Kent County

Your Partner, Your Place

Understanding Your Benefits

2024 Retiree Benefits Guide

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2024 Benefits Guide

Kent County takes pride in providing a robust compensation package that includes comprehensive benefits designed to protect you and your dependents. This booklet provides details on all the benefit plans available to you.

What This Guide Will Do For You

- ✓ Define who is eligible for coverage
- ✓ Outline the cost to enroll
- ✓ Explain how to enroll
- ✓ Provide a high-level summary of benefit coverage
- ✓ Provide the knowledge on how to get the most value from your benefit plans through carrier-provided tools and resources

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I. General Information

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, the Retirement Services Division of Human Resources will provide enrollment forms, costs and available options. Should you have any questions, please reach out to Retirement Services. 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 5.

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 Retirement Services.

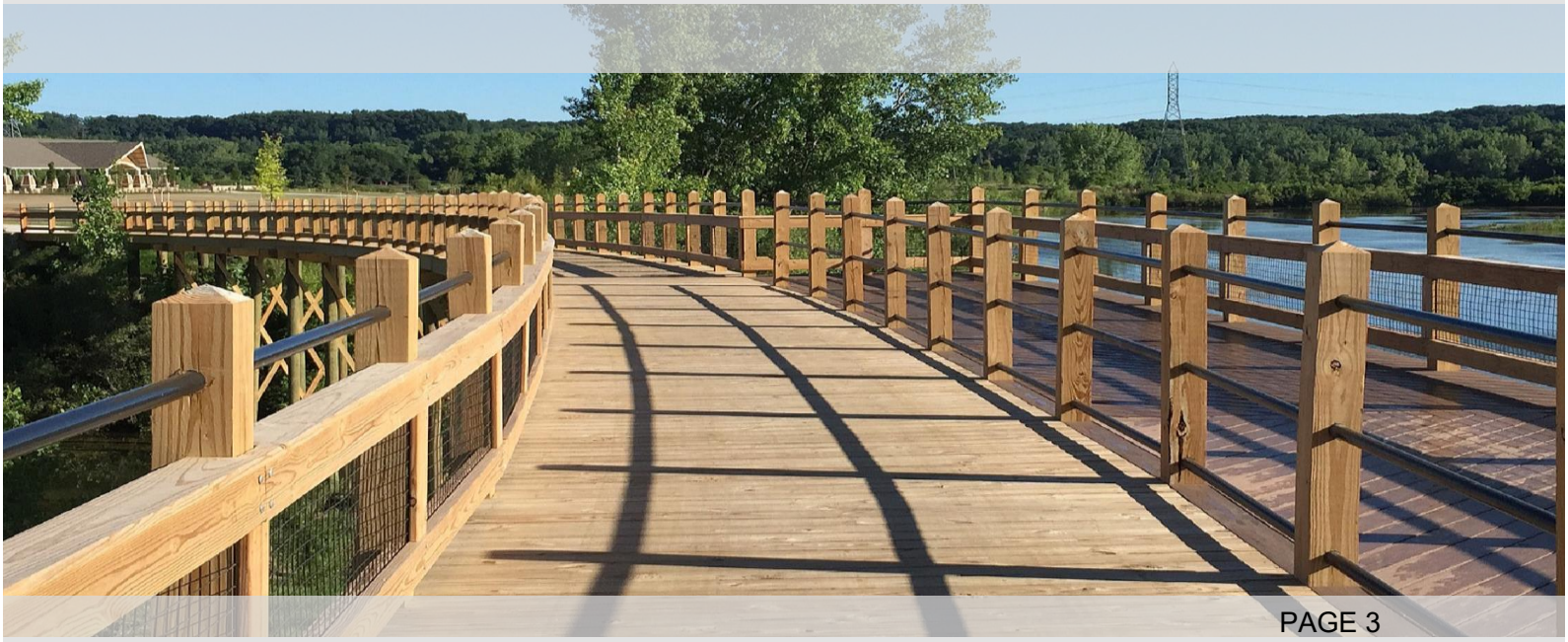
Every effort has been made to ensure the accuracy and completeness of the benefit descriptions contained within this guide. However, in the event of any interpretation, discrepancy, application and/or decision in specific circumstances, the official text or terms of the plan document will govern. This 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.

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 48 for more details.

I. General Information

What's Changing in 2024?

- NEW Partnership with **Retiree First**! More information starting on page 29!
- In 2024, Kent County will offer a Medicare Advantage (MAPD/PART C) plan, administered by Retiree First and underwritten by Priority Health. This plan is open to all Medicare-Eligible retirees.
- Plan F will now be offered through United American, new in 2024.
- NEW PLAN OFFERING with BCBSM! Wellness High Deductible Health Plan with Health Savings Account (HSA)
- New Mail-Order prescription drug partner if you elect prescription drug coverage with Capital Rx effective 1/1/2024, Optum Home Delivery and Optum Specialty More information on page 18!
- Updated Pharmacy Cost Sharing Limitations for those enrolling in the Wellness PPO and Wellness HMO Plans
    - Individual out-of-pocket maximum: $4,500
    - Family out-of-pocket maximum: $9,000
- NEW Rx Cap Pharmacy Savings Programs for eligible participants taking certain specialty medications and elect coverage with Capital Rx.
- NEW! ALEX, a decision support tool, can assist you in choosing the right coverage for you and your family! More information on page 4!



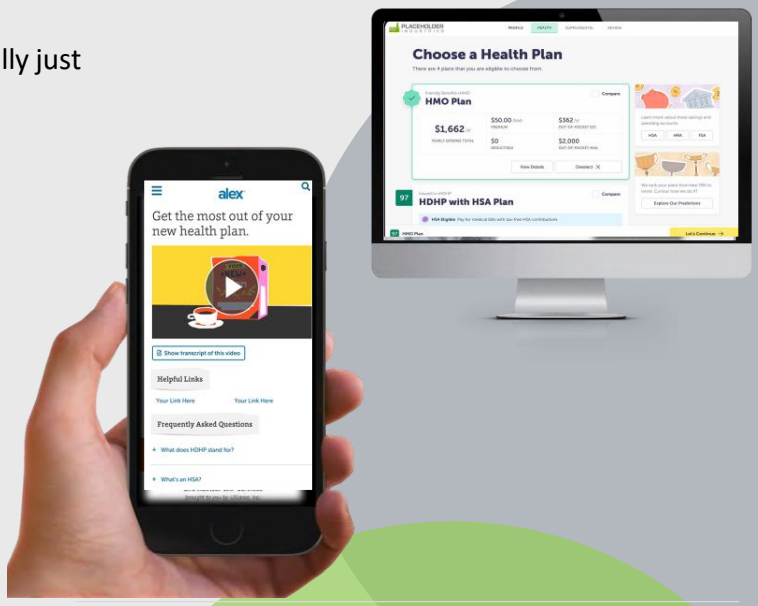
I. General Information

Meet ALEX

ALEX is an online tool that helps you select the best benefit plan for you and your family. When you talk to **ALEX** you'll be asked a few questions about your health care needs, and then ALEX will crunch some numbers, and point out what makes the most sense for you. And anything you tell ALEX remains between the two of you, so don't be afraid to really let loose about that weird tooth thing.

How long will this take?

Most users spend about 7 minutes with ALEX, but it really just depends how much guidance you'd like.



Can I use ALEX on my phone?

Oh yeah. ALEX is optimized for any device you've got.

Can I trust ALEX with my secrets?

Yes! Your ALEX experience is totally private and secure.

How should I prepare?

You don't need to do much of anything. ALEX will ask you to estimate what type of medical care you might need this year (doctors visits, surgeries, ER visits, prescriptions, etc.), so you may want to tally those up and talk to your family about their needs, but ALEX can also help you come up with some estimates.

How does ALEX know what plan is best for me?

ALEX takes the amount each plan would cost (your premium) and adds that to the amount it would cost for the services you said you might use. Then he'll recommend the least expensive plan for your needs.

Get started at www.myalex.com/kent-county-early-retirees/2024

Changing your elections

Benefits cannot be changed outside of the open enrollment period, except in the event of significant status changes (also know as a qualified event). 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,
- If you or your dependents have other coverage, but lose eligibility for that other coverage,
- Spouse's loss or gain of equivalent coverage through his/her employer, or
- Change in job status of employee 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, dental, and vision plans:

Eligible Spouse:

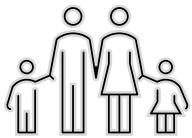
Your legally married spouse as defined by the State of Michigan.

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 26.



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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.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30-days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30-days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("SCHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60-days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact HR.

Proof of eligibility document requirements

The County reserves the right to require proof of eligibility. To add dependents to your plan, documentation is required for proof of eligibility. See requirements below. To ensure confidentiality, 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 AND
- A copy of the front page of your most recently filed federal tax return confirming this dependent as a spouse, OR 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; OR 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).

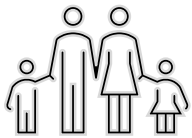
For stepchildren: provide documentation listed below.

- 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 OR 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). AND
- 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. AND
- A copy of the front page of your most recently filed federal tax return confirming that you claimed this dependent.

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



Medical Plan Options:

Kent County offers, to its non-Medicare retirees, 3 wellness medical plans to select from:

- **NEW!** Wellness Plan High Deductible Health Plan (HDHP) - 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 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)

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) and Wellness Plan High Deductible Health 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 , is a preferred provider organization health care plan and consists of participating providers. These plans are 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 and Wellness Plan High Deductible Health Plan give 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.

Blue Care Network HMO

Blue Care Network is the insurance company and plan administrator for the County's health maintenance organization (HMO) medical plan. With an HMO plan, you pick 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.

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.

Medicare Advantage (MAPD/Part C) Plan – See Page 22

The endorsed insurance administrator of the Kent County MAPD / Part C plan is Retiree First, underwritten by Priority Health. This is a change for 2024! The plan is available to Kent County retirees and their spouses who are age Medicare-eligible and enrolled in Medicare Parts A & B.

Medicare Supplement Plan F (Retiree First) – See Page 25

The endorsed insurance administrator of the Kent County Medicare Supplemental Plan is United American administered through Retiree First. The plan is available to Kent County retirees and their spouses who are age Medicare-eligible and currently enrolled in Medicare Parts A & B.

Medical General Questions:

Blue Cross Online Visits

Employees and their families with Blue Cross Blue Shield of Michigan or Blue Care Network can get fast, affordable online medical and behavioral health care by accessing the BCBSM Online Visits app, by visiting the web or via phone. This service allows you to simply use your smartphone, tablet, or computer to meet face-to-face online with a U.S. board-certified doctor.

You can rest assured knowing you and your covered family members can see and talk to:

- A doctor for minor illnesses such as a cold, flu, or sore throat when your primary care doctor is not available
- A behavioral health clinician or psychiatrist to help work through different challenges such as anxiety, depression, and grief.

Value Added Benefits

BCBSM and BCN offer additional value-added enhancements to the services it provides to Kent County employees. Employees are encouraged to review those additional benefits on the internet at www.accesskent.com/benefits.

Diabetes Management:

Kent County offers 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 employees to participate. Take Omada's 1-minute health screener to see if you are eligible: omadahealth.com/bcbsm.

II. Non-Medicare Medical Coverage

Medical Plan Summary

	Wellness High Deductible Health Plan		Wellness PPO		Wellness HMO
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**
Co-Pays/ Deductibles / Co-Insurance					
Flat Dollar Amount	100% After Deductible	80% After Deductible	$25 co-pay for: Office visits Online visits $40 co-pay for: Urgent care $125 co-pay for: Emergency Room Services	$125 co-pay for: Emergency Room Services	$20 for Office visits $20 for Online visits $40 for Specialist visits $100 for Emergency Room $20 Urgent Care
Deductible	$2,200 per individual $4,400 per family	$4,400 per individual $8,800 per family	$300 per individual, $600 per two-party/family	$600 per individual, $1,200 per two-party/family	$250 per individual, $500 per two-party/family
Coinsurance	N/A	N/A	15%, unless otherwise noted 50% for private duty nursing	35%, unless otherwise noted 50% for private duty nursing	10% unless otherwise noted
Co-Pay/ Coinsurance/ Dollar Amounts					
Flat Dollar Amount	Does Not Apply	Does Not Apply	Does Not Apply	Does Not Apply	Does Not Apply
Coinsurance Maximums – Excludes Deductibles	Does Not Apply	Does Not Apply	Does Not Apply	Does Not Apply	Does Not Apply
Out of Pocket Maximums (includes medical co-pays, deductibles, and coinsurance	$3,150 per individual, $6,300 per two party/ family	$6,300 per individual, $12,600 per two party/family	$3,150 per individual, $6,300 per two-party/family	$6,300 per individual $12,600 per two-party/family	$3,150 per individual, $6,300 per two-party/family
Lifetime Maximum	None	None	None		None

II. Non-Medicare Medical Coverage

Medical Plan Summary

	Wellness High Deductible Health Plan		Wellness PPO		Wellness HMO
	In Network	Out of Network	In Network	Out of Network	In Network
Preventative Services					
Health Maintenance Exam	Covered - 100%	Covered - 80%	Covered - 100%	Covered – 65%	Covered - 100%
Annual Gynecological Exam	Covered - 100%,	Covered - 80%,	Covered - 100%, one per calendar year	Covered - 65% after deductible, one per calendar year	Covered - 100%, one per calendar year
Pap Smear Screening – laboratory services only	Covered - 100%,	Covered - 80%,	Covered - 100%, one per calendar year	Covered - 65% after deductible, one per calendar year	Covered - 100%, one per calendar year
Well Baby and Well Child Visit	Covered - 100%	Covered - 80%	Covered - 100%, through age 15	Covered - 65% after deductible – through age 15	Covered - 100%
			8 visits, birth through 12 months 6 visits, 13 months through 23 months 6 visits, 24 months through 35 months 2 visits, 36 months through 47 months visits beyond 47 months are limited to one per member per calendar		
Immunizations, Adult and Pediatric	Covered - 100%	Covered - 80%	Covered - 100%	Covered - 65%	Covered - 100%
Fecal Occult Blood Screening	Covered - 100%	Covered - 80%	Covered - 100%, one per calendar year	Covered - 65% after deductible, one per calendar year	Covered - 100%, one per calendar year
Endoscopic Exam (includes colonoscopy)	Covered - 100%	Covered - 80%	Covered - 100%, one per calendar year	Covered - 65% after deductible, one per calendar year	Covered - 100%, one per calendar year

II. Non-Medicare Medical Coverage

Medical Plan Summary

	Wellness High Deductible Health Plan		Wellness PPO		Wellness HMO
	In Network	Out of Network	In Network	Out of Network	In Network
Preventative Services					
Prostate Specific Antigen (PSA) Screening	Covered - 100%	Covered - 80%	Covered - 100%, one per calendar year	Covered - 65% after deductible, one per calendar year	Covered - 100%, one per calendar year
Mammography Screening	Covered - 100%	Covered - 80%	Covered - 100%, one per calendar year – no age restrictions	Covered - 65% after deductible, one per calendar year – no age restrictions	Covered - 100%, one per calendar year – no age restrictions
Voluntary Sterilization	Covered - 100%,	Covered - 80%	Covered - 100%	Covered – 65% after deductible	Female – Covered – 100% Male – Covered – 100% after deductible
Contraceptive Devices	Covered - 100%	Covered - 80%	All FDA-approved devices covered – 100%	All FDA-approved devices covered – 65% after deductible	Approved devices covered – 100%
Emergency Medical Care					
Hospital Emergency Room	Covered - 100% after deductible	Covered - 80% after deductible	Covered – 100% after $125 co-pay*; co-pay waived if admitted	Covered – 65% after $125 co-pay*; co-pay waived if admitted	Covered – 100% following $100 co-pay after deductible; co-pay does not apply if admitted
Ambulance Services – Medically Necessary	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Covered – 90% after deductible
Urgent Care Visits	Covered - 100% after deductible	Covered - 80% after deductible	Covered – 100% after $40 co-pay*	Covered - 65% after deductible	Covered – 100% after $20 co-pay

II. Non-Medicare Medical Coverage

Medical Plan Summary

	Wellness High Deductible Health Plan		Wellness PPO		Wellness HMO
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**
Preventative Services					
PCP Office Visits **Specialist Office Visits**	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 100% after $25 co-pay* Includes: Primary care and specialist physicians Presurgical consultations Initial visit to determine pregnancy	Covered - 65% after deductible	Covered - 100% after $20 co-pay Covered – 100% after $40 co-pay
Online Visits	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 100% after $25 co-pay	Covered - 65% after deductible	Covered – 100% after $20 co-pay
Outpatient and Home Visits	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 100% after $25 co-pay	Covered - 65% after deductible,	Covered – 100% after $20 co-pay for a PCP; $40 co-pay for a specialist
			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% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Covered – 100%
Diagnostic Tests and X-rays	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Covered – 90% after deductible
Advanced Imaging	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Covered 100% following $150 co-pay after deductible
Radiation Therapy	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Covered – 90% after deductible

II. Non-Medicare Medical Coverage

Medical Plan Summary

	Wellness High Deductible Health Plan		Wellness PPO		Wellness HMO
	In Network	Out of Network	In Network	Out of Network	In Network
Maternity Services					
Pre-Natal and Post-Natal Care	Covered - 100% after deductible	Covered - 80% after deductible	Covered – 100%, after initial co-pay	Covered - 65% after deductible	Covered – 100%
Delivery and Nursery Care	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Covered - 100% for professional services. 90% after deductible for facility charges
Hospital Care					
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered – 65% after deductible	Covered - 90% after deductible
Inpatient Consultations	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered – 65% after deductible	Covered - Inpatient professional 100% after deductible; Inpatient facility 90% after deductible
Chemotherapy	Covered - 100% after deductible	Covered - 80% after deductible	Covered – 85% after deductible	Covered – 65% after deductible	Covered - 90% after deductible
Outpatient Hospital	Covered - 100% after deductible	Covered - 80% after deductible	Covered – 85% after deductible	Covered – 65% after deductible	Covered - 90% after deductible
Alternatives to Hospital Care					
Skilled Nursing Care	Covered - 80% after deductible	Covered - 80% after deductible	Covered - 85% after deductible. Limited to 120 days per calendar year	Covered - 65% after deductible. Limited to 120 days per calendar year	Covered – 90% after deductible. Maximum of 45 days per contract year.
Hospice Care	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Covered - 100% (when authorized) after deductible
Home Health Care	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible, unlimited visits	Covered - 65% after deductible, unlimited visits	Covered – 100% following $40 co-pay after deductible, unlimited visits.

II. Non-Medicare Medical Coverage

	Wellness High Deductible Health Plan		Wellness PPO		Wellness HMO
	In Network	Out of Network	In Network	Out of Network	In Network
Surgical Services					
Surgery – includes related surgical services	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Covered - 90% after deductible
Human Organ Transplants					
Specified Human Organ	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Covered - 90% after deductible
Bone Marrow, Kidney, Cornea and Skin	Covered - 100% after deductible	Covered - 80% after deductible	Covered – 85% after deductible	Covered – 65% after deductible	Covered - 90% after deductible
Behavioral Health Care and Substance Abuse Treatment					
Inpatient Behavioral Health Care & Substance Abuse Care	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Behavioral Health Care: Covered - 90% after deductible Substance Abuse Care: Covered - 90% after deductible
Autism Spectrum Disorders, Diagnoses, and Treatment (Visits are not combined with PT/OT/ST)	Covered – 100% after deductible. No age restrictions for autism services.	Covered – 80% after deductible	$25 Copay. No age restrictions for autism services.	Covered – 65% after deductible	Covered – 100% after $40 copay. Unlimited Visits.
Outpatient Mental Health Care	Covered - 100% after deductible	Covered - 80% after deductible	Covered – 100% after $25 Copay	Covered – 65% after deductible	Covered – 100% after $20 co-pay
Outpatient Substance Abuse Care	Covered - 100% after deductible	Covered - 80% after deductible	Covered – 100% after $25 Copay	Covered – 65% after deductible	Covered – 100% after $20 co-pay
Other Services					
Allergy Testing and Therapy	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Covered – 50% after deductible
Chiropractic Office Visits	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible. One new patient visit per 36 months.	Covered - 65% after deductible. One new patient visit per 36 months.	Covered – 100% after $40 co-pay when referred. Up to 30 visits per calendar year.
Outpatient Physical, Speech and Occupational Therapy, Pulmonary, Cardiac Rehabilitation	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Covered – 100% following $40 co-pay after deductible. One period of treatment for any combination of therapies within 60 consecutive days per calendar year

II. Non-Medicare Medical Coverage

	Wellness High Deductible Health Plan		Wellness PPO		Wellness HMO
	In Network	Out of Network	In Network	Out of Network	In Network
Other Services					
Chiropractic Services – Hot/Cold Modalities, etc.	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Durable Medical Equipment	Covered – 100% after deductible	Covered – 80% after deductible	Covered – 85% after deductible	Covered – 85% after deductible	Covered – 100%
Prosthetic Devices	Covered – 100% after deductible	Covered – 80% after deductible	Covered – 85% after deductible	Covered – 85% after deductible	Covered – 100%
Orthotic Appliances	Covered – 100% after deductible	Covered – 80% after deductible	Covered – 85% after deductible	Covered – 85% after deductible	Covered – 100%

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 employees, to realize significant savings in the cost of prescription drugs by participating in large-scale purchasing through Capital Rx.

You have a four-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 four 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 a higher coinsurance level, which still represents a significant savings compared to the full retail cost.

- Specialty – these drugs do not have generic or brand equivalents. If you choose a drug in this tier, you are covered at the highest coinsurance level.

Rx CAP Program – for those eligible, Capital Rx will maximize the value of manufacturer-sponsored patient assistance programs for commonly prescribed specialty drugs to drive plan savings without impacting member access or out-of-pocket obligation.

Prescriptions can also be ordered by mail through the Optum Home Delivery and Optum Specialty 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.

Value Investment Prescription Plan

Kent County has established a value-based prescription design. For those employees 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 employees, 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 employees and lower overall health care costs.

Women's Preventive Services

To comply with Patient Protection and Affordable Care Act (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

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

What is Step Therapy?

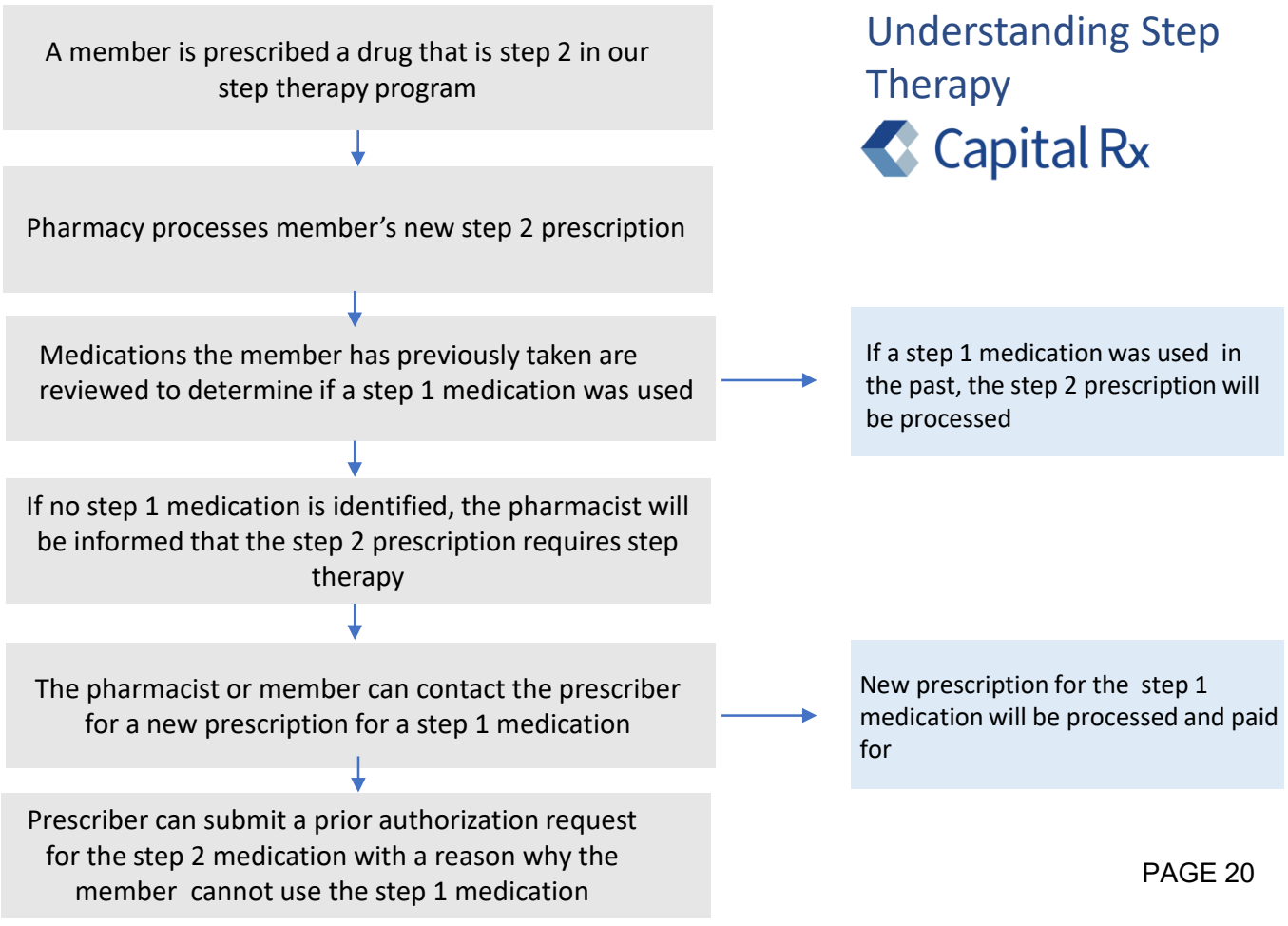
To help keep your costs low, step therapy allows you to try an equally effective medication that is less expensive before using other drugs that cost more.

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.



Understanding Step Therapy

Capital Rx

Kent County Prescription Plan Schedule of Prescription Drug Benefits

CO-PAYMENTS

Plan Election	Wellness PPO or Wellness HMO	Wellness High Deductible Health Plan
Generic medication and supplies used for the treatment of: ▪ diabetes ▪ hypertension Generic contraceptive medicines or devices or medication for women at increased risk for breast cancer	▪ $0.00 Prescription Co-Pay	▪ $0.00 Prescription Co-Pay
Generic medication not listed above Insulin on the formulary (preferred) list	▪ $15.00 for one-month supply ▪ $30.00 for a 90-day supply	▪ $15.00 after deductible has been satisfied for one-month supply ▪ $30.00 after deductible has been satisfied for a 90-day supply
Formulary (Preferred)/ Brand Name	▪ $25.00 for one-month supply ▪ $50.00 for 90-day supply	▪ $25.00 after deductible has been satisfied for one-month supply ▪ $50.00 after deductible has been satisfied for 90-day supply
Non-Formulary (Non-Preferred)/ Brand Name	▪ $45.00 for one-month supply ▪ $90.00 for 90-day supply	▪ $45.00 after deductible has been satisfied for one-month supply ▪ $90.00 after deductible has been satisfied for 90-day supply
Specialty	▪ $100.00 for one-month supply	▪ $100.00 after deductible has been satisfied for one-month supply
Out of Pocket Maximums • Individual • Family	 • $4,500 • $9,000	Combined Medical / Rx Out of Pocket Maximums • $3,150 • $6,300

PLAN PARAMETERS

- 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 may apply for certain medications.
- NOTE: For non-covered medications, please refer to "Exclusions" in the Plan Document.

Overview of in-network benefits

Deductible	Maximum out-of-pocket responsibility	Primary care physician (PCP)	Inpatient hospital
$200	$1,000	$15*	10% for each stay

Virtual care	Emergency and urgent care	Ambulance and observation	Specialist and pallative care
PCP: $0*	Emergency care: $75*	Ambulance: 10%*	Specialist visit: $30*
Specialist: $0*	Urgently needed services: $30*	Observation: 10%*	Palliative care visit: $0*
Mental health: $0*			

Outpatient hospital and diagnostic radiology	Outpatient tests, labs and x-rays	Anticoagulant labs
Outpatient hospital: 10%	Outpatient tests and labs: $15	Lab services required to manage blood thinner drugs such as Warfarin or Coumadin. $15*
Outpatient diagnostic radiology: 10%	Outpatient x-rays: $15	

Rehabilitation services	Outpatient mental health and opioid treatment	Chiropractic care and acupuncture
PT/OT/ST: $30*	Outpatient mental health: $30* individual and group	Chiropractic care: $20*
Cardiac and pulmonary rehab: $30* cardiac/ $15* pulmonary	Opioid treatment: $0*	Acupuncture: $20*

Dialysis	DME and prosthetics and orthotics	Diabetic supplies	Podiatry (foot care)
10%*	10%	$0*	$30*

Preventive care: Services that Medicare pays for to keep you healthy	
Preventive services such as mammograms, colonoscopy screening and immunizations:	$0*

Prior authorization may apply for some benefits. Contact the plan for more information.

* Deductible does not apply

Overview of in-network benefits

Skilled nursing facility (SNF)	**Inpatient Services in a psychiatric hospital**	**Hospice care** Services are covered by Original Medicare.	**Home health care**
$0/ day, days 1-20 10%/day, days 21-100	10% for each stay	10%* for the initial consultation	10%*

Hearing services	**Vision services**
Diagnostic exam: $30*	Diagnostic exam: $30*
Routine exam: $0*	Routine exam: $0*
Hearing aids: $1,000* allowance towards one hearing aid per ear, every three years	Eyewear: $200* allowance every year for non-Medicare covered eyewear. $0* for Medicare-covered eyewear after cataract surgery.

Supplemental benefits
$0* membership with participating SilverSneakers fitness centers nationwide. Plus, options for working out from the comfort of your home with access to members-only virtual exercise classes and online workshops with the SilverSneakers GO™ fitness app or SilverSneakers home fitness kits. $0* for BrainHQ a personal gym for the brain. You can access online exercises that improve memory, attention and brain speed. Train on any device like a computer, tablet or smartphone. $0* for nutrition education, in-home safety assessments and telemonitoring.

Out-of-network benefits:
You will pay in-network prices when seeking care from Medicare-participating providers anywhere in the U.S. outside the lower peninsula of Michigan. Our partnership with Multiplan can make accessing Medicare-participating providers easier.
$200 combined in-network and out-of-network deductible
$1,000 combined in-network and out-of-network maximum out-of-pocket

Prior authorization may apply for some benefits. Contact the plan for more information.

* Deductible does not apply

Overview of in-network benefits

Part B drugs

Chemotherapy drugs	**Part B drugs** Obtained in a provider's office or outpatient setting	**Part B drugs** Obtained in a pharmacy or by mail order service
Up to 10%*	Up to 10%*	Up to 10%*

Part D prescription drug benefits

Prescription drug deductible: $0

	Standard retail pharmacy	
	30-day	**90-day**
Tier 1	$0	$0
Tier 2	$9	$27
Tier 3	$25	$75
Tier 4	$30	$90
Tier 5	$100	Not offered

	Mail order	
	30-day	**90-day**
Tier 1	$0	$0
Tier 2	$9	$18
Tier 3	$25	$50
Tier 4	$30	$60
Tier 5	$100	Not offered

Prior authorization may apply for some benefits. Contact the plan for more information.

* Deductible does not apply

PLAN F with $200 Medicare Part B Deductible Rider, 50% Part B Coinsurance Rider and $1,000 Out-of-Pocket Maximum
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD – 2024

* 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION *			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a 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 thru 100th day	All but $204.00 a day	Up to $204.00 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F with $200 Medicare Part B Deductible Rider, 50% Part B Coinsurance Rider and $1,000 Out-of-Pocket Maximum
MEDICARE (PART B) – MEDICAL SERVICES – PER BENEFIT PERIOD – 2024

* Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), Medicare Part B Deductible will have been met for the calendar year.

(1) Your certificate has a $200 deductible on Medicare's Part B services. Depending upon the order in which the claims are submitted to us, your calendar year deductible may be met by the Medicare Part B Deductible, Medicare Part B Coinsurance, and/or Excess Charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT 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 First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	 $0 Generally 80% $0	 $0 until your $200 per calendar year deductible is met (1), then 50% of the amount not paid by Medicare until you reach your out-of-pocket maximum of $1,000, then 100% of the amount not paid by Medicare	 100% until your $200 per calendar year deductible is met (1), then 50% of the amount not paid by Medicare until you reach your $1,000 out-of-pocket maximum, then $0
BLOOD First 3 pints Next $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0	 All Costs $0 until your $200 per calendar year deductible is met (1) then 50% of the amount not paid by Medicare until you reach your out-of-pocket maximum of $1,000, then 100% of the amount not paid by Medicare	 $0 100% until your $200 per calendar year deductible is met (1) then 50% of the amount not paid by Medicare until you reach your $1,000 out-of-pocket maximum, then $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 until your $200 per calendar year deductible is met (1), then 50% of the amount not paid by Medicare until you reach your out-of-pocket maximum of $1,000, then 100% of the amount not paid by Medicare	 $0 100% until your $200 per calendar year deductible is met (1), then 50% of the amount not paid by Medicare until you reach your $1,000 out-of-pocket maximum, then $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum

HUMANA MEDICARE EMPLOYER PDP PLAN

2024 PDP for County of Kent Plan 037 Option 326
Group Plus Formulary - PDG 2
Effective Date: 01/01/2024 - 12/31/2024

30 day

PDP Option Number	30 day Standard Retail from $0 to Catastrophic (1)				30 day Standard Retail from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
PDP 119	$9	$25	$30	$100	$0	$8,000

PDP Option Number	30 day Standard Mail Order from $0 to Catastrophic (1)				30 day Standard Mail Order from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
PDP 119	$9	$25	$30	$100	$0	$8,000

Note: Part D vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) for adults may be available at no cost. Note: Plan covered insulin products will not exceed $35 for a one-month supply no matter what cost-sharing tier it's on.

*Tier 1: Generic or Preferred Generic - Generic or brand drugs that are available at the lowest cost share for this plan.
Tier 2: Preferred Brand - Generic or brand drugs that Humana offers at a lower cost than Tier 3 Non-Preferred Drug.
Tier 3: Non-Preferred Drug - Generic or brand drugs that Humana offers at a higher cost than Tier 2 Preferred Brand drugs.
Tier 4: Specialty Tier - Some injectables and other higher-cost drugs.

90 day Supplies

PDP Option Number	90 day Standard Retail (2) from $0 to Catastrophic (1)				90 day Standard Retail (2) from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
PDP 119	$27	$75	$90	N/A	$0	$8,000

PDP Option Number	90 day Standard Mail Order (2) from $0 to Catastrophic (1)				90 day Standard Mail Order (2) from Catastrophic to Unlimited	Out-of-Pocket that triggers Catastrophic
	Tier 1*	Tier 2	Tier 3	Tier 4		
PDP 119	$18	$50	$60	N/A	$0	$8,000

Footnotes

1. Catastrophic: When a member's True Out of Pocket (TROOP) cost reaches $8,000
2. Retail and Mail Order: Benefit for a 90-day supply is limited to Rx formulary Tier 1-2 and most drugs on Tier 3. Regardless of tier placement, Specialty drugs are limited to a 30 day supply.

Out of Network: Emergency Situations

When a member purchases a drug at an out-of-network pharmacy in an emergency situation:

a. The member will pay the same coinsurance as would have applied at a network pharmacy, but at the out of network pharmacy price, and/or,
b. The member will pay the same copayment as would have applied at a network pharmacy, plus the difference between the out of network pharmacy price and the network pharmacy price.

Retiree Healthcare Advocacy

Whether facing a serious health problem or dealing with a confusing bill, it is easy for retirees to become confused, frustrated, or even frightened by the complicated healthcare system. You need experienced support to navigate the many issues that sometimes arise while using your benefits.

Retiree First brings a high-touch personalized concierge solution to Kent County retirees. Our Retiree Advocates are there to guide you through the healthcare maze, acting as your true ally. Each retiree has direct access to a Retiree Advocate to help you fully understand your healthcare benefits, options, and resources available to you, while working on your behalf to resolve any issue that may arise.

This seamless end-to-end retiree service solution puts retirees first. Whether it's finding a doctor or pharmacy, resolving co-payment/coinsurance issues, resolving a denied claim issue, obtaining a new ID card, questions on coverage, financial challenges, or whatever the healthcare concern may be, we are here to make the retirement healthcare experience simple and stress free. RetireeFirst is available Monday – Friday 9:00 AM – 5:00 PM EST at 616.359.6403 (TTY 711) or toll free 833.274.5115 (TTY 711).

Our Retiree Advocates are:

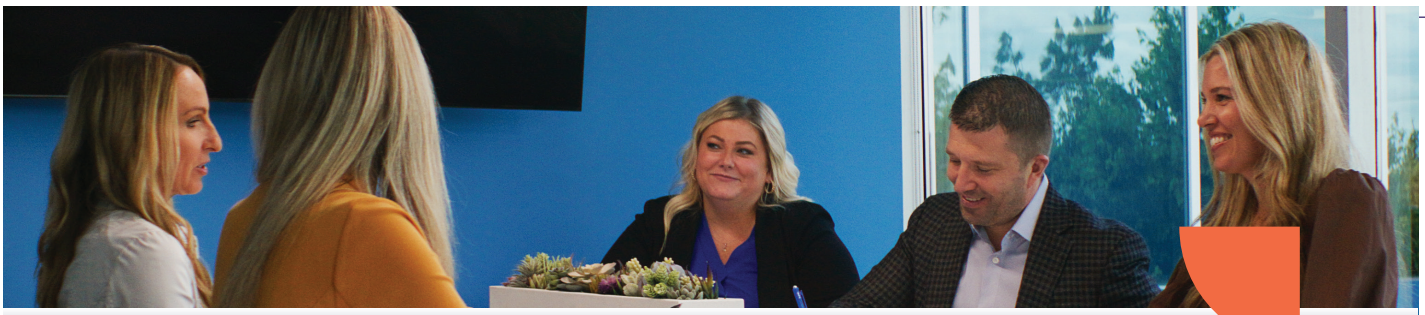
- AHIP Certified
- Life and Health Insurance Licensed
- HIPAA Compliant
- Medicare and Geriatric Trained

Retiree Advocate Services:

- Personal Information Changes
- Card Replacements
- Formulary, tier and copay assistance and exceptions
- Physician and pharmacy outreach
- Inbound/Outbound three-way calls to Medicare, vendors, providers, pharmacies and Social Security
- Financial assistance, including Low-Income Premium Subsidy (LIPS) filing support
- Assistance with pharmacy related questions such as generic availability, prior authorizations and mail-order services
- Status calls throughout the process of any open item, making sure members know their problem is of highest concern and we are working on a resolution
- In-person or virtual appointment scheduling assistance and wellness program enrollment support and engagement
- Claims, billing and payment support

RetireeFirst

1000 Midlantic Drive, Suite 100 | Mount Laurel, NJ 08054 www.retireefirst.com



RetireeFirst

About Us

RetireeFirst brings decades of retiree benefits strategy and experience to the table. Our expertise and consultative approach, proven solutions, and proprietary carrier relationships mean we can help our clients secure the most robust rates and maintain cost-effective retiree benefits. We also seamlessly transition members, handle carrier communications, and provide retirees with personalized advocacy services that meet their unique needs.

We simplify the Medicare retirement benefits landscape to preserve and enhance retiree benefits, deliver a stress-free experience, and improve outcomes.

Fast Facts

- For 18 years, our sole focus continues to be group retiree healthcare
- We serve 300+ clients and 275,000 Medicare plan lives across all 50 states
- Awarded a full URAC Core Accreditation for our commitment to upholding federal regulatory requirements and improving business processes

A Clear Path to Unrivaled Outcomes

With our comprehensive solutions, industry-leading NPS, and people-centric approach, we're the only partner that can dramatically reduce costs and increase member satisfaction at the same time.

20–50%
Immediate bottom-line savings for groups moving to Medicare Advantage for the first time

90+
Net Promoter Score

100%
Client retention rate

Preserving Retiree Healthcare. *Ensuring Peace of Mind.*

RetireeFirst.com

Retiree Healthcare Advo
Is Our Hallmark

RetireeFirst

We Are Caregivers

Navigating retiree healthcare benefits is complex. Let us be your
Our Advocates are dependable, compassionate, and focused on cr
meaningful, lasting impacts on retirees' lives.

Retirees receive personalized support through every phase of their journey.

Creating a positive experience through retiree healthcare advocacy is our priority—and it starts with people. Our unparalleled MemberFirst service is at the heart of everything we do. **We work every day to create a seamless benefits experience and deliver on the promise of improving the health and happiness of the people we serve.**

Retirees talk to a live person based in the U.S.—no chatbots—who helps proactively resolve any healthcare benefits challenge they may face. Whether it's making calls to insurance carriers, pharmacies, or providers' offices on behalf of members, RetireeFirst Advocates truly care about helping members navigate Medicare and improve their health and wellbeing, resulting in happier and more engaged members.

Our MemberFirst service is not a call center. Our Advocates are measured on call quality—not time to completion or daily call quota. They spend as much time as necessary to answer members' questions, achieve successful resolution of issues, and educate members on wellness programs to promote engagement and reduce care gaps. Each member has a dedicated Advocate with whom he/she can speak at any time—**this builds trust, personal friendships, and ensures members' peace of mind.**

RetireeFirst: Going Above and Beyond for Retirees

Everyone can relate to the challenges of using health insurance. We all have family members or friends who have struggled to understand their benefits. RetireeFirst is dedicated to going above and beyond for our clients and members, ensuring that no call or question goes unanswered, and no challenge goes unmet. Our mission is personal, driven by a commitment to provide exceptional support and advocacy.

Resolving Member Issues: The Story of Eleanor

Eleanor's story is a shining example of how RetireeFirst Advocates go to amazing lengths for our members. Eleanor, a valued member of Teamsters 282, relied on weekly medical appointments to manage her condition. However, her lack of transportation options became a significant hurdle as she didn't own a car and had no local assistance. When Eleanor sought help from her dedicated Advocate, Brooke, our team sprang into action. Brooke diligently explored various options, ultimately finding a reasonably-priced solution with a rideshare app. She went the extra mile by providing step-by-step guidance on using the app, ensuring Eleanor's access to vital appointments and peace of mind.

MemberFirst's Personalized Support

For over two years, Eleanor and Brooke have developed a trusting friendship as Brooke resolved multiple issues on Eleanor's behalf. Retirees face numerous benefits-related challenges during retirement and seek **human-centric support and compassionate care.**

Through our MemberFirst service, **members with open cases are connected with their dedicated Advocate.** If the primary Advocate is unavailable, another team member steps in to offer assistance or take a message. This personalized approach ensures continuity and fosters strong connections with our members.

Delivering exceptional service has resulted in a **90+ Net Promoter Score (NPS) and a 100% client retention rate, surpassing industry benchmarks.** These outstanding outcomes reflect our people-first approach and tangible results.

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) or a panorex 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 payable on posterior teeth.
- Porcelain and resin facings on crowns are Covered Services 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.
- People with special health care needs may be eligible for additional services including exams, hygiene visits, dental case management, and sedation/anesthesia. Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in major life activity.

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 website 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 Member total per Benefit Year on all services.

Deductible – $50 Deductible per Member 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.

Waiting Period – Not Applicable - Retiree Only Plan.

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 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 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.

VI. Other Benefit Information
Vision

VSP Coverage:

The vision plan offers additional value-added enhancements to the services it provides to Kent County employees.

Your VSP Vision Benefits Summary

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

PROVIDER NETWORK:
VSP Choice
EFFECTIVE DATE:
01/01/2024

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 • 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. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	
FRAME[+]	• $180 frame allowance • $200 featured frame brands allowance • 20% savings on the amount over your allowance • $180 Walmart®/Sam's Club® frame allowance • $100 Costco® frame allowance	Included in Prescription Glasses	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 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 • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • 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.

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**

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!

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

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.

	Non-Medicare Plan Options		
	Medical		Prescription
	Blue Cross Blue Shield Wellness PPO	***Blue Care Network HMO***	***Capital Rx***
Single	$591.76	$516.40	$144.66
Double	$1,242.70	$1,239.37	$303.78
Family	$1,479.41	$1,549.21	$361.64

	Medicare-Eligible Plan Options		
	Retiree First		
	Plan F & Part D are closed to new enrollments. If you are currently in these plans, you may continue for 2024 or switch to the Medicare Advantage Part C.		
	Medicare Supplement (Plan F) *United American*	**Prescription Part D** *Humana*	**Medicare Advantage (Part C)** *Priority Health*
One Person with Medicare	$157.00	$140.38	$160.00
Two Person with Medicare	$314.00	$280.76	$320.00

	Other Benefits	
	Dental	**Vision**
Single	$39.98	$11.21
Double	$77.15	$17.11
Family	$133.17	$30.69

High Deductible Health Plan Insurance Rates
Only Available to Select Retirees
2024

If, at the time of retirement, you were in one of the following employee groups, and if you are not yet Medicare eligible, a new non-Medicare health plan option is available to you:

- Prosecuting Attorneys
- Circuit Court Referees
- Teamsters Parks
- Management Pay Plan

The new option is a qualified high deductible health plan (HDHP) which is also compatible with a Health Savings Account (HSA). In order to meet the standards of a qualified health plan, you must elect both medical **and** prescription drug coverage with this plan.

Since this is a qualified health plan, you are eligible to open a Health Savings Account. Contributions made to an HSA account may be tax-deductible depending on your situation, consult with your tax advisor. Contributions can be spent tax-free on eligible expenses, and also grow tax-free for the life of the account.

You may only open and contribute to an HSA account if you, or anybody else covered under the health plan, is not also enrolled in another non-qualified first-dollar medical plan, which includes Medicaid, Medicare, or coverage through another employer.

An HSA can be established at a bank or credit union of your choice.

	Non-Medicare Plan HDHP Option	
	Medical	**Prescription**
	Blue Cross Blue Shield HDHP PPO	***Capital Rx***
Single	$515.19	$133.23
Double	$1,081.90	$279.79
Family	$1,287.98	$333.08

Health Savings Account:

A Health Savings Account (HSA) is a tax-favored bank account allowed when enrolled in a qualified plan, like the Kent County Wellness High Deductible Health Plan. Dollars put into the health savings account help to pay the medical plan's required deductibles, coinsurances, and copayments as well as other qualified expenses like dental and vision services and supplies. Note: In order to open an HSA you cannot be enrolled in other coverage that is a non-qualified high deductible health plan, Medicaid, Medicare or have received veterans benefits in the last three months, this also includes a healthcare reimbursement flexible spending account.

HSA Advantages

- Triple Tax Advantage: Contributions made to an HSA are tax deductible, withdrawals are not taxed when used for qualified expenses, and interest grows tax-free.
- You own the HSA and you control how you use your dollars. If you have dollars in your account saved when you are of normal retirement age, you may use those dollars to pay for Medicare premiums.
- There is no "use it or lose it" rule with HSA's. Once the money is deposited into your HSA account, it remains yours.

Financial Institution

- The 2024 HSA contribution maximums are $4,150 if enrolled in single coverage, or $8,300 if enrolled with one or more dependents. There is an additional $1,000 catch up contribution that can be added for individuals aged 55 or older. You must include (count) any employer contributions in the annual contribution maximum.

Using your HSA

At the Physician's Office

- Provide the physician's office your BCBSM ID card. The physician's office will submit a claim to BCBSM for payment. If the service is billed as preventive, it will be covered at 100%. If the service is not billed as preventive, BCBSM will apply network discounts.
- You will receive an Explanation of Benefits (EOB) from BCBSM outlining how the claim was processed. The EOB will show how much was paid by BCBSM and what your out-of-pocket responsibilities are. The physician will then send you a bill. Make sure the physician bills you for the amount noted on the EOB.
- You may use your HSA funds to pay the physician. Make sure to save your receipt for tax purposes.

At the Pharmacy

- Obtain a prescription from your doctor. At the pharmacy, present your BCBSM / Capital Rx ID card. The pharmacy will submit your claim to Capital Rx. Capital Rx will apply the network discount and apply the charge to your benefits. The pharmacy will then apply your out-of-pocket costs.
- You may use your HSA to pay for prescriptions at the point of sale. Again, make sure you keep your receipt.

Eligible Expenses

A full list of HSA eligible expenses can be found by referencing IRS Publication 502. Sites like HSAstore.com can also be used to view eligible expenses and purchase eligible items online. Examples include:

- OTC Medications
- Hearing Aids
- Dental, vision expenses
- Medical supplies
- Cold and Flu Medications
- COVID Tests and Supplies
- Feminine Hygiene Products
- Breastfeeding supplies and classes

IX. Northern Trust

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 status (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.

X. General Information

Contact Information

	Carrier	Contact
Medical	Blue Cross Blue Shield of Michigan Blue Care Network	Customer Service: (888) 890-5754 Blue Cross Blue Shield of Michigan Customer Service: (800) 662-6667 Blue Care Network
Prescription Drugs	Capital Rx	(844) 532-2779 www.cap-rx.com Capital Rx
Retiree First **Priority Health** **United American** **Humana**	(616) 359-6403 Toll-Free Number (833) 274-5115	https://retireefirst.com/ members@retireefirst.com
Dental	(800) 524-0149	www.deltadentalmi.com 4100 Okemos Rd. Okemos, MI 48864
Vision	(800) 877-7195	www.vsp.com 3333 Quality Drive Rancho Cordova, CA 95670
Kent County Retirement Services	Devon Mapes (616) 632-7447 Mandy Lee (616) 632-7442 Tara Beatty (616) 632-7457	kcretirement@kentcountymi.gov Kent County Human Resources Dept. 300 Monroe NW Grand Rapids, MI 49503
Senior Neighbors	(616) 233-0282	MMAPTeam@seniorneightbors.org 678 Front Ave NW Suite 205 Grand Rapids, MI 49504
Insurance Agent	Advantage Benefits Group	(616) 458-3597 Mike Cutlip (Agent): mcutlip@advantageben.com Steve Miller (Agent): smiller@advantageben.com

Annual Maximum
The most the plan will pay for covered services. Once you reach the annual maximum, the member is responsible for 100% of expenses.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference.

Coinsurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe.

Coinsurance Maximum
The highest amount you are required to pay for covered services that are subject to coinsurance. Once you reach the coinsurance maximum, the plan pays 100% of expenses that would normally apply coinsurance.

Coordination of Benefits (COB)
A provision to help avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care/treatment. One plan becomes “primary” and the other becomes “secondary”. This establishes an order in which the plans pay their benefits. You may be asked to verify COB information before claims can be paid.

Copay
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won’t pay anything until you’ve met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

In-Network
Refers to the use of health care professionals who participate in the health plan’s provider and hospital network.

Out-of-Network
Refers to the use of health care professionals who are not contracted with the health insurance plan.

Out-of-Pocket Maximum
The highest amount you are required to pay for covered services. Once you reach the out-of-pocket maximum(s), the plan pays 100% of expenses for covered services.

Prior Authorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or medical equipment is durable medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

Referral
Specific directions or instructions from your primary care physician that direct a member to a participating health care professional for medically necessary care.

X. Employee Information
FAQs

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 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. You may, however, make changes to your beneficiaries at any time during the year.

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

A: 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 this plan year, you should add the child on your open enrollment form. You must provide proof of relationship such as a birth certificate.

Dental & Vision

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 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 Vision Plan?

A. The **Vision Plan** is administered by Vision Service Plan (VSP). Services are covered through physicians on the preferred provider list (available at www.vsp.com).

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.

Medical Benefits

Q. What are my medical plan options?

A. **Non-Medicare Eligible**: Blue Cross/Blue Shield Wellness High Deductible Health Plan, Wellness PPO Plan and Blue Care Network Wellness HMO. **Medicare Eligible**: Medicare Supplement Plan F (if currently enrolled) or Medicare Advantage / Part C through Retiree First.

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 is my annual maximum for co-pays and coinsurance?

A. The out-of-pocket maximum as defined by the PPACA is $3,150 for an individual and $6,300 for family coverage for in-network services. The co-pay applies as many times as you access services requiring an office, urgent care, or emergency room visit or fill a prescription up to the applicable out-of-pocket maximum. The co-pay does not apply to the deductible.

Q. Can I only elect Medical Coverage and Waive Prescription Coverage?

A. Depends on which plan you enroll in. If you are electing the Wellness High Deductible Health Plan medical coverage, then you must also elect prescription coverage for yourself and any dependents you wish to be covered.

Q. How does a high deductible health plan work?

A. All in-network services track towards your plan deductible, with exception of preventive care. You must satisfy your deductible before the plan will pay for any non-preventive services. Once your deductible is met some copays may apply.

Q. How does the out-of-pocket maximum work on a high deductible health plan?

A. All in-network services track towards your plan out of pocket maximum, with the exception of preventive care. Once you reach your out-of-pocket maximum, the plan will pay 100% of all covered in-network services copays no longer apply once you've satisfied your out-of-pocket maximum.

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-preventive 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.

Prescription

Q. Are there any changes regarding prescription coverage?
A. Yes. The out-of-pocket maximum for prescription drug coverage will be $4,500 for an individual and $9,000 for a family under the Capital Rx plan.

Q. Are there any prescription drugs that are not covered under the prescription plan?
A. Yes. For example, all the 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.

Q. What are our 2024 prescription drug copays through Capital Rx?
A. If enrolled in Wellness PPO or Wellness HMO:

The co-pays for a 30-day supply:
$15 – Generics
$25 – Brand Name Formulary
$45 – Brand Name Non-Formulary
$100 – Specialty

If enrolled in Wellness High Deductible Health Plan:

The co-pays for a 30-day supply:
$15 after deductible has been satisfied – Generics
$25 after deductible has been satisfied – Brand Name Formulary
$45 after deductible has been satisfied – Brand Name Non-Formulary
$100 after deductible has been satisfied – Specialty

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. 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.

Q. Will I receive a separate prescription drug ID card?
A. Depends on which plan you enroll in. Capital Rx will provide you with a prescription drug ID card to fill prescriptions (separate from your medical coverage card) if you're enrolled in the Wellness PPO or Wellness HMO plans. If you enroll in the Wellness High Deductible Health Plan, you only receive 1 ID card, this card will come from BCBSM but will have Capital Rx's detail on the back of the ID card. If you're enrolled in the Priority Health MAPD you will receive one card. If you are enrolled in the Plan F and/or Part D you will receive separate cards from United American and/or Humana.

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 for 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.

Q. What if I have health insurance options through my employer? Reminder to use ALEX
A. You'll have the option 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.

Medicare Information:

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 part of your medical coverage from County of Kent. You cannot drop your County of Kent prescription drug coverage unless you also drop 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.

Medicare Information:

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 Retirement Services by emailing KCretirement@kentcountymi.gov. **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).

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 25, 2023
Name of Entity/Sender:	Kent County
Contact--Position/Office:	Human Resources
Address:	300 Monroe Ave NW 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.

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.

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. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.
Call your HR Department for more information.

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

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.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes

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

What is "balance billing" (sometimes called "surprise billing")?

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

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

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

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

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

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

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is 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 types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

<u>When balance billing isn't allowed, you also have these protections:</u>

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

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in- network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

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

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal 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, 3000 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. 1-616-632-7468번으로 전화해 주십시오.
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
7468-632-616-1ةظوحلم: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
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

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