

**1997-39**

**RESOLUTION TO AUTHORIZE AMENDMENT NO. 2  
TO THE CLINTON COUNTY EMPLOYEE BENEFIT PLAN**

The Clinton County Board of Commissioners hereby accepts the following Amendment No. 2 to their Employee Benefit Plan originally effective April 1, 1985 and revised and reissued effective April 1, 1990 and January 1, 1996. This shall also serve as a Summary of Material Modification for the Summary Plan Description of their Employee Benefit Plan.

The effective date of the following Amendment/Summary of Material Modification shall be January 1, 1997.

1. A definition of Qualified Medical Child Support Order (QMCSO) has been added to comply with Federal Regulation.
2. The COBRA section of the Plan has been revised to comply with Federal Regulation.
3. The Claims Denied - Procedure for Review Section has been revised to comply with ERISA Regulation.

This Amendment/Summary of Material Modification is subject to all terms, provisions and conditions recited on the following page hereof.

APPROVED BY:

\_\_\_\_\_  
David D. Benda  
County Administrator  
for the Clinton County Board of Commissioners

\_\_\_\_\_  
Date

WITNESSED BY:

\_\_\_\_\_  
Julie Bales-Trego  
Contract Services Specialist  
for WEYCO, INC.

\_\_\_\_\_  
Date

**AMENDMENT NO. 2  
AND  
SUMMARY OF MATERIAL MODIFICATION**

Effective January 1, 1997, Clinton County Board of Commissioners shall amend the Summary Plan Description and Plan Document of their Employee Benefit Plan as follows:

A definition of Qualified Medical Child Support Order (QMCSO) has been added to comply with Federal Legislation mandated by OBRA '93.

The COBRA Section of the Plan has been revised to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as it relates to COBRA.

The Claims Denied-Procedure for Review Section of the Plan has been revised to comply with ERISA regulation.

**FOLLOWING ARE THE SECTIONS OF THE PLAN THAT HAVE BEEN REVISED AS OUTLINED ABOVE:**

• **THE FOLLOWING SHALL BE ADDED TO THE DEFINITION SECTION OF THE PLAN:**

**QUALIFIED MEDICAL CHILD SUPPORT ORDER ("QMCSO"):** In order to qualify as a QMCSO, a medical child support order must:

1. State the name and last known address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order.
2. Contain a reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined.
3. State the period to which the order applies.
4. Designate each plan to which the order applies.
5. Not require the Plan to provide any type or form of benefit, or option, not otherwise provided, except to the extent necessary to meet the requirements of a state law described in Section 1908 of the Social Security Act.

• **THE COBRA SECTION OF THE PLAN SHALL BE REVISED AS FOLLOWS:**

## **CONTINUATION OF BENEFITS (COBRA)**

### **VERY IMPORTANT NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER THE CLINTON COUNTY BOARD OF COMMISSIONERS EMPLOYEE BENEFIT PLAN**

On April 7, 1986, a Federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This Federal law was enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, and it is generally referred to as COBRA. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of COBRA. Both you and your spouse should take the time to read this notice carefully.

If you are an employee of Clinton County ("employer") or individual performing services for the employer covered by the Clinton County Board of Commissioners Employee Benefit Plan (the "Plan") you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part) or, if you are a retiree, because the employer has filed for Chapter 11 reorganization and coverage is terminated within twelve (12) months of the Chapter 11 reorganization.

If you are the spouse of an employee or individual performing services for the employer covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any of the following five (5) reasons:

- I. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or judgment of separate maintenance or legal separation (if applicable within your state) from your spouse;
4. Your spouse becomes entitled to Medicare benefits; or
5. For retirees, if the employer files for Chapter 11 reorganization and coverage is terminated within twelve (12) months of the Chapter 11 reorganization.

If a child is born to or placed for adoption by the covered employee during a period of COBRA coverage, that child may be eligible for coverage under the Plan. Upon proper notification to employer of the birth or adoption, this child will be added to COBRA coverage in accordance with the terms of the Plan and the requirements of federal law.

In the case of a dependent child of an employee or an individual performing services for employer covered by the Plan, he or she has the right to continuation coverage if group health coverage under the Plan is lost for any of the following six (6) reasons:

1. The death of a parent;
2. The termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with employer;
3. Parents' divorce or judgment of separate maintenance or legal separation (if applicable within your state);
4. A parent becomes entitled to Medicare benefits;
5. The dependent ceases to be a "dependent child" under the Plan; or
6. For retirees, if the employer files for Chapter 11 reorganization and coverage is terminated within twelve (12) months of the Chapter 11 reorganization.

Under COBRA, the employee or a family member has the responsibility to inform employer of a divorce, judgment of separate maintenance, legal separation, or a child losing dependent status under the Plan within sixty (60) days of the qualifying event. Employer will be presumed to have knowledge of an employee's death, termination of employment or reduction in hours, or entitlement to Medicare benefits.

When employer is notified that one of the events described above (referred to as "qualifying events") has happened, employer will in turn notify you that you have the right to choose continuation coverage. Under COBRA, you have at least sixty (60) days from the date you would lose coverage because of one of the events described above to inform employer that you want continuation coverage.

If you do not choose continuation coverage, your Clinton County Board of Commissioners Employee Benefit Plan coverage will end.

If you choose continuation coverage, employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. COBRA requires that you be afforded the opportunity to maintain continuation coverage for thirty-six (36) months unless you lost group health coverage because of termination of employment or reduction in hours. In that case, the required continuation coverage period is eighteen (18) months. If, during that eighteen (18) months, another event takes place that also entitles you to coverage, coverage may be extended. In no case may the total period of continuation coverage exceed thirty-six (36) months.

If the qualifying event that gives rise to your COBRA continuation is the termination of your employment or a reduction in the number of hours you work, and preceding your qualifying event you became entitled to Medicare, the continuation coverage period for your covered

beneficiaries will be extended up to a total of thirty-six (36) months following the date of your entitlement to Medicare.

If the qualifying event that gives rise to your COBRA continuation coverage is the termination of your employment or a reduction in the number of hours you work, and within your eighteen (18) month continuation coverage period your coverage terminates due to the fact that you become entitled to Medicare, the continuation coverage period for your covered beneficiaries will be extended to thirty-six (36) months from the date of your original qualifying event.

If a qualified beneficiary entitled to eighteen (18) months continuation coverage is disabled at any time during the first sixty (60) days of COBRA coverage and submits to employer proof of the disability (as determined under Title 2 or Title 16 of the Social Security Act) within sixty (60) days of the determination of disability under the Social Security Act and within the initial eighteen (18) month continuation coverage period, continuation coverage for all qualified beneficiaries may be extended for an additional eleven (11) months for a total of twenty-nine (29) months. If another event takes place that also entitles the disabled person to coverage, coverage may be extended to thirty-six (36) months.

However, COBRA also provides that your continuation coverage may be cut short for any of the following five (5) reasons:

1. Employer no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid in a timely fashion;
3. You become covered under another group health plan, other than a plan containing limitations or exclusions with respect to pre-existing conditions;
4. You become entitled to Medicare benefits; or
5. In the case of a qualified beneficiary receiving extended continuation coverage due to disability, a determination is made that the person is no longer disabled, under Title 2 or Title 16 of the Social Security Act.

You do not have to show evidence of good health to choose continuation coverage. However, you will have to pay all of the premium for your continuation coverage. You will have a grace period of thirty (30) days to pay the premium after it is due. An increased premium applies to the additional eleven (11) months available to a qualified beneficiary found to be disabled under Title 2 or Title 16 of the Social Security Act.

If employer changes the Plan benefits available to similarly situated employees and their spouses and dependent children, those changes will be extended on the same basis to persons who have purchased continuation coverage. The premium for continuation coverage will be adjusted to reflect the change in Plan benefits. COBRA also provides that, at the end of the applicable continuation coverage period, you must be allowed to enroll in an individual conversion health plan, if one is provided under the Plan.

If you have changed marital status, or if you or your spouse have changed addresses, or if you have any other questions about COBRA, please contact:

Office of Administrative Services  
Clinton County Court House  
St. Johns, Michigan 48879  
(517) 224-5115

- **THE PROCEDURE FOR REVIEW OF DENIED CLAIMS SHALL BE REVISED AS FOLLOWS:**

### **CLAIMS DENIED - PROCEDURE FOR REVIEW**

If your claim to receive benefits is denied, you will be notified by the Plan Administrator within ninety (90) days after the date you submitted your claim. This date may be extended for another ninety (90) days if required by special circumstances, but in order to make the extension, the Plan

Administrator must notify you in writing. The notice of denial which you receive will specifically state the reasons for the denial, refer to the controlling provisions of the Plan, and specifically inform you of any additional information which you may need to submit in order to qualify for benefits. It will also explain what procedures you must follow to get a review of the denial. If you have not received either a notice of denial or a notice that your claim is being honored within ninety (90) days after you have submitted the claim, the claim will be deemed to have been denied.

If you wish to challenge the denial of your claim, there is a review procedure which you may use. You must submit a written appeal to the Plan Administrator which states specifically why you think the decision to deny your claim was wrong. This written appeal must be submitted no later than sixty (60) days after your receipt of the notice which denied your claim. If your claim has been deemed denied because of the lapse of ninety (90) days without notice, you must submit your written appeal no later than sixty (60) days after that deemed denial date.

Once you have submitted a written appeal, you will have the right to review any documents held by the Plan Administrator which are relevant to your claim. However, your physician must authorize us, in writing, to release to you any information which has been provided to us in a confidential manner. You also have the right to have a personal representative submit the appeal for you.

A decision will be issued within sixty (60) days after you have submitted your written appeal unless special circumstances required more time. If more time is required, the Plan Administrator is required to give you written notice of the time extension and this extension cannot be for more than an additional sixty (60) days.

The decision on your appeal will be given to you in writing. It will give specific reasons for the result reached and will make specific reference to the part of the Plan on which the result is based. This decision will be final.

**ALL OTHER PROVISIONS OF THIS PLAN SHALL REMAIN UNCHANGED.**

Clinton County Board of Commissioners  
All Branches and Classes  
Amendment No. 2 and  
Summary of Material Modification  
Effective January 1, 1997