
*Understanding Your Benefits*

# Kent County Retiree
# 2023 Benefit Book

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**If you (and /or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 45 for more details.**

## *INTRODUCTION*

Each year, as your benefit needs change due to changing family situations and responsibilities, you will have the opportunity to change your coverage. This opportunity for change is called “Open Enrollment.” During this event, Human Resources will provide enrollment forms, costs and available options. Should you have any questions, please reach out to Human Resources. We are here to help you and your family address any benefit related questions you might have.

Your benefits will be administered for the plan year to comply with your election choices. You will **not** have the opportunity to change your benefit elections again until the next open enrollment period, unless you experience a significant family status change as outlined on page 3.

The following plan descriptions are brief and are not intended to give you all the details about the available plans. You should refer to, and rely on, the actual plan documents for complete information. Summary Plan Descriptions are available from Human Resources.

Every effort has been made to ensure the accuracy and completeness of the benefit descriptions contained within this guide. However, in the event of any interpretation, discrepancy, application and/or decision in specific circumstances, the official text or terms of the plan document will govern. This guide is not intended to create nor be construed as a contract between the County of Kent and its retirees for any matter, including for the provision of benefits described.

# *CHANGING YOUR ELECTIONS AND ELIGIBILITY RULES*

## CHANGING YOUR ELECTIONS

Benefits cannot be changed outside of the open enrollment period, except in the event of significant family status changes. These changes in circumstances include:

- Marriage, divorce or legal separation,
- Birth or adoption of a child,
- A covered dependent reaching the limiting age (see Eligible Dependents section below),
- Death of a spouse or covered dependent,
- Spouse's loss or gain of equivalent coverage through his/her employer, or
- Change in job status of retiree or spouse.

**You must notify the Human Resources Department within thirty (30) days of the event to make any changes to your benefits. Documentation must be submitted, along with a completed Kent County Benefit Election Form, to verify eligibility for the change(s) requested. Proof of relationship will be required if you are adding a dependent(s).**

### Newborn Children

Children born during the plan year will be covered as of their date of birth, if the County is timely notified. **If you submit a completed Benefit Election Form and copy of Birth Certificate more than *30-days after the birth*, you will not be able to add your newborn to your health insurance until the next open enrollment period. In that case, benefits would not be effective until January 1st of the next calendar year.**

## ELIGIBLE DEPENDENTS

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

### Eligible SPOUSE:

- Your legally married spouse as defined by the State of Michigan.

### Eligible CHILDREN:

- Your or your spouse's child through the end of the month in which they turn 26.

### Eligible DISABLED DEPENDENTS:

- An unmarried child 26 years of age or older who depends on you or your spouse for support as they are unable to support themselves due to a mental or physical condition. The child must depend on you or your spouse for financial support. The disability must have occurred by the end of the year in which the dependent turns 18.

## *CHANGING YOUR ELECTIONS AND ELIGIBILITY RULES*

A child is defined as your or your spouse's natural child, stepchild, legally adopted child, a child placed with you for adoption, a child for whom you are required to provide health insurance by a Qualified Medical Child Support Order, or a child for whom you or your spouse have legal guardianship.

### PROOF OF ELIGIBLITY DOCUMENT REQUIREMENTS

**Kent County reserves the right to require proof of eligibility. To <u>add</u> dependents to your plan, documentation is required for proof of eligibility. See requirements below. To ensure confidentially, please write "NOT FOR OFFICIAL USE" and BLOCK OUT all social security numbers or income information on all documents. Intentionally providing false information is a violation of County policy and could result in disciplinary action.**

**FOR SPOUSE:** *Provide documentation listed below.*

- A copy of your marriage certificate ***<u>AND</u>***
- A copy of the front page of your most recently filed federal tax return confirming this dependent as a spouse, ***<u>OR</u>*** documentation dated within the last 6 months establishing current relationship status such as a joint household bill, joint bank/credit account, joint mortgage/lease, or insurance policies. The document must list you and your spouse's name, the date, and mailing address.

**FOR CHILDREN:** *Provide documentation listed below.*

- A copy of the child's birth certificate, naming you as the child's parent, or appropriate court order / adoption decree naming you as the child's legal guardian; ***<u>OR</u>*** if applicable, a copy of a court-issued Qualified Medical Child Support Order (QMCSO) or other court order where you are required to provide health care (names of all parties must be included).

**FOR STEPCHILDREN:** *Provide documentation listed below.*

- A copy of the child's birth certificate, naming your spouse as the child's parent, or appropriate court order / adoption decree naming your spouse as the child's legal guardian ***<u>OR</u>*** if applicable, a copy of a court-issued Qualified Medical Child Support Order (QMCSO) or other court order where your spouse is required to provide health care (names of all parties must be included). ***<u>AND</u>***
- A copy of your marriage certificate as proof of the dependent's relationship to you.

**FOR DISABLED DEPENDENTS:** *Provide documentation listed below.*

- A copy of the child's birth certificate, naming you or your spouse as the child's parent, or appropriate court order / adoption decree naming you or your spouse as the child's legal guardian. ***<u>AND</u>***
    - A copy of the front page of your most recently filed federal tax return confirming that you claimed this dependent.

**<u>Note:</u>** *If this disabled dependent is a stepchild, the documentation required for a spouse listed above will also be required.*

## Change in Medicare Eligible Plan Options

In 2023, Kent County will continue to offer a Medicare Advantage (MAPD/PART C) plan, administered by AmWINS and underwritten by Humana. This plan is open to all retirees.

In addition, in 2023, rather than sending the 300-page Evidence of Coverage (EOC) Humana will only send out the Annual Notification of Change (ANOC) which will include instructions on how you can order an EOC if desired.

## Changes because of PPACA (Patient Protection and Affordable Care Act)

### Plans Must Continue Cost Sharing Limitations

Cost-sharing limitations have been imposed under Health Care Reform. In 2023, a member's out-of-pocket maximums for medical expenses are limited to $3,150 for an individual and $6,300 for family coverage. The out-of-pocket maximum as defined by the PPACA includes co-pays, deductibles and coinsurance.

For prescription drug coverage, a member's out-of-pocket maximums are limited to $5,950 for an individual and $11,900 for a family. Total combined retiree cost for medical and prescriptions cannot exceed the federal annual limit of $9,100 for an individual and $18,200 for a family- adjusted annually.

## Consent & Disclosure for Electronic Delivery of Benefit Documents (Opt-Out)

Kent County will electronically provide the additional Summaries of Benefits and Coverage for Non-Medicare Plans effective January 1, 2023. This includes the Blue Cross PPO, Blue Care Network HMO and Capital Rx plans.

Notice of Internet Availability (NOIA)
Important information about your benefit plans will now be available electronically and will be updated annually.

**Consent & Disclosure for Electronic Delivery of Benefit Documents (Opt-Out)**
(continued)

Documents will be made available in PDF format and can be downloaded by visiting the following link below.

https://www.accesskent.com/Benefits/summary_benefits_coverage.htm

By receiving this notice, you are consenting to the electronic disclosure of the Summaries of Benefits and Coverage for the Non-Medicare plan documents. You are entitled to withdraw your consent at any time at no cost. You have the right to receive paper copies of all Retiree Benefit notices at any time, which may be requested from the Kent County Human Resources department at 616-632-7440, Option 4 then Option 1.

Kent County offers, to its non-Medicare retirees, the following medical options:

- Wellness Plan Preferred Provider Organization (PPO) - Network coverage for this option is provided through Blue Cross Blue Shield of Michigan (BCBSM). The specific network is Blue Cross Blue Shield PPO.

- Wellness Plan Health Maintenance Organization (HMO) – Coverage for this option is provided by Blue Care Network (BCN), a fully-funded HMO.

**Blue Cross Blue Shield of Michigan**

Blue Cross Blue Shield of Michigan (BCBSM) serves as administrator for the County's self-funded preferred provider organization (PPO) medical plan. Claims will be processed and paid by BCBSM, and all questions regarding claims should be addressed to them.

The network, Blue Cross Blue Shield PPO, is a preferred provider organization health care plan and consists of participating providers. This plan is designed to provide you the highest level of benefit payment and limit your out-of-pocket costs when you use physicians, hospitals and other health care specialists that are a part of the network. You may select any doctor or specialist of your choice, without a referral from your primary care physician.

BCBSM Wellness Plan PPO gives you the opportunity to receive care from either a network physician or an out-of-network physician. We suggest that you visit www.bcbsm.com for a list of Blue Cross Blue Shield PPO in-network providers.

Effective January 1, 2020 Kent County implemented two diabetes management programs. The Livongo for Diabetes program is a new health benefit that provides an advanced blood glucose meter, unlimited strips, tips with every check, and coaches to support you so you never miss a beat. Register at join.livongo.com/BCBSM/register or call (800) 945-4355. Use registration code: BCBSM.

Omada is a digital lifestyle change program. Omada combines the latest technology with ongoing support so you can make the changes that matter most – whether that's around eating, activity, sleep, or stress. It's an approach shown to help you lose weight and reduce the risks of type 2 diabetes and heart disease. There is no cost to retirees to participate. Take Omada's 1-minute health screener to see if you are eligible: omadahealth.com/bcbsm.

**Blue Care Network HMO**

Blue Care Network is the insurance company and plan administrator for the County's fully-funded health maintenance organization (HMO) medical plan. With an HMO plan, you choose one primary care physician. All your health care services go through that doctor. That means that you need a referral before you can see any other health care professional, except in an emergency. Visits to health care professionals outside of your network typically aren't covered by your insurance.

**Blue Care Network HMO** (continued)

How to Choose a PCP

It is important to choose a PCP as soon as you become a member, so you can get the care you need. With thousands of qualified primary care physicians in network, how do you decide?

Start with convenience. Search for physicians by county and city at www.bcbsm.com/find-a-doctor.
You can also search for a doctor by hospital affiliation and extended office hours. If you want more information, call the doctor's office or BCN Customer Service. Here are some questions to ask:

- Is the doctor in my plan?
- How many years has the doctor been in practice?
- What languages are spoken in the office?

You can designate your PCP online or call customer service and tell BCN which PCP you selected.

To reach Customer Service, call the number on the back of your BCN ID card or BCN's main number (1-800-662-6667) from 8 a.m. to 5:30 p.m. Monday through Friday. The TTY number is 711.

***Patient Protection Disclosure***

Blue Care Network (BCN) generally allows the designation of a primary care provider. You have the right to designate any Primary Care Provider (PCP) who participates in our network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of the participating primary care providers, contact BCN Customer Services at 800-662-6667 or visit www.bcbsm.com.

You do not need prior authorization from BCN or from any other person (including a Primary Care Provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact BCN Customer Services at 800-662-6667 or visit www.bcbsm.com.

**Medicare Advantage (MAPD/PART C) Plan – see page 19**

The endorsed insurance administrator of the Kent County MAPD/Part C Plan is AmWINS, underwritten by Humana. The plan is available to Kent County retirees and their spouses who are age Medicare-eligible and enrolled in Medicare Parts A and B.

**Medicare Supplemental Plan (AmWINS) – see page 25**

The endorsed insurance administrator of the Kent County Medicare Supplemental Plan is Transamerica Premier Life Insurance Company administered through AmWINS. The plan is available to Kent County retirees and their spouses who are age Medicare-eligible and currently enrolled in this plan as of 01/01/2020 and enrolled in Medicare Parts A and B.

# *NON-MEDICARE - MEDICAL PLANS COMPARISON OF BENEFITS*

| | Blue Care Network Wellness HMO | Blue Cross/Blue Shield Wellness PPO | |
|---|---|---|---|
| | | In Network | Out-Of-Network |
| **Co-Pays / Deductibles / Co-Insurance** | | | |
| Flat Dollar Co-Pays | $20 for Office visits<br>$20 for Online visits<br>$40 for Specialist visits<br>$100 for Emergency Room<br>$20 Urgent Care | $25 co-pay for:<br>1. Office visits<br>$40 co-pay for:<br>2. Urgent care<br>$125 co-pay for:<br>3. Emergency Room Services | $125 co-pay for:<br>• Emergency Room Services |
| Deductible | $250 per individual,<br>$500 per two-party/family | $300 per individual, $600 per two-party/family | $600 per individual, $1,200 per two-party/family |
| | | In-Network and Out-of-Network deductibles accumulate separately per calendar year. | |
| Coinsurance | 10% unless otherwise noted | 15%, unless otherwise noted<br>50% for private duty nursing | 35%, unless otherwise noted<br>50% for private duty nursing |
| **Co-Pay / Coinsurance / Dollar Maximums** | | | |
| Flat Dollar Co-Pay | Does not apply | Does not apply | Does not apply |
| Coinsurance Maximums – Excludes Deductibles | Does not apply | Does not apply | Does not apply |
| Out of Pocket Maximums (includes medical co-pays, deductibles and coinsurance) | $3,150 per individual,<br>$6,300 per two-party/family | $3,150 per individual,<br>$6,300 per two-party/family | $6,300 per individual,<br>$12,600 per two-party/family |
| Lifetime Maximum | None | None | |
| **Preventive Services** | | | |
| Health Maintenance Exam | Covered - 100% | Covered - 100% | Covered - 65% after deductible |
| | | One per calendar year - beginning age 16, includes related X-rays, EKG, and lab procedures performed as part of the physical exam. | |
| Annual Gynecological Exam | Covered - 100%, one per calendar year | Covered - 100%, one per calendar year | Covered - 65% after deductible, one per calendar year |
| Pap Smear Screening – laboratory services only | Covered - 100%, one per calendar year | Covered - 100%, one per calendar year | Covered - 65% after deductible, one per calendar year |
| Well Baby and Well Child Visit | Covered - 100% | Covered - 100%, through age 15 | Covered - 65% after deductible – through age 15 |
| | | • 8 visits, birth through 12 months<br>• 6 visits, 13 months through 23 months<br>• 6 visits, 24 months through 35 months<br>• 2 visits, 36 months through 47 months<br>• visits beyond 47 months are limited to one per member per calendar | |
| Immunizations, Adult and Pediatric | Covered - 100% | Covered - 100% | Covered - 65% after deductible |
| Fecal Occult Blood Screening | Covered - 100%, one per calendar year | Covered - 100%, one per calendar year | Covered - 65% after deductible, one per calendar year |
| Endoscopic Exam (includes colonoscopy) | Covered - 100%, one per calendar year | Covered - 100%, one per calendar year | Covered - 65% after deductible, one per calendar year |

| | Blue Care Network Wellness HMO | Blue Cross/Blue Shield Wellness PPO | |
|---|---|---|---|
| | | In Network | Out-Of-Network |
| Preventive Services (Cont'd) | | | |
| Prostate Specific Antigen (PSA) Screening | Covered - 100%, one per calendar year | Covered - 100%, one per calendar year | Covered - 65% after deductible, one per calendar year |
| Mammography Screening | Covered - 100%, one per calendar year – no age restrictions | Covered - 100%, one per calendar year – no age restrictions | Covered - 65% after deductible, one per calendar year – no age restrictions |
| Voluntary Sterilization | Female – Covered – 100%<br>Male – Covered – 100% after deductible | Covered - 100% | Covered - 65% after deductible |
| Contraceptive Devices | Approved devices covered – 100% | All FDA-approved devices covered – 100% | All FDA-approved devices covered – 65% after deductible |
| Physician Office Services | | | |
| PCP Office Visits<br><br><br>Specialist Office Visits | Covered - 100% after $20 co-pay<br><br>Covered – 100% after $40 co-pay | Covered - 100% after $25 co-pay*<br>Includes:<br>Primary care and specialist physicians<br>Presurgical consultations<br>Initial visit to determine pregnancy | Covered - 65% after deductible |
| Online Visits | Covered – 100% after $20 co-pay | Covered – 100% after $25 co-pay | Covered – 65% after deductible |
| Outpatient and Home Visits | Covered – 100% after $20 co-pay for a PCP; $40 co-pay for a specialist | Covered - 100% after $25 co-pay* | Covered - 65% after deductible |
| | | *One co-pay applies per visit. Deductibles may apply to services performed (e.g., lab, x-rays, etc.) | |
| Emergency Medical Care | | | |
| Hospital Emergency Room – | Covered – 100% following $100 co-pay after deductible; co-pay does not apply if admitted | Covered – 100% after $125 co-pay*; co-pay waived if admitted | Covered – 100% after $125 co-pay*; co-pay waived if admitted |
| Ambulance Services – Medically Necessary | Covered – 90% after deductible | Covered - 85% after deductible | Covered - 85% after deductible |
| Urgent Care Visits | Covered – 100% after $20 co-pay | Covered – 100% after $40 co-pay* | Covered - 65% after deductible |
| | | *One co-pay applies per visit. Deductibles may apply to services performed (e.g., lab, x-rays, etc.) | |
| Diagnostic Services | | | |
| Laboratory and Pathology Test | Covered – 100% | Covered - 85% after deductible | Covered - 65% after deductible |
| Diagnostic Tests and X-rays | Covered - 90% after deductible<br>Advanced Imaging, Covered – 100% following $150 co-pay after deductible | Covered - 85% after deductible | Covered - 65% after deductible |
| Radiation Therapy | Covered - 90% after deductible | Covered - 85% after deductible | Covered - 65% after deductible |

| | Blue Care Network Wellness HMO | Blue Cross/Blue Shield Wellness PPO | |
|---|---|---|---|
| | | In Network | Out-Of-Network |
| Maternity Services | | | |
| Pre-Natal and Post-Natal Care | Covered – 100% | Covered – 100%, after initial co-pay | Covered - 65% after deductible |
| Delivery and Nursery Care | Covered - 100% for professional services. 90% after deductible for facility charges | Covered - 85% after deductible | Covered - 65% after deductible |
| Hospital Care | | | |
| Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies | Covered - 90% after deductible | Covered - 85% after deductible | Covered – 65% after deductible |
| Inpatient Consultations | Covered - Inpatient professional 100% after deductible; Inpatient facility 90% after deductible | Covered - 85% after deductible | Covered - 65% after deductible |
| Chemotherapy | Covered - 90% after deductible | Covered - 85% after deductible | Covered - 65% after deductible |
| Outpatient Hospital | Covered - 90% after deductible | Covered – 85% after deductible | Covered – 65% after deductible |
| Alternatives to Hospital Care | | | |
| Skilled Nursing Care | Covered - 90% after deductible. Maximum 45 days per contract year | Covered - 85% after deductible. Limited to 120 days per calendar year | Covered - 65% after deductible. Limited to 120 days per calendar year |
| Hospice Care | Covered - 100% (when authorized) after deductible | Covered - 85% after deductible. | Covered - 65% after deductible. |
| Home Health Care | Covered - 100% following $40 co-pay after deductible, unlimited visits | Covered - 85% after deductible, unlimited visits | Covered - 65% after deductible, unlimited visits |
| Surgical Services | | | |
| Surgery – includes related surgical services | Covered - 90% after deductible | Covered - 85% after deductible | Covered - 65% after deductible |
| Human Organ Transplants | | | |
| Specified Human Organ | Covered - 90% after deductible | Covered - 85% | Covered - 65% after deductible |
| Bone Marrow, Kidney, Cornea and Skin | Covered - 90% after deductible | Covered - 85% | Covered - 65% after deductible |
| Behavioral Health Care and Substance Abuse Treatment | | | |
| Inpatient Behavioral Health Care and Substance Abuse Care | **Behavioral Health Care**: Covered - 90% after deductible<br><br>**Substance Abuse Care**: Covered - 90% after deductible | **Behavioral Health Care:** Covered - 85% after deductible<br><br>**Substance Abuse Care:** Covered - 85% after deductible | **Behavioral Health Care:** Covered - 65% after deductible<br><br>**Substance Abuse Care:** Covered - 65% after deductible |
| Outpatient Mental Health Care | Covered – 100% after $20 co-pay | Covered - 85% after deductible | Covered - 65% after deductible |
| Outpatient Substance Abuse Care | Covered – 100% after $20 co-pay | Covered - 85% after deductible | Covered - 65% after deductible |
| Other Services | | | |
| Allergy Testing and Therapy | Covered – 50% after deductible | Covered - 85% after deductible | Covered - 65% after deductible |
| Allergy Injections | Covered – 100% after $5 co-pay | Covered - 85% after deductible | Covered - 65% after deductible |
| Chiropractic Office Visits | Covered – 100% after $40 co-pay when referred. Up to 30 visits per calendar year | Covered - 85% after deductible; one new patient visit per 36 months | Covered – 65% after deductible; one new patient visit per 36 months |

| | Blue Care Network Wellness HMO | Blue Cross/Blue Shield Wellness PPO | |
|---|---|---|---|
| | | In Network | Out-Of-Network |
| Other Services (Cont'd) | | | |
| Chiropractic Spinal Manipulation | Covered – 100% after $40 co-pay when referred. Up to 30 visits per calendar year | Covered - 85% after deductible; one per day, up to 24 visits per calendar year | Covered - 65% after deductible; one per day, up to 24 visits per calendar year |
| Chiropractic X-rays | Covered – 90% after deductible | Covered - 85% after deductible | Covered – 65% after deductible |
| Chiropractic Services – Hot/Cold Modalities etc. | Not Covered | Not Covered | Not Covered |
| Outpatient Physical, Speech and Occupational Therapy, Osteopathic, Pulmonary, Cardiac Rehabilitation | Covered – 100% following $40 co-pay after deductible. One period of treatment for any combination of therapies within 60 consecutive days per calendar year | Covered - 85% after deductible | Covered - 65% after deductible |
| | | Limited to 60 combined visits per calendar year. Services are covered when performed in the outpatient department of the hospital or approved freestanding facility. Physical therapy is also covered in an independent therapist's office. Speech and language therapy limited to services that restore speech. | |
| Applied Behavioral Analyses (ABA treatment) Limited to 25 hours per week | Covered – 100% after $20 co-pay | Not Covered | |
| Outpatient Physical Therapy, Speech Therapy, Occupational Therapy, Nutritional Counseling for Autism Spectrum Disorder Through Age 18 | Covered – 100% following $40 co-pay after deductible | Not Covered | |
| Other Covered Services, including mental health services, for Autism Spectrum Disorder | Covered – See other outpatient mental health benefit and medical office visit benefit | Not Covered | |
| Durable Medical Equipment | Covered - 100% | Covered - 85% after deductible | |
| Prosthetic Devices | Covered - 100% | Covered - 85% after deductible | |
| Orthotic Appliances | Covered - 100% | Covered - 85% after deductible | |

This comparison is intended as an easy-to-read summary. It is not a contract. An official description of benefits can be found in the Summary Plan Description. Note for Wellness PPO Members: If you go to an out-of-network provider/doctor/facility, even if you are referred, you may have additional costs including any charges not paid at the out-of-network benefit level.

## *NON-MEDICARE – PRESCRIPTION (Capital Rx)*

Kent County offers a self-funded prescription drug program which is administered through Capital Rx. The prescription drug plan enables the County, and its retirees to realize significant savings in the cost of prescription drugs by participating in large-scale purchasing through Capital Rx.

You have a three-tier prescription benefit that gives you choices over which medications you use while also balancing costs. To do this, the benefit breaks prescription medications into three categories, or tiers:

- **Generic** – these drugs provide the most affordable way for you to obtain quality medications at the lowest co-payment. The U. S. Food and Drug Administration (FDA) requires that generic drugs have the same active chemical composition, same potency and be offered in the same form as their brand-name equivalents.
- **Formulary (Preferred) brand-name** – a list of medicines prepared by Capital Rx that helps identify products that are clinically appropriate and cost effective. These are brand-name drugs that generally have no generic equivalent and are commonly prescribed by physicians. The cost for preferred drugs is generally lower than non-preferred drugs.
- **Non-formulary (Non-Preferred) brand-name** – these are brand name drugs that have either equally effective or less costly generic alternatives or one or more preferred brand options. If you choose a drug in this tier, you are covered at the highest coinsurance level, which still represents a significant savings compared to the full retail cost.

Prescriptions can be filled at several pharmacies, including major chain retailers such as Meijer, Walgreens, Target, etc.

Prescriptions can also be ordered by mail through Capital Rx's mail order pharmacy. The mail order program will save you money by allowing you to purchase a three-month supply of a medication for the cost of two months' co-payment. If you take one or more maintenance medicines, you may save time and money with mail service and have your medicine conveniently delivered to your home. Telephone and on-line ordering are also available for prescription refills. When you sign up for mail order service, you can also register for automatic prescription refills and prescription renewals through the Capital Rx website.

To start:

- Ask your doctor to write a prescription for a 90-day supply of medicine.
- Complete the mail service order form - available in the Human Resources Department or on-line at: www.accesskent/benefits.com .
- Mail your order form along with your prescription(s) and payment to the Capital Rx mail order pharmacy printed on the form.

NOTE: Drugs classified as controlled substances cannot be purchased through the mail.

**Value Investment Prescription Plan**

Kent County has established a value-based prescription design. For those retirees who are eligible and who wish to participate, we have designed a Value Investment Prescription (VIP) Plan.

Kent County's VIP plan has removed the co-pay for generic drugs used in the treatment of diabetes and hypertension. By making these medications available with no co-pay, Kent County is supporting members who must take their medication correctly and consistently to avoid developing more serious health problems. Additionally, insulin that is on Capital Rx's formulary (preferred) list will be made available for the cost of generic medications.

With the VIP Plan, Kent County is making a strategic investment in its health management practice that improves the health of retirees, especially those at high risk for chronic illness or costly major medical events. At least two investment returns that we aim to achieve include productive, healthy retirees and lower overall health care costs.

**Women's Preventive Services**

To comply with PPACA, generics will be provided without cost share for contraceptive medicines and devices.

Additionally, under certain conditions, generic medications that reduce the risk of breast cancer may be covered by your Kent County pharmacy benefit plan at $0 cost-share if you meet the following conditions:

- Are a woman age 35 or older
- Are at increased risk for the first occurrence of breast cancer – after risk assessment and counseling
- Obtain Prior Authorization

**Cost Sharing Limitations**

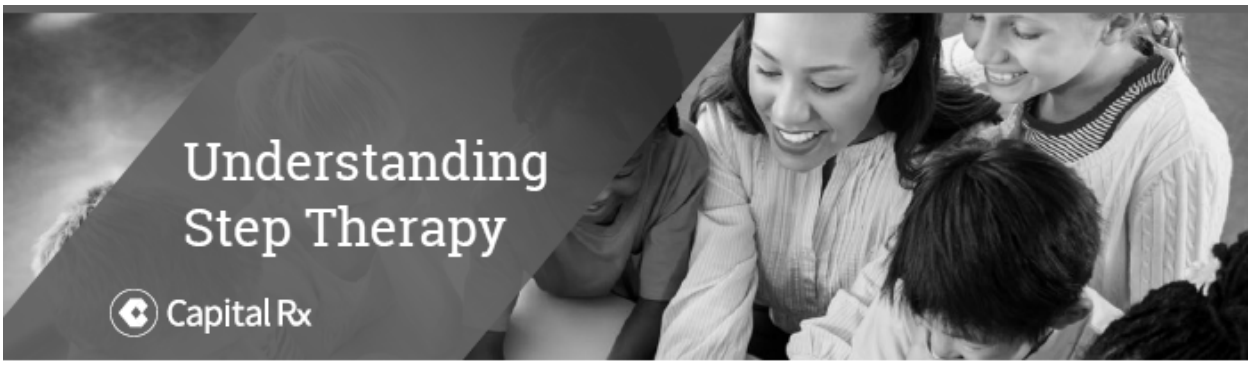
Cost sharing limitations have been imposed under Health Care Reform. In 2023, a member's out-of-pocket maximums for prescription drug coverage, are limited to $5,950 for an individual and $11,900 for a family. Total combined retiree cost for medical and prescriptions cannot exceed the federal annual limit of $9,100 for an individual and $18,200 for a family – adjusted annually.

## Step Therapy

The cost of prescription drugs continues to rise, for both you and the County. To help control costs and make sure you get the proper medicine, Kent County has implemented a step therapy program.

The step therapy program helps flatten rising prescription costs by encouraging you to use formulary medications as the first step in your treatment plan. Some medications deliver similar value, safety and effectiveness, but cost less than others. Step therapy identifies those cost saving medications for you and your pharmacy benefit plan. By trying first-line therapies, you actively help to manage the cost of your pharmacy benefit.

The following describes the mapping process when you are filling a medicine identified as part of the step therapy program.



# Understanding Step Therapy

Capital Rx

## WHAT IS STEP THERAPY?

To help keep your costs low, step therapy allows you to try an equally effective medication that is less expensive before using other drugs that cost more.

Step therapy makes sure you receive the safest, most effective, and affordable medication available. We know that a more expensive drug doesn't always mean a better treatment, so our team uses step therapy to ensure you receive the medication that works best for you at an appropriate price.

## HOW DOES IT WORK?

**Medications included in our step therapy program fall into two categories:**

STEP 1 MEDICATIONS – usually generic medications or low-cost brand medications. Generic medications have the same quality, strength, purity, and stability as brand medications at a fraction of the cost.

STEP 2 MEDICATIONS – brand medications that are typically more expensive than a step 1 medication.

A member is prescribed a drug that is step 2 in our step therapy program

↓

Pharmacy processes member's new step 2 prescription

↓

Medications the member has previously taken are reviewed to determine if a step 1 medication was used → If a step 1 medication was used in the past, the step 2 prescription will be processed

↓

If no step 1 medication is identified, the pharmacist will be informed that the step 2 prescription requires step therapy

↓

The pharmacist or member can contact the prescriber for a new prescription for a step 1 medication → New prescription for the step 1 medication will be processed and paid for

↓

Prescriber can submit a prior authorization request for the step 2 medication with a reason why the member cannot use the step 1 medication

For a list of medications that require a prior authorization, visit our member portal at www.cap-rx.com/member-tools.

**Schedule of Prescription Drug Benefits**

CO-PAYMENTS

| | |
|---|---|
| Generic medication and supplies used for the treatment of:<br>▪ diabetes<br>▪ hypertension<br>Generic contraceptive medicines or devices<br>Generic medication for women at increased risk for breast cancer<br>Smoking cessation drugs | ▪ $0.00 Prescription Co-Pay |
| Generic medication not listed above<br>Insulin on the formulary (preferred) list | ▪ $15.00 for one-month supply<br>▪ $30.00 for a 90-day supply |
| Formulary (Preferred)/<br>Brand Name | ▪ $25.00 for one-month supply<br>▪ $50.00 for 90-day supply |
| Non-Formulary (Non-Preferred)/<br>Brand Name | ▪ $45.00 for one-month supply<br>▪ $90.00 for 90-day supply |

PLAN PARAMETERS

- Individual out-of-pocket maximum - $5,950
- Family out-of-pocket maximum - $11,900

- Maximum days' supply at the pharmacy window – 90-days
- Maximum days' supply when you use mail order – 90-days

- When you fill a prescription at the pharmacy window, you must consume 75% of the supply before a refill is authorized
- When you fill a prescription through mail order, you must consume 50% of the supply before a refill is authorized

PRE-AUTHORIZATION

- Growth and biosynthetic hormones require prior authorization

For non-covered medications, please refer to "Exclusions" in the Plan Document.

This prescription summary is intended as an easy-to-read document. It is not a contract. An official description of benefits can be found in the Plan Document.

The Medicare Advantage (MAPD/Part C) plan covers your health and drug needs in one convenient plan. The plan option is available to all retirees. You will pay set copays/coinsurances for medical services received after your deductible up to the $1,000 out-of-pocket maximum. The Humana Plan offered is a PPO which means there is no physician network limitations.

## Monthly Premium, Deductible and Limits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **PLAN COSTS** | | |
| **Monthly premium**<br>You must keep paying your Medicare Part B premium. | For information concerning the actual premiums you will pay, please contact your employer group benefits plan administrator. | |
| **Medical deductible** | **$200** per year for some combined in- and out-of-network services | **$200** per year for some combined in- and out-of-network services |
| **Maximum out-of-pocket responsibility**<br>The most you pay for copays, coinsurance and other costs for medical services for the year. | **In-Network Maximum Out-of-Pocket**<br>**$1,000** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; COVID-19 Testing; COVID-19 Treatment; Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Vision Services (Routine) and the Plan Premium.<br><br>If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services. | **Combined In and Out-of-Network Maximum Out-of-Pocket**<br>**$1,000** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; COVID-19 Testing; COVID-19 Treatment; Fitness Program; Health Education Services; Hearing Services (Routine); Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional); Vision Services (Routine) and the Plan Premium do not apply to the combined maximum out-of-pocket.<br><br>Out-of-Network Exclusions: Part D Pharmacy; COVID-19 Testing; COVID-19 Treatment; Hearing Services (Routine); Vision Services (Routine); Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket.<br><br>Your limit for services received from in-network providers will count toward this limit.<br><br>If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the |

## Monthly Premium, Deductible and Limits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| | | year on covered hospital and medical services. |

## Covered Medical and Hospital Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **ACUTE INPATIENT HOSPITAL CARE** | | |
| Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. | **10%** of the cost per stay | **10%** of the cost per stay |
| **OUTPATIENT HOSPITAL COVERAGE** | | |
| **Outpatient hospital visits** | **10%** of the cost | **10%** of the cost |
| **Ambulatory surgical center** | **10%** of the cost | **10%** of the cost |
| **DOCTOR OFFICE VISITS** | | |
| **Primary care provider (PCP)** | **$15** copay | **$15** copay |
| **Specialists** | **$30** copay | **$30** copay |
| **PREVENTIVE CARE** | | |
| Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Any additional preventive services approved by Medicare during the contract year will be covered. | **Covered at no cost** | **Covered at no cost** |
| **EMERGENCY CARE** | | |
| **Emergency room**<br>If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. | **$75** copay for Medicare-covered emergency room visit(s) | **$75** copay for Medicare-covered emergency room visit(s) |

## Covered Medical and Hospital Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Urgently needed services**<br>Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. | **$15** to **$30** copay | **$15** to **$30** copay |
| **DIAGNOSTIC SERVICES, LABS AND IMAGING** | | |
| **Diagnostic radiology** | **$15** to **$30** copay or **10%** of the cost | **$15** to **$30** copay or **10%** of the cost |
| **Lab services** | **10%** of the cost | **10%** of the cost |
| **Diagnostic tests and procedures** | **$0** to **$30** copay or **10%** of the cost | **$0** to **$30** copay or **10%** of the cost |
| **Outpatient X-rays** | **$15** to **$30** copay or **10%** of the cost | **$15** to **$30** copay or **10%** of the cost |
| **Radiation therapy** | **$30** copay or **10%** of the cost | **$30** copay or **10%** of the cost |
| **HEARING SERVICES** | | |
| **Medicare-covered hearing** | **$30** copay | **$30** copay |
| **Routine hearing** | **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year.<br>**$1000** combined in and out of network maximum benefit coverage amount for a hearing aid(s) (all types) up to 1 every 3 years. | **$0** copay for fitting/evaluation, routine hearing exams up to 1 per year.<br>**$1000** combined in and out of network maximum benefit coverage amount for a hearing aid(s) (all types) up to 1 every 3 years.<br>Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| **DENTAL SERVICES** | | |
| **Medicare-covered dental** | **$30** copay | **$30** copay |
| **VISION SERVICES** | | |
| **Medicare-covered vision services** | **$30** copay | **$30** copay |
| **Medicare-covered diabetic eye exam** | **0%** of the cost | **0%** of the cost |

## Covered Medical and Hospital Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Medicare-covered glaucoma screening** | **$0** copay | **$0** copay |
| **Medicare-covered eyewear (post-cataract)** | **$30** copay | **$30** copay |
| **Routine vision** | **$0** copay for routine exam (includes refraction). | **$0** copay for routine exam (includes refraction). Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions. |
| **MENTAL HEALTH SERVICES** | | |
| **Inpatient** The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility | **10%** of the cost per stay | **10%** of the cost per stay |
| **Outpatient group and individual therapy visits** | **$15** to **$30** copay or **10%** of the cost | **$15** to **$30** copay or **10%** of the cost |
| **SKILLED NURSING FACILITY** | | |
| Our plan covers up to 100 days in a SNF.<br><br>No 3-day hospital stay is required.<br>Plan pays $0 after 100 days | **0%** of the cost per stay for days 1-20<br>**10%** of the cost per stay for days 21-100 | **0%** of the cost per stay for days 1-20<br>**10%** of the cost per stay for days 21-100 |
| **PHYSICAL THERAPY** | | |
| | **$30** copay or **10%** of the cost | **$30** copay or **10%** of the cost |
| **AMBULANCE** | | |
| Per date of service regardless of the number of trips. Limited to Medicare-covered transportation. | **10%** of the cost | **10%** of the cost |

## Covered Medical and Hospital Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **PART B PRESCRIPTION DRUGS** | | |
| | **0%** to **10%** of the cost | **0%** to **10%** of the cost |
| **ACUPUNCTURE SERVICES** | | |
| **Medicare-covered acupuncture**<br><br>**20** combined In & Out-of-Network visit limit per plan year<br><br>Your plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements. | **$30** copay | **$30** copay |
| **ALLERGY** | | |
| **Allergy shots & serum** | **$15** to **$30** copay | **$15** to **$30** copay |
| **CHIROPRACTIC SERVICES** | | |
| **Medicare-covered chiropractic visit(s)** | **$20** copay | **$20** copay |
| **COVID-19** | | |
| **Testing and Treatment** | **$0** copay for testing and treatment services for COVID-19 | |
| **DIABETES MANAGEMENT TRAINING** | | |
| | **$0** copay | **$0** copay |
| **FOOT CARE (PODIATRY)** | | |
| **Medicare-covered foot care** | **$30** copay | **$30** copay |
| **HOME HEALTH CARE** | | |
| | **10%** of the cost | **10%** of the cost |
| **MEDICAL EQUIPMENT/SUPPLIES** | | |
| **Durable medical equipment (like wheelchairs or oxygen)** | **10%** of the cost | **10%** of the cost |
| **Medical supplies** | **10%** of the cost | **10%** of the cost |
| **Prosthetics (artificial limbs or braces)** | **10%** of the cost | **10%** of the cost |
| **Diabetes monitoring supplies** | **10%** of the cost | **10%** of the cost |

## Covered Medical and Hospital Benefits

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **OUTPATIENT SUBSTANCE ABUSE** | | |
| **Outpatient group and individual substance abuse treatment visits** | **$15** to **$30** copay or **10%** of the cost | **$15** to **$30** copay or **10%** of the cost |
| **REHABILITATION SERVICES** | | |
| **Occupational and speech therapy** | **$30** copay or **10%** of the cost | **$30** copay or **10%** of the cost |
| **Cardiac rehabilitation** | **$30** copay or **10%** of the cost | **$30** copay or **10%** of the cost |
| **Pulmonary rehabilitation** | **$30** copay or **10%** of the cost | **$30** copay or **10%** of the cost |
| **RENAL DIALYSIS** | | |
| **Renal dialysis** | **10%** of the cost | **10%** of the cost |
| **Kidney disease education services** | **$0** copay | **$0** copay |
| **TELEHEALTH SERVICES (in addition to Original Medicare)** | | |
| **Primary care provider (PCP)** | **$0** copay | Not Covered |
| **Specialist** | **$30** copay | Not Covered |
| **Urgent care services** | **$0** copay | Not Covered |
| **Substance abuse or behavioral health services** | **$0** copay | Not Covered |
| **FITNESS AND WELLNESS** | | |
| | SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes. | |
| **HOSPICE**<br>You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice. | | |

## Deductible

| | |
|---|---|
| **Pharmacy (Part D) deductible** | This plan does not have a deductible. |

## Prescription Drug Benefits

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total yearly drug costs reach **$4,430**. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

| Tier | Standard Retail Pharmacy | Standard Mail Order |
|---|---|---|
| **30-day supply** | | |
| **1 (Generic or Preferred Generic)** | **$9** copay | **$9** copay |
| **2 (Preferred Brand)** | **$25** copay | **$25** copay |
| **3 (Non-Preferred Drug)** | **$30** copay | **$30** copay |
| **4 (Specialty Tier)** | **$100** copay | **$100** copay |
| **90-day supply** | | |
| **1 (Generic or Preferred Generic)** | **$27** copay | **$18** copay |
| **2 (Preferred Brand)** | **$75** copay | **$50** copay |
| **3 (Non-Preferred Drug)** | **$90** copay | **$60** copay |
| **4 (Specialty Tier)** | N/A | N/A |

There may be generic and brand-name drugs, as well as Medicare-covered drugs, in each of the tiers. To identify commonly prescribed drugs in each tier, see the Prescription Drug Guide/Formulary.

### ADDITIONAL DRUG COVERAGE

#### Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches **$4,430**.
You will continue to pay the same amount as when you were in the initial coverage stage.

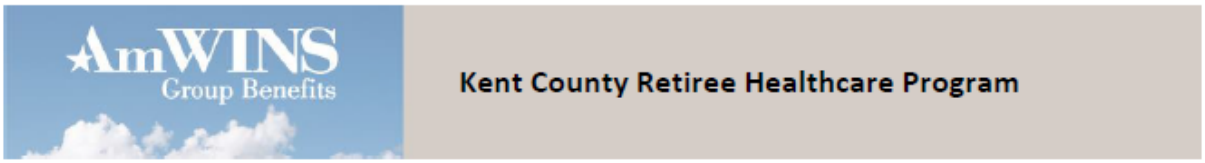
#### Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,050,** you pay the greater of:

- **$3.95** for generic (including brand drugs treated as generic) and a **$9.85** copay for all other drugs, or
- **5%** coinsurance (**$100** maximum out-of-pocket per prescription for a one-month supply) regardless of tier.

**This is only an option for those enrolled in the Transamerica Plan F as of 1/1/2020.**

The Medicare Supplement covers your health and the Medicare Part D covers your drugs. The plan options are only available those who are currently enrolled in these options. New enrollees are not eligible for the Medicare Supplement (Plan F) or the Medicare Part D plan.




**Understanding the Insurance Companies and Vendors that manage your benefits**

In order to provide competitive healthcare options with comprehensive coverage and exceptional service, Kent County contracts with a program administrator to manage the retiree medical plan, the Medicare Part D prescription drug plan and all the retiree customer service. Our Program Administrator is AmWINS Group Benefits.

As the program administrator, AmWINS Group Benefits works with a number of vendors that work to provide your benefits. We know the names of these different vendors can be confusing. We hope this summary will help you better understand these vendors and their role in your healthcare program.

Please remember that AmWINS Group Benefits is the Program Administrator, and they should be your first point of contact, should you have questions regarding any issues with your retiree healthcare program. They can be reached Monday – Friday 8AM – 8PM (EST) at **888.883.3757.**

**Please familiarize yourself with the companies and vendors listed on the back of this document.**

**This is only an option for those enrolled in the Transamerica Plan F as of 1/1/2020.**

**Program Administration:**

Program Administration –AmWINS Group Benefits handles all retiree customer service, annual enrollment, plan changes, billing & collection, eligibility, Medicare Part D questions, claims issues, billing issues, and any general questions you may have regarding your healthcare program. AmWINS Group Benefits can be reached at **888.883.3757.**

**Retiree Healthcare Program:**

AEGON is the 4th largest international life insurance company in the world. Located in The Netherlands, they are the parent company of many U.S. based insurance companies, including Transamerica Life Insurance Company which also owns Transamerica Financial, Transamerica Premier and Stonebridge Life Insurance Company.

Transamerica Premier Life Insurance Company is the insurance company that underwrites your Retiree Medical insurance coverage in all states except New York. Transamerica Premier Life Insurance Company will appear on the benefit summaries, certificates, and master policies.

Transamerica Financial Life Insurance Company is a New York insurance company and is the underwriting carrier used for Retiree Medical in the state of New York. Transamerica Financial Life Insurance will appear on the benefit summaries, certificates, and the master policy. Only residents of New York will receive a certificate issued under Transamerica Financial Life Insurance Company.

Humana

**Prescription Drug Program –** Humana is the insurance company that underwrites the Medicare Part D Rx program.

**Medicare Advantage (MAPD/Part C) Plan** – Humana is the insurance company that underwrites the new MAPD/Part C plan.

**This is only an option for those enrolled in the Transamerica Plan F as of 1/1/2020.**

## Retiree Medical Insurance Plan Summary of Benefits

Underwritten by: Transamerica Life Insurance Company

| | |
|---|---|
| **Calendar Year Deductible:** | **$200.00** |
| **Part B Coinsurance:** | **10%** |
| **Out-of-Pocket Maximum:** | **$1,000.00 (Includes Part B Deductible)** |
| **Lifetime Maximum:** | **Unlimited** |

**MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD***

| Services | Medicare Pays | Plan Pays | You Pay |
|---|---|---|---|
| **HOSPITAL CONFINEMENT BENEFIT*** Semiprivate room and board, general nursing and miscellaneous services and supplies: | | | |
| First 60 days | All but $1,600 | $1,600 (Part A Deductible) | $0 |
| 61st through 90th day | All but $400 per day | $400 per day | $0 |
| 91st through 150th day (While using 60 lifetime reserve days) | All but $800 per day | $800 per day | $0 |
| Once Lifetime Reserve days are used: | | | |
| Additional 365 days: | $0 | 100% of Medicare Eligible Expenses | $0 |
| Beyond the Additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $200 a day | Up to $200 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD DEDUCTIBLE – Hospital Confinement and Out-Patient Medical Expense** When furnished by a hospital or skilled nursing facility during a covered stay. | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services. | All but very limited coinsurance for outpatient drugs and inpatient respite care | $0 | Balance |

**This is only an option for those enrolled in the Transamerica Plan F as of 1/1/2020.**

## Retiree Medical Insurance Plan Summary of Benefits

Underwritten by: Transamerica Life Insurance Company

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

| Services | Medicare Pays | Plan Pays | You Pay |
|---|---|---|---|
| **OUT-PATIENT MEDICAL EXPENSES - - In or Out of the Hospital and Out-Patient Hospital Treatment,** such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment: | | | |
| Medicare Part B Deductible: First $203 of Medicare-approved amounts** | $0 | Remaining $26 of Part B Deductible | $200 (Part B Deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | 10% until $1,000 OOPX is met, then 0% |
| Part B Excess Charges (Above Medicare Approve Amounts) | $0 | 100% | 0% |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $203 of Medicare Approved Amounts** | $0 | Remaining $26 of Part B Deductible | $200 (Part B Deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | 10% until $1,000 OOPX is met, then 0% |
| **CLINICAL LABORATORY SERVICES** | | | |
| Blood tests for Diagnostic Services | 100% | $0 | $0 |

MEDICARE PARTS A & B

| Services | Medicare Pays | Plan Pays | You Pay |
|---|---|---|---|
| **HOME HEALTH CARE** – Medicare Approved Services: | | | |
| Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| **DURABLE MEDICAL EQUIPMENT** | | | |
| First $203 of Medicare Approved Amounts** | $0 | Remaining $26 of Part B Deductible | $200 (Part B Deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | 10% until $1,000 OOPX is met, then 0% |

**This is only an option for those enrolled in the Transamerica Plan F as of 1/1/2020.**

## Retiree Medical Insurance Plan Summary of Benefits

Underwritten by: Transamerica Life Insurance Company

OTHER BENEFITS NOT COVERED BY MEDICARE

| Services | Medicare Pays | Plan Pays | You Pay |
|---|---|---|---|
| FOREIGN TRAVEL - Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA: | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum of $50,000 | 20% and amounts over the $50,000 lifetime max |

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**Once you have been billed the first dollars of Medicare-Approved amounts for covered services (which are noted with two asterisks), your Medicare Part B Deductible will have been met for the calendar year.

***Benefits are paid only for those expenses which have been approved as eligible by the federal Medicare program.***

***Benefits will not be paid for any expenses which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except as otherwise specified.***

***This policy's renewability, cancellability and termination provisions are at the option of the group policy holder except in cases of non-payment of premium***

***The summary of program benefits described herein is for illustrative purposes only. In case of differences or errors, the Group Policy governs.***

*The Medicare Parts A and B deductibles and coinsurance amounts shown are the 2023 amounts.*

**This is only an option for those enrolled in stand-alone Part D as of 1/1/2020.**

**2023 Prescription Drug Summary**
**Underwritten by Humana**

If your out-of-pocket costs reach $7,400 ("Catastrophic Limit") your co-payment will be reduced to the greater of a $4.15 co-payment for generic drugs (including brand drugs treated as generic) and a $10.35 co-payment for all other drugs, or a 5% co-insurance.

| | 30 Day Retail Retiree Pays | 90 Day Mail Order Retiree Pays |
|---|---|---|
| Annual Deductible | $0 | |
| Tier 1: Generic or Preferred Generic | $9 | $18 |
| Tier 2: Preferred Brand | $30 | $60 |
| Tier 3: Non-Preferred Brand | $30 | $60 |
| Tier 4: Specialty | $100 | N/A |
| Coverage in Gap | Same copay as above | |
| Catastrophic Coverage Level $7,400.01+ | Greater of 5% or $4.15 for generic and multi-source drugs and $10.35 for all other drugs; OR 5% coinsurance ($100 maximum out-of-pocket per prescription) | |

**Prescriptions are covered based on the Humana Rx formulary.**

Medicare Part D Rx is underwritten by Humana, an employer group waiver plan, and PDP with a Medicare contract. Enrollment in this plan depends on contract renewal. The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact, AmWINS. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, premium and/or co-payments/co-insurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium.

# Manage My Health

Your enrollment in the Group Medical Plans also includes **Manage My Health**, a comprehensive program to enhance your health and well-being. **Manage My Health** is designed to offer assistance to you and your spouse by providing easy, confidential access to extensive programs and services that can improve physical and mental health.

### 24/7 PHYSICIAN CONSULTATION

Members and their families can receive 24/7 phone consultation from board certified licensed emergency room and internal medicine physicians, all from the comfort of their home.

### COMMON CONDITIONS TREATED

- Allergies
- Arthritic Pain
- Bronchitis
- Certain Rashes
- Cold/Flu
- Gastroenteritis
- Headaches
- Insect Bites
- Respiratory Infections
- Sinus Infections
- Stomach Ache/Diarrhea
- Urinary Tract Infections
- Minor Burns
- General Information

...And other non-emergency conditions.

After receiving a call, the physician will review the health records and call the patient, generally within 1 hour but guaranteed within two hours. The physician has the ability to e-prescribe medications directly to the patient's pharmacy of choice, when needed.

***Manage My Health*** includes a web-based health and wellness program that promotes personal health and fitness through the natural therapies of diet, nutritional supplements, the benefits of exercise and a healthy attitude.

The exercises included online are the same core workouts used by hundreds of professional athletes.

***Benefits Include:***

- Personalized home-based workouts with animations
- Daily health tips on nutrition, weigh-loss, exercise and disease prevention
- Over 4,500 health and wellness related articles
- Health calculators for easy tracking and self-assessments
- Unlimited health risk assessments for personal well-being
- Complete medical conditions library
- Links to hundreds of additional wellness resources

Plus, retirees can receive daily wellness tips, articles, health risk assessments and fitness calculators, nutrition planning tools and weight loss strategies.

### NUTRITION & PERSONALIZED EXERCISE

Good health requires physical and mental wellness. Exercise and good nutrition play a major role in a retiree's quality of health. For those not currently living an active lifestyle or on a fixed budget, gym memberships can be expensive and intimidating.

### HEARING DISCOUNTS FOR THE ENTIRE FAMILY

Retirees and their loved ones who suffer from hearing loss can use this benefit to offset the costs associated with screenings & hearing aid purchase/maintenance.

### SMOKING CESSATION

As we continue to learn more about the health risks of smoking, we also learn about the health benefits of quitting. As a result, many retirees who have spent quite literally decades smoking are making an effort to quit for an improved quality of life, including spending more time with their grandchildren.

To assist, Manage My Health offers retirees up to eight face-to-face visits during a 12-month period in a smoking cessation program. These visits must be provided by a qualified doctor or other Medicare-recognized practitioner. There is no cost for the counseling sessions.

### EMERGENCY ONLINE PERSONAL HEALTH RECORD

Manage My Health also provide the ability to create an online personal health record and print a card with important information. Carrying this emergency identification card enables emergency medical professionals to instantly access critical information, including medical history, current medications, blood type, health insurance information, medical images, living will and more. Caregivers and retirees can appreciate the value of having one location for this health information, accessible worldwide from any computer.

This personal health record can also be printed out prior to a doctor's appointment without answering redundant lengthy questionnaire forms.

**AmWINS Group Benefits reserves the right to change service providers at any time based upon the quality and usage.*

**For questions regarding Manage My Health, please call AmWINS toll-free at 1-888-883-3757 or visit: http://www.managemyhealth.amwins.com**

DELTA DENTAL®

## Delta Dental PPO (Point-of-Service)
## Summary of Dental Plan Benefits
## For Group# 5414-0001
## Kent County Retirees

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

**Control Plan** – Delta Dental of Michigan

**Benefit Year** – January 1 through December 31

**Covered Services –**

| | Delta Dental PPO Dentist | Delta Dental Premier Dentist | Nonparticipating Dentist |
|---|---|---|---|
| | Plan Pays | Plan Pays | Plan Pays* |
| **Diagnostic & Preventive** | | | |
| **Diagnostic and Preventive Services** – exams, cleanings, fluoride, and space maintainers | 100% | 100% | 100% |
| **Sealants** – to prevent decay of permanent teeth | 100% | 100% | 100% |
| **Brush Biopsy** – to detect oral cancer | 100% | 100% | 100% |
| **Bitewing Radiographs** – bitewing X-rays | 100% | 100% | 100% |
| **Basic Services** | | | |
| **Emergency Palliative Treatment** – to temporarily relieve pain | 80% | 80% | 80% |
| **All Other Radiographs** – other X-rays | 80% | 80% | 80% |
| **Minor Restorative Services** – fillings and crown repair | 80% | 80% | 80% |
| **Non-Surgical Periodontic Services** – non-surgical services to treat gum disease | 80% | 80% | 80% |
| **Simple Extractions** – non-surgical removal of teeth | 80% | 80% | 80% |
| **Other Basic Services** – misc. services | 80% | 80% | 80% |
| **Major Services** | | | |
| **Endodontic Services** – root canals | 50% | 50% | 50% |
| **Surgical Periodontic Services** – surgical services to treat gum disease | 50% | 50% | 50% |
| **Occlusal Guards/Adjustments** – bite guards and occlusal adjustments | 50% | 50% | 50% |
| **Other Oral Surgery** – dental surgery | 50% | 50% | 50% |
| **Major Restorative Services** – crowns | 50% | 50% | 50% |
| **Relines and Repairs** – to prosthetic appliances | 50% | 50% | 50% |
| **Prosthodontic Services** – bridges, implants, dentures, and crowns over implants | 50% | 50% | 50% |

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people age 18 and under.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for first permanent molars for people age eight and under and second permanent molars for people age 13 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are Covered Services on posterior teeth.

- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

**Benefit Waiting Period** – There is a 12-month waiting period for certain services. Endodontic Services, Surgical Periodontic Services, Occlusal Guards/Adjustments, Other Oral Surgery, Major Restorative Services, Relines and Repairs, and Prosthodontic Services will not be covered until after a person is enrolled in the dental plan for 12 consecutive months. The waiting period(s) can be waived for enrollees covered for at least 12 months under an immediately preceding dental plan. It is the enrollees' responsibility to provide the necessary documentation for this to be waived.

**Maximum Payment** – $1,000 per person total per Benefit Year on all services.

**Deductible –** $50 Deductible per person total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to oral exams, preventive services, bitewing X-rays, brush biopsy, and sealants.

**Eligible People** – All pre and post 65 retirees of County of Kent, Michigan who choose the dental plan.

Also eligible are your Spouse and your Children to the end of the month in which they turn 26, including your Children who are married, who no longer live with you, who are not your Dependents for Federal income tax purposes, and/or who are not permanently disabled.

Enrollees and dependents choosing this dental plan are required to remain enrolled for a minimum of 12 months. Should an Enrollee or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

**Coordination of Benefits –** If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled together on one application or separately on individual applications, but not both. Your Dependent Children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Enrollees under This Plan.

Benefits will cease on the last day of the month in which the subscriber is terminated.

# A Look at Your VSP Vision Coverage

**With VSP and KENT COUNTY RETIREES, your health comes first.**

**Enroll in VSP® Vision Care to get access to savings and personalized vision care from a VSP network doctor for you and your family.**

**Value and savings you love.**
Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

**Provider choices you want.**
Maximize your benefits at a Premier Program location, which is part of our incredible network of doctors.

**Shop online and connect your benefits.**
Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

**Quality vision care you need.**
You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

**Using your benefit is easy!**
Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with Exclusive Member Extras. At your appointment, just tell them you have VSP.

vsp vision care

## More Ways to Save

**Extra**
$20
**to spend on Featured Brands†**

bebe · CALVIN KLEIN · COLE HAAN · DRAGON · FLEXON · LACOSTE · and more

**See all brands and offers** at **vsp.com/offers**.

+

**Up to**
40%
**Savings on lens enhancements‡**

Enroll through your employer today.
Contact us: **800.877.7195** or **vsp.com**

## Your VSP Vision Benefits Summary

KENT COUNTY RETIREES and VSP provide you with an affordable vision plan.

**PROVIDER NETWORK:**
VSP Choice
**EFFECTIVE DATE:**
01/01/2023

vsp vision care

| BENEFIT | DESCRIPTION | COPAY | FREQUENCY |
|---|---|---|---|
| **Your Coverage with a VSP Provider** | | | |
| **WELLVISION EXAM** | • Focuses on your eyes and overall wellness | $10 | Every calendar year |
| **ESSENTIAL MEDICAL EYE CARE** | • Retinal screening for members with diabetes<br>• Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more.<br>• Coordination with your medical coverage may apply. Ask your VSP doctor for details. | $0 per screening<br>$20 per exam | Available as needed |
| **PRESCRIPTION GLASSES** | | **$25** | |
| **FRAME**[†] | • $180 frame allowance<br>• $200 featured frame brands allowance<br>• 20% savings on the amount over your allowance<br>• $180 Walmart®/Sam's Club® frame allowance<br>• $100 Costco® frame allowance | Included in Prescription Glasses | Every other calendar year |
| **LENSES** | • Single vision, lined bifocal, and lined trifocal lenses<br>• Impact-resistant lenses for dependent children | Included in Prescription Glasses | Every calendar year |
| **LENS ENHANCEMENTS** | • Standard progressive lenses<br>• Premium progressive lenses<br>• Custom progressive lenses<br>• Average savings of 30% on other lens enhancements | $0<br>$95 - $105<br>$150 - $175 | Every calendar year |
| **CONTACTS (INSTEAD OF GLASSES)** | • $150 allowance for contacts; copay does not apply<br>• Contact lens exam (fitting and evaluation) | Up to $60 | Every calendar year |
| **EXTRA SAVINGS** | **Glasses and Sunglasses**<br>• Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details.<br>• 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. | | |
| | **Routine Retinal Screening**<br>• No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam | | |
| | **Laser Vision Correction**<br>• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities | | |

**YOUR COVERAGE GOES FURTHER IN-NETWORK**

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

## Save Up to 60% on Brand-name Hearing Aids

TruHearing™

Like vision loss, hearing loss can have a huge impact on your quality of life. However, the cost of a pair of quality hearing aids usually costs more than $5,000, and few people have hearing aid insurance coverage.

TruHearing® makes hearing aids affordable by providing exclusive savings to all VSP® Vision Care members. You can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible, too.

In addition to great pricing, TruHearing provides you with:

- Three provider visits for fitting and adjustments
- 45-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 48 free batteries per hearing aid

Plus, with TruHearing you'll get:

- Access to a national network of more than 3,800 hearing healthcare providers
- Straightforward, nationally-fixed pricing on a wide selection of the latest brand-name hearing aids
- Deep discounts on batteries shipped directly to your door

Best of all, if you already have a hearing aid benefit from your health plan or employer, you can combine it with TruHearing prices to reduce your out-of-pocket expense even more!

Here's how it works:

**Contact TruHearing.**
Call **877.396.7194**. You and your family members must mention VSP.

**Schedule exam.**
TruHearing will answer your questions and schedule a hearing exam with a local provider.

**Attend appointment.**
The provider will perform a hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for you.

**Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or, call 877.396.7194 with questions.**

The relationship between VSP and TruHearing is that of independent contractors. VSP makes no endorsement, representations or warranties regarding any products or services offered by TruHearing, a third-party vendor. TruHearing is solely responsible for the products or services offered by them. Savings based on a survey of national average retail hearing aid prices compared to average TruHearing pricing. Actual customer savings will vary. Three follow-up visits must be used within one year after the date of initial purchase. Forty-five-day trial and hearing aid returns, repairs, and replacements subject to provider and manufacturer fees. For questions regarding fees, contact TruHearing customer service. Not available in the state of Washington.



JOB#5007-16-VCXA 6/16

| | Non-Medicare Plan Options | | |
|---|---|---|---|
| | Medical | | Prescription |
| | ***Blue Cross Blue Shield Wellness PPO*** | ***Blue Care Network HMO*** | ***Capital Rx*** |
| **Single** | $579.59 | $447.62 | $144.55 |
| **Double** | $1,217.14 | $1,074.28 | $303.56 |
| **Family** | $1,448.98 | $1,342.85 | $361.38 |

| | Medicare-Eligible Plan Options | | |
|---|---|---|---|
| | ***AmWINS*** | | |
| | **Plan F & Part D are closed to new enrollments. If you are currently in these plans, you may continue for 2023 or switch to the Medicare Advantage Part C.** | | |
| | **Medicare Supplement (Plan F)** *Transamerica* | **Prescription Part D** *Humana* | **Medicare Advantage (Part C)** *Humana* |
| **One Person with Medicare** | $154.89 | $130.22 | $164.62 |
| **Two Person with Medicare** | $309.78 | $260.44 | $329.24 |
| **One Person (under 65) with Medicare*** | $154.89 | $130.22 | $164.62 |

*subject to medical underwriting for new

| | Other Benefits | |
|---|---|---|
| | **Dental** | **Vision** |
| **Single** | $39.10 | $11.21 |
| **Double** | $75.45 | $17.11 |
| **Family** | $130.26 | $30.69 |

Kent County has partnered with Northern Trust to provide retirees with immediate and secure access to their benefit payment information. Kent County Retirees can access their Benefit Payments 24 hours a day, 7 days a week through Northern Trust's secure Web Passport.

Benefits of using the Web Passport Include:

- **Real-Time** account information as well as historical tax statements
- **Instant** on-the-spot payment statue (paid vs. outstanding)
- **Access** to payment history, images of paid checks and the ability to stop payment instructions
- **Ability** to update Address, Tax and Electronic Deposit information

For more information, please contact the Benefit Payment Participant Service Center at 866-252-5395 or log on to www.northerntrust.com/bppweb.

## *WHERE TO CALL ☎ , OR WRITE ✉ , OR ACCESS INFORMATION*

| COMPANY | PHONE NUMBER ☎ | WEBSITE / E-MAIL / MAIL |
|---|---|---|
| **MEDICAL** | Customer Service<br>(888) 890-5754 | www.bcbsm.com<br>Blue Cross Blue Shield of Michigan |
| **Blue Cross Blue Shield of Michigan (BCBSM)** | Provider Locator<br>(800) 810-2583 | West Michigan Customer Service<br>P.O. Box 230555<br>Grand Rapids, MI 49523-0555 |
| | | www.bcbsm.com |
| **Blue Care Network** | (800) 662-6667 | Blue Care Network<br>P.O. Box 68767<br>Grand Rapids, MI 49516-8767 |
| **AmWins**<br>Transamerica Premier Life Insurance Company | (888) 883-3757 | 50 Whitecap Drive<br>North Kingstown, RI 02852 |
| Humana MAPD/Part C | | |
| **PRESCRIPTION DRUG** | | www.cap-rx.com<br>Capital Rx |
| **CapitalRx** | (844) 532-2779 | 228 Park Avenue S<br>New York, NY 10003 |
| **AmWins**<br>Humana | (888) 883-3757 | 50 Whitecap Drive<br>North Kingstown, RI 02852 |
| **DENTAL** | | www.deltadentalmi.com<br>4100 Okemos Rd. |
| Delta Dental of Michigan | (800) 524-0149 | Okemos, MI 48864 |
| **VISION** | | www.vsp.com |
| Vision Service Plan Insurance Company (VSP) | (800) 877-7195 | 3333 Quality Drive<br>Rancho Cordova, CA 95670 |
| **KENT COUNTY RETIREMENT SERVICES** | Tara Beatty<br>(616) 632-7457<br>Mandy Lee<br>(616) 632-7442 | tara.beatty@kentcountymi.gov<br>mandy.lee@kentcountymi.gov<br>kcretirement@kentcountymi.gov<br>Kent County Human Resources Dept.<br>300 Monroe NW<br>Grand Rapids, MI 49503 |
| **SENIOR NEIGHBORS** | Brianna Bonewell<br>(616) 233-0282 | MMAPTeam@seniorneightbors.org<br>678 Front Ave NW Suite 205<br>Grand Rapids, MI 49504 |
| **BENEFITS STAFF**<br>Kent County Human Resources Department | Mirela Ruiz<br>(616) 632-7462<br>Nicole Joyce<br>(616) 632-7464<br>Rebecca Hatfield<br>(616) 632-7471 | mirela.ruiz@kentcountymi.gov<br>nicole.joyce@kentcountymi.gov<br>jessica.hitchcock@kentcountymi.gov<br>Kent County Human Resources Dept.<br>300 Monroe NW<br>Grand Rapids, MI 49503 |
| **PAYROLL STAFF**<br>Kent County Fiscal Services Department | Alecia Terry (616) 632-7710<br>Stacey Steffes (616) 632-7712 | alecia.terry@kentcountymi.gov<br>stacey.steffes@kentcountymi.gov<br>Kent County Fiscal Services Dept.<br>Attn: Payroll<br>300 Monroe NW<br>Grand Rapids, MI 49503 |

## GENERAL QUESTIONS

**Q. Can I make changes to my benefits at any time during the year?**

**A.** Changes during the year can **only** be made within 30 days of the event based on the following family status changes:

- Marriage*
- Birth / Adoption*
- Divorce*
- Death*
- Loss of Other Coverage*

*Documentation of proof is required to make changes such as a copy of a marriage certificate, finalized divorce decree, proof of loss of other coverage, etc.

**Q. Can I add an adult child to my insurance at this time?**

**A.** Effective as of January 1, 2011, your dependent child can be covered through the end of the month in which he/she turns 26. If you want to add an adult child to your insurance for 2023, you should add the child on your open enrollment form. You must provide proof of relationship such as a birth certificate.

**Q. Do I have to return my OE form even if I do not have any changes?**

**A.** No. Return the election form ONLY if you are making a change.

**Q. What are my medical plan options for 2023?**

**A.** Medicare Eligible: Medicare Supplement Plan F (if currently enrolled) or Medicare Advantage/Part C through AmWINS.
Non-Medicare Eligible: Blue Care Network Wellness HMO or Blue Cross/Blue Shield Wellness PPO.

**Q. What is a Medicare Advantage Plan?**

**A.** A Medicare Advantage (Part C) plan combines hospital coverage (Part A), medical coverage (Part B) and prescription coverage (Part D). You must be enrolled in Parts A and B and you will continue to pay your Part B premium to the government.

**Q. What are my 2023 Out-of-Pocket Maximums (Non-Medicare)?**

**A.** Cost-sharing limitations have been imposed under Health Care Reform. In 2023, a member's out-of-pocket maximums for medical expenses are limited to $3,150 for an individual and $6,300 for family coverage. The out-of-pocket maximum as defined by the PPACA includes co-pays, deductibles and coinsurance. For prescription drug coverage, a member's out-of-pocket maximums are limited to $5,950 for an individual and $11,900 for a family. Total combined retiree cost for medical and prescriptions cannot exceed the federal annual limit of $9,100 for an individual and $18,200 for a family-adjusted annually.

**Q. I am a Blue Care Network participant; do I have to pay deductibles, coinsurance or co-pays?**

**A.** Yes. Blue Care Network participants are responsible for a $20 co-pay for non-preventative office visits and a $40 co-pay for a visit to a specialist. BCN participants are also responsible for a $250 individual deductible or $500 family deductible as well as a 10% coinsurance for certain services.

**GENERAL QUESTION (cont'd)**

**Q. Are cards issued for the VSP vision plan?**

**A.** No, cards are not issued for the vision plan. Simply find a VSP doctor by calling (800) 877-7195 or www.vsp.com. Tell them you're a VSP member and they'll handle the rest.

**Q. Are cards issued for the Dental plan?**

**A.** No, cards are not issued for the dental plan. Simply find a Delta Dental provider by calling (800) 524-0149 or www.deltadentalmi.com. Tell them you're a Delta Dental member and they'll handle the rest.

**Q. How do I use the Dental Plan?**

**A.** The dental plan is administered by Delta Dental. You may select the dental care provider(s) of your choice. If you choose an in-network provider, discounts for services will be applied. The provider will be paid directly for eligible dental services they provide to you and your eligible dependents. Your provider will directly bill Delta Dental.

**Q. Are there any changes regarding prescription coverage?**

**A.** No, not for 2023. For 2023, the out-of-pocket maximum for prescription drug coverage will be $5,950 for an individual and $11,900 for a family under the Capital Rx plan.

**Q. Are there any changes regarding my prescription co-pays through Capital Rx?**

**A.** No. The 2023 co-pays for a 30-day supply remain:
$15 – Generics
$25 – Formulary
$45 – Non-Formulary

When you get a 90-day supply, you will pay two times the prescription co-pay ($30/$50/$90). In other words, you are paying for 2 months and getting one month free.

**Q. Are there any prescription drugs that are not covered under the Capital Rx prescription plan?**

**A.** Yes. For example, erectile dysfunction drugs are not covered under the plan. Examples of these types of drugs are Viagra and Cialis. You are responsible for the entire cost of the medication. For a list of other non-covered prescription drugs, please refer to the summary plan description.

## GENERAL QUESTION (cont'd)

**Q. How can I keep my Prescription Costs at a lower co-pay?**

**A.** You should discuss your current prescription and prescription alternatives with your doctor and/or pharmacist to determine if you can benefit from a less costly prescription, e.g. generic. You may also consider visiting pharmacies at major retailers that offer special pricing on generic maintenance drugs. Retailers may offer a lower co-pay to the participant and the cost is not charged to the plan.

## HEALTH CARE REFORM

**Q. What is a health insurance marketplace or exchange?**

A. A marketplace, or exchange, is a website where you can shop for health insurance. You can compare all your options and costs side-by-side and see if you qualify for financial help. All the plans offered in a marketplace, or exchange, must meet certain rules of affordability, required benefits, and market standards.

**Q. What can I do through a health insurance exchange?**

A. You'll be able to:

- Shop for health insurance offered by well-known insurance companies.
- Choose from health plans grouped by metallic levels: Bronze, Silver, Gold, and Platinum. The different plans will offer you choices in:
    - How much you'll pay for coverage (premium amounts)
    - How much you'll pay out of your own pocket for medical care and prescription drugs (deductibles, coinsurance, copays, and out-of-pocket maximums)
    - Networks of participating doctors, hospitals, labs, and other health care providers
- Complete an application to find out if you qualify for financial help.
- Enroll in health insurance that's right for you or your family. The federal and state health insurance marketplaces will begin enrollment in November 2022 for coverage starting January 1, 2023.

**HEALTH CARE REFORM (cont'd)**

**Q. Can I get help paying for health insurance?**

A. If you're going to buy insurance through a state or federal health insurance exchange, financial help may be available.

**Q. What if I have health insurance options through my employer?**

A. You'll have the options to get insurance through your employer *or* a health insurance exchange. The choice is yours. Before you choose a plan:

- Think about your health care needs.
    - Do you see the doctor often and take one or more prescription drugs for an ongoing condition, such as high blood pressure or diabetes? Or do you only see the doctor once or twice a year for checkups and the occasional illness?
    - The answer to these questions can help you decide which option presents the best coverage and value for you and your family.

- Review **all** the options that are available to you.
    - Depending on your situation, you may also be eligible for coverage through Medicare or Medicaid. Or your children may be eligible for coverage through the Children's Health Insurance Program (CHIP) in your state.

If, after reviewing all your options, you decide to buy coverage through an exchange, you may qualify for financial help if your income is low or modest.

However, you will not qualify for financial help if you choose to buy insurance through an exchange and your employer offers you coverage that is:

- Considered "affordable" (how much you pay for coverage is less than 9.5% of your income); and
- Meets coverage standards as required by law.

## *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 County of Kent and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

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

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

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

---

***When Can You Join A Medicare Drug Plan?***

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan and drop your County of Kent prescription drug coverage, be aware that **your current prescription drug coverage is not part of your medical coverage from County of Kent. Therefore, you can drop your County of Kent prescription drug coverage without dropping your County of Kent medical coverage.** If you enroll in a Medicare Part D plan and drop your creditable coverage with County of Kent, you may not be able to return to the same plan through County of Kent until the next enrollment period.

## *ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE*

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

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

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

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

Contact the person listed below for further information or call your local Human Resources Department. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through County of Kent changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

## *ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE*

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

| | |
|---|---|
| Date: | October 15, 2022 |
| Name of Entity/Sender: | Kent County |
| Contact--Position/Office: | Human Resources |
| Address: | 300 Monroe Ave NW<br>Grand Rapids, MI 49503 |
| Phone Number: | 616-632-7440 |

## Notice of Privacy Practices

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.

This notice is being provided to you pursuant to the federal law known as HIPAA and an amendment to that law known as HITECH. If you have any questions about this notice, please contact the Privacy Officer at County of Kent, Attention Human Resources Director, 300 Monroe Ave NW, Grand Rapids MI 49503, (616) 632-7477.

### Who Will Follow This Notice

This notice describes the medical information practices of all the group health plans (collectively, the "Plan") maintained by County of Kent (the "Plan Sponsor") and that of any third party that assists in the administration of Plan claims. The Plan has been amended to incorporate the requirements of this notice.

### Our Pledge Regarding Your Protected Health Information

We understand that medical information about you and your health is personal. We are required by law to protect medical information about you. This notice applies to the medical records and information we maintain concerning the Plan. Your health care provider may have different policies or notices regarding the use and disclosure of your medical information created in the health provider's facility.

This notice, which is required by law, will tell you about the ways in which we may use and disclose medical information about you (known as "protected health information" under federal law). It also describes our obligations and your rights regarding the use and disclosure of protected health information.

### How We May Use and Disclose Protected Health Information About You

The following categories describe different ways that we use and disclose protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment**. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, or other hospital personnel who are involved in taking care of you.

**For Payment**. We may use and disclose your protected health information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, or to determine benefit payment under the Plan. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

**For Health Care Operations**. We may use and disclose your protected health information for Plan operations purposes. These uses and disclosures are necessary to run the Plan. For example, we may use your protected health information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

**To Business Associates and Subcontractors**. We may contract with individuals and entities known as Business Associates to perform various functions or provide certain services. To perform these functions or provide these services, Business Associates may receive, create, maintain, use and/or disclose your protected health information, but only after they sign an agreement with us requiring them to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, but only after the Business Associate enters into a Business Associate Agreement with us. Similarly, a Business Associate may hire a Subcontractor to assist in performing functions or providing services in connection with the Plan. If a Subcontractor is hired, the Business Associate may not disclose your protected health information to the Subcontractor until after the Subcontractor enters into a Subcontractor Agreement with the Business Associate.

**As Required by Law**. We will disclose your protected health information when required to do so by federal, state or local law.

**To Avert a Serious Threat to Health or Safety**. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

**Disclosure to Health Plan Sponsor**. Information may be disclosed to another health plan maintained by Plan Sponsor for purposes of facilitating claims payments under that plan. In addition, your protected health information may be disclosed to Plan Sponsor and its personnel for purposes of administering benefits under the Plan or as otherwise permitted by law and Plan Sponsor's HIPAA privacy policies and procedures.

**Special Situations**

**Organ and Tissue Donation**. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans**. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation**. We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

**Public Health Risks**. We may disclose your protected health information for public health activities, such as to prevent or control disease, injury or disability, report births and deaths, or notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**Health Oversight Activities**. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Law Enforcement**. We may release protected health information if asked to do so by a law enforcement official in certain situations, such as:

- in response to a court order, subpoena, warrant, or summons;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; or
- about criminal conduct.

**Coroners and Medical Examiners**. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

### Your Rights Regarding Your Protected Health Information

You have the following rights regarding your protected health information which we maintain:

**Right to Access**. You have the right to request access to the portion of your protected health information containing your enrollment, payment and other records used to make decisions about your Plan benefits. This includes the right to inspect the information as well as the right to a copy of the information. You may request that the information be sent to a third party. You must submit a request for access in writing to the Privacy Officer. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request (such as a thumb drive in the case of a request for electronic information – see next paragraph). We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

If the Plan maintains your protected health information electronically in a designated record set, the Plan will provide you with access to the information in the electronic form and format you request if readily producible or, if not, in a readable electronic form and format as agreed to by the Plan and you.

**Right to Amend**. If you feel that protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

**Right to an Accounting of Disclosures**. You have the right to request an accounting of certain disclosures of your protected health information. The accounting will not include disclosures to carry out treatment, payment and health care operations, disclosures to you about your own protected health information, disclosures pursuant to an individual authorization or other disclosures as set forth in Plan Sponsor's HIPAA privacy policies and procedures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the reasonable costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Effective at the time prescribed by federal regulations, you may also request an accounting of uses and disclosures of your protected health information maintained as an electronic health record in the event the Plan maintains such records.

**Right to Request Restrictions**. You have the right to request a restriction or limitation regarding your protected health information we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on your protected health information we disclose to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us: (1) What information you want to limit; (2) Whether you want to limit our use, disclosure or both; and (3) To whom you want the limits to apply, for example, disclosures to your spouse.

**Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate
all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of this Notice**. If you received this notice electronically, you have the right to a paper copy of this notice. You may ask us to give you a paper copy of this notice at any time. To obtain a paper copy of this notice, contact the Privacy Officer.

### Genetic Information

If we use or disclose protected health information for underwriting purposes with respect to the Plan, we will not (except in the case of any long-term care benefits) use or disclose protected health information that is your genetic information for such purposes.

### Breach Notification Requirements

In the event unsecured protected health information about you is "breached," unless we determine that there is a low probability that the protected health information has been compromised, we will notify you of the situation. We will also inform HHS and take any other steps required by law.

### Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for protected health information we already have about you as well as any information we receive in the future. We will notify you in the event of a change.

### Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan by contacting the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

### Other Uses of Your Protected Health Information

Other uses and disclosures of your protected health information not covered by this notice or applicable laws will be made only with your written permission. If you provide us permission to use or disclose your protected health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

### Effective Date

This notice is effective September 23, 2013.

***Women's Health and Cancer Rights Act of 1998***

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

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

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

Call your HR Department for more information.

***GINA Notice***

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

| IOWA – Medicaid and CHIP (Hawki) | MONTANA – Medicaid |
|---|---|

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

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**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid | COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | Health First Colorado Website: https://www.healthfirstcolorado.com/<br>CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/ State Relay 711<br>Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program<br>HIBI Customer Service: 1-855-692-6442 |
| **ALASKA – Medicaid** | **FLORIDA – Medicaid** |
| The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx | Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |
| **ARKANSAS – Medicaid** | **GEORGIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162 ext 2131 |
| **CALIFORNIA – Medicaid** | **INDIANA – Medicaid** |
| Health Insurance Premium Payment (HIPP) Program<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Email: hipp@dhcs.ca.gov | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.in.gov/fssa/hip/<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>Phone 1-800-457-4584 |

| | |
|---|---|
| Medicaid Website:<br>https://dhs.iowa.gov/ime/members<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>http://dhs.iowa.gov/Hawki<br>Hawki Phone: 1-800-257-8563<br>HIPP Website:<br>https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp<br>HIPP Phone: 1-888-346-9562 | Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084 |
| **KANSAS – Medicaid** | **NEBRASKA – Medicaid** |
| Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884 | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **KENTUCKY – Medicaid** | **NEVADA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website:<br>https://kidshealth.ky.gov/Pages/index.aspx<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website: https://chfs.ky.gov | Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 |
| **LOUISIANA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) | Website: https://www.dhhs.nh.gov/oii/hipp.htm<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext 5218 |
| **MAINE – Medicaid** | **NEW JERSEY – Medicaid and CHIP** |
| Enrollment Website:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br><br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: -800-977-6740.<br>TTY: Maine relay 711 | Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 |
| **MASSACHUSETTS – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa<br><br>Phone: 1-800-862-4840 | Website: https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **MINNESOTA – Medicaid** | **NORTH CAROLINA – Medicaid** |
| Website:<br>https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp<br>Phone: 1-800-657-3739 | Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 |
| **MISSOURI – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 | Website:<br>http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-844-854-4825 |

| OKLAHOMA – Medicaid and CHIP | UTAH – Medicaid and CHIP |
|---|---|
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **OREGON – Medicaid** | **VERMONT– Medicaid** |
| Website: http://healthcare.oregon.gov/Pages/index.aspx<br>http://www.oregonhealthcare.gov/index-es.html<br>Phone: 1-800-699-9075 | Website: http://www.greenmountaincare.org/<br>Phone: 1-800-250-8427 |
| **PENNSYLVANIA – Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website:<br>https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx<br>Phone: 1-800-692-7462 | Website: https://www.coverva.org/en/famis-select<br>https://www.coverva.org/en/hipp<br>Medicaid Phone: 1-800-432-5924<br>CHIP Phone: 1-800-432-5924 |
| **RHODE ISLAND – Medicaid and CHIP** | **WASHINGTON – Medicaid** |
| Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) | Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 |
| **SOUTH CAROLINA – Medicaid** | **WEST VIRGINIA – Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://mywvhipp.com/<br>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **SOUTH DAKOTA - Medicaid** | **WISCONSIN – Medicaid and CHIP** |
| Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 | Website:<br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 |
| **TEXAS – Medicaid** | **WYOMING – Medicaid** |
| Website: http://gethipptexas.com/<br>Phone: 1-800-440-0493 | Website:<br>https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
**www.dol.gov/agencies/ebsa**
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
**www.cms.hhs.gov**
1-877-267-2323, Menu Option 4, Ext. 61565

## *DISCRIMINATION IS AGAINST THE LAW*

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

County of Kent:

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

If you need these services, contact Darius Quinn. If you believe that County of Kent has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Darius Quinn, 300 Monroe Avenue NW, Grand Rapids, MI 49503, P: 1-616-632-7468, F: 1-616-632-7445, E: darius.quinn@kentcountymi.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Darius Quinn is available to help you.

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

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

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-616-632-7468
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-616-632-7468
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-616-632-7468
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-616-632-7468 번으로 전화해 주십시오.

## *DISCRIMINATION IS AGAINST THE LAW*

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-616-632-7468

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-616-632-7468

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-616-632-7468

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-616-632-7468

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-616-632-7468

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-616-632-7468

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-616-632-7468

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-616-632-7468 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-616-632-7468).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-616-632-7468

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-616-632-7468

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 your 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.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan’s in- network cost-sharing amount (such as copayments and coinsurance). 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 balanced billed for these post-stabilization services.

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 may bill you is your 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 balance billed.

If you get other 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 never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

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

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:
Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services, at 1-800-985-3059.

Visit https://www.cms.gov/files/document/memo-no-surprises-act-phone-number-and-website-url-clean-508-mm2.pdf for more information about your rights under federal law.

Additional information on No Surprise Billing can be found at the following links:

https://www.cms.gov/files/document/model-disclosure-notice-patient-protections- against-surprise-billing-providers-facilities-health.pdf

https://www.bcbsm.com/index/common/important-information/caa/federal-no- surprises-act.html