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator, in writing or by e-mail, within 60 days after the qualifying event occurs. You must provide this written notice to:
The Office of Human Resources, Health Insurance Team
101 Monroe Street, 7th floor
Rockville, Maryland 20850

If timely notice is not provided, no continuation coverage will be offered.

How is COBRA coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

If timely notice is not provided, no continuation coverage will be offered.

Termination of Continuation Coverage
Continuation coverage will be terminated before the end of the maximum period if:
- The required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan;
- A qualified beneficiary becomes enrolled in Medicare (under Part A, Part B, or both) after electing continuation coverage;
- The employer ceases to provide any group health plan for its employees.

Other coverage options besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep OHR informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to OHR.

PROOF OF ELIGIBILITY FOR DEPENDENTS

Below are the types of documentation required to add or remove dependents from the Plan or to change plans during the Plan year.

For Spouse or Domestic Partner	For Children	For Legal Custody
To add a Spouse: Official State Marriage Certificate (certified by appropriate State or County Official) **To add a Domestic Partner:** County's Domestic Partner Affidavit or an official copy of a State issued Domestic Partnership Registration	**For a Biological Child:** State Birth Certificate (must show employee/retiree or spouse/domestic partner as parent). **For newborns, OHR will accept hospital discharge papers for first 60 days (State birth certificate must then be submitted).**	Copy of Court Order granting legal custody
To remove a Spouse: Divorce Decree	**For an Adopted Child:** Copy of Adoption or Placement for Adoption Papers	
To remove a Domestic Partner: County's Dissolution of Domestic Partnership Affidavit	**For a Step Child:** State Birth Certificate (must show employee/retiree or spouse/ domestic partner as parent), Marriage Certificate and Divorce Decree or Custody Papers	
	For a Disabled Child: Medical plan verification of disability	

Domestic Partner Proof of Eligibility requirements are detailed in the separate *Domestic Partner Benefits* Affidavit document.

You are responsible for notifying the OHR Health Insurance Team when your dependents are no longer eligible for coverage. If you do not do so within 60 days, this will be considered fraud and you will be responsible for 100% of any claims incurred.

MONTGOMERY COUNTY GROUP HEALTH PLAN PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by the Plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the Indemnity Plan:

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Montgomery County as an employer — that's the way the HIPAA rules work. Different policies may apply to other Montgomery County programs or to data unrelated to the health plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of Health Care Treatment, Payment activities, and Health Care Operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one (1) or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. *For example, the Plan may share health information about you with physicians who are treating you.*

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. *For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.*

- **Health Care Operations** include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. *For example, the Plan may use information about your claims to review the effectiveness of wellness programs. However, the Plan may not use genetic information for underwriting purposes.*

The amount of health information used or disclosed will be limited to the "Minimum Necessary" for these purposes, as defined under the HIPAA rules. The Plan may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

How the Plan may share your health information with Montgomery County

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Montgomery County for plan administration purposes. Montgomery County may need your health information to administer benefits under the Plan. Montgomery County agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Montgomery County Office of Human Resources, Department of Finance and County Attorney's Office staff are the only Montgomery County employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Montgomery County, as allowed under the HIPAA rules:

- The Plan, or its Insurer or HMO, may disclose "summary health information" to Montgomery County if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information have been removed.

- The Plan, or its Insurer or HMO, may disclose to Montgomery County information on whether an individual is participating in the Plan, or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Montgomery County cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Montgomery County from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts).

You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan is also allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project

Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization if the Plan has taken action relying on it. In other words, you can't revoke your authorization with respect to disclosures the Plan has already made.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the Contact section at the end of this notice for information on where to submit requests.

Right to make authorizations

Certain uses of your health information require your written consent such as the use of your health information for marketing purposes and disclosures that constitute a sale.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for Treatment, Payment, or Health Care Operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- The access or copies you requested;

- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or

- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan may also charge reasonable fees for copies or postage.

If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a Designated Record Set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for six (6) years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective). You do not have a right to receive an accounting of any disclosures made:

- For Treatment, Payment, or Health Care Operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the

delay and the date by which the Plan expects to address your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to Receive Notification in the Event of a Breach
The Plan has the obligation to maintain the privacy of your health information and you have the right to receive notification in the event of a breach

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the Privacy Notice currently in effect. However, the Plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised Privacy Notice mailed to your home address.

Complaints

If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of the U. S. Department of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint to the Plan, write:

Montgomery County
Office of Human Resources – Health Insurance Team
Executive Office Building 7th Floor
101 Monroe Street
Rockville, Maryland 20850

You may also fax Plan at: 240-777-5131

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact MC311 Customer Service Representatives, Monday-Friday, 7:00 a.m. – 7:00 p.m.: 240-777-0311 (311 locally) or 1-877-613-5212 toll free 301-251-4850 TTY; any questions MC311 representatives cannot answer are immediately routed via a service request to the OHR Health Insurance Customer Care Center, Monday through Friday, open 8:00 am – 5:00 pm.

Notice of Creditable Coverage

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Montgomery County and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Montgomery County has determined that the prescription drug coverage offered by the County's group insurance plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

At this time, the County offers Medicare eligible retirees the following prescription plans:

- Caremark High Option Prescription Plan.
- Caremark Standard Option Prescription Plan.
- Prescription coverage available through the CareFirst Indemnity Carve out medical plan*
- Prescription coverage available through the CareFirst Indemnity Supplemental medical plan*
- Prescription coverage available through the Kaiser's Medicare Plus plan.*

*covers other health expenses, in addition to prescription drugs

If you (and/or your dependents) are eligible for Medicare (including due to disability) and elect to participate in the County's plans, you (and/or your dependents) will automatically be enrolled in Medicare Part D. Medicare requires that you have a 21 day period to opt out of Medicare Part D participation. However, if you opt out, you (and your dependents, if applicable) will not have any prescription drug coverage through the County's prescription drug plans. If you elect to participate in the Kaiser plan, this is not applicable.

If you or your Medicare eligible dependents decide to join a Medicare drug plan, coverage under the County plan will terminate for that individual. Therefore, please note that if **you** join a Medicare drug plan, and as a result your County coverage is terminated, **coverage for your dependents will also terminate.**

If you decide to join a Medicare drug plan and you decide to drop the Plan, be aware that you and your dependents will not be able to get back into this Plan. You will be able to elect other coverage at open enrollment.

Under Medicare, if you pay an income based adjusted premium, you will also pay an additional amount for Part D.

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

You should also know that if you drop or lose your coverage with the County and don't enroll in Medicare prescription drug coverage within 63 days after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage determined to be Creditable Coverage, your monthly premium may go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may always be at least 19% higher. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

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

The Office of Human Resources, Health Insurance Team
101 Monroe Street, 7th floor
Rockville, Maryland 20850

Contact MC311 Customer Service Representatives, Monday-Friday, 7:00 a.m. – 7:00 p.m.: 240-777-0311 (311 locally) or 1-877-613-5212 toll free 301-251-4850 TTY; any questions MC311 representatives cannot answer are immediately routed via a service request to the OHR Health Insurance Customer Care Center, Monday through Friday, open 8:00 am – 5:00 pm.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Montgomery County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

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

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

October 2015
Montgomery County Office of Human Resources, Health Insurance Team
101 Monroe Street, 7th floor
Rockville, Maryland 20850

Women’s Health and Cancer Rights Act of 1998

The Plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call the OHR Health Insurance Team for more information.

Newborns' and Mothers' Health Protection Act of 1996

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