2020
Employee Benefit Guide

If you 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 refer to the Medicare D notice in this benefits guide for more details.

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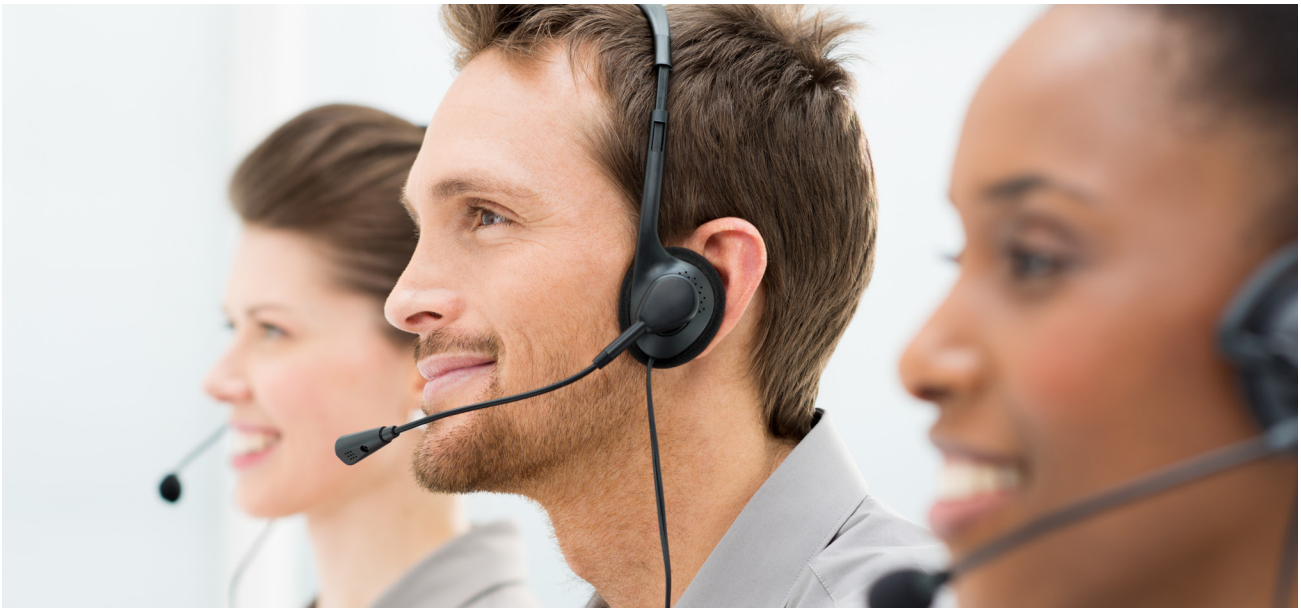
Resource/Service Provider	Contact Source	Details
Community Care Plan (Medical Insurance)	Member Services Website	954.622.3400 member.services@ccpcares.org
Southern Scripts (Rx)	Member Services Website	800.710.9341 www.southernscripts.net
Lincoln Financial (Dental Insurance)	Member Services Website	800.423.2765 www.lfg.com
EyeMed (Vision Insurance)	Member Services Website	866.800.5457 www.eyemedvisioncare.com
Symetra (Basic Life and AD&D Insurance, Voluntary Supplementary Life / Dependent Life) Disability (STD and LTD)	Member Services Website	800.426.7784 www.symetra.com
	Claims	877.377.6773



Introduction

Broward Regional Health Planning Council, Inc. (BRHPC) understands that your benefits are important to you and your family. Helping you understand the benefits available to you is essential. This Benefits Guide provides a description of our company's benefit program.

Included in this guide are summary explanations of the benefits, as well as contact information for each provider. It is important to remember that only those benefit programs for which you are eligible and have enrolled in apply to you.

We encourage you to review each section and to discuss your benefits with your family members. Be sure to pay close attention to applicable copayments and deductibles, how to file claims, preauthorization requirements, participating networks, and services that may be limited or not covered (exclusions).

This guide is not an associate/employer contract. It is not intended to cover all provisions of all plans, but rather a quick reference to help answer most of your questions. Please see the carrier benefit summaries for more details. We hope this guide will give you an overview of your benefits and help you to be better prepared for the enrollment process.

Benefits Eligibility

Employee Eligibility

Benefit eligible employees are provided an opportunity to participate in the BRHPC Employer sponsored benefits program upon initial hire and annually during Open Enrollment. You are eligible on the first day of the month following 60 days from your hire date if you are a full-time employee (regularly scheduled to work 30 or more hours per week), or within 30 days of a qualifying event (see page 5). Please refer to the following guidelines regarding eligibility and election changes.

Dependent Eligibility – Medical Only

A dependent is defined as a covered employee's legal spouse/domestic partner, a dependent child of the employee or employee's spouse/domestic partner. Dependent children may be covered through the end of the calendar year in which they turn age 26. A dependent child is defined as:

- A natural child
- A step-child
- A legally adopted child
- A child placed for adoption
- A child placed for foster care
- A child for whom legal guardianship has been awarded to the covered associate or the associate's spouse
- A newborn child of an enrolled dependent (Medical: 18 months ONLY)
- Children of any age who become mentally or physically disabled before reaching the age limit

FL Statute 627.6562 Dependent Coverage: Health insurance coverage may be available for dependents ages 26 to 30. Please contact your Human Resources Department for more information.

Dependent Eligibility – Dental and Vision

A dependent is defined as a covered employee's legal spouse/domestic partner, an unmarried dependent child of the employee or employee's spouse/domestic partner. Dependent children will be covered through the end of the calendar year in which they turn age 26.

Qualifying Event

Coverage elections made at Open Enrollment cannot be changed until the next annual Open Enrollment period. The only exception to this IRS Section 125 Rule is if you experience a "Qualifying Event." A Qualifying Event allows you to make a change to your benefit elections within 30 days of the event.

Examples of Qualifying Events include, but are not limited to:

- Marriage
- Divorce
- Birth, adoption, or legal custody of a dependent child
- Involuntary loss of other group insurance coverage
- Death
- Spouse's open enrollment

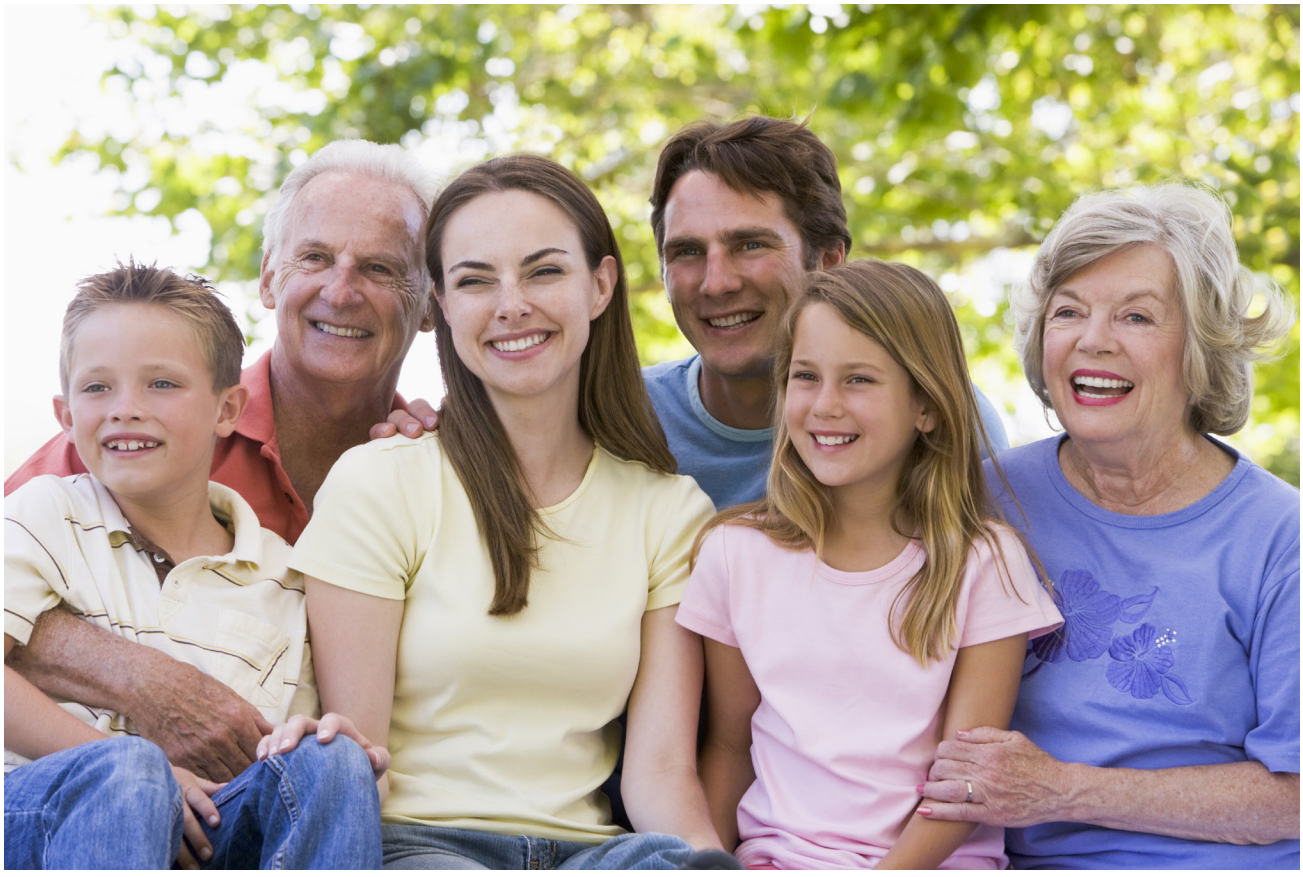
If you experience a Qualifying Event, contact Human Resources and submit all required documents within 30 days of the event.

Your Responsibility

Before you enroll, make sure you understand the plans and ask questions if you do not. After you enroll, you should always check your first paycheck stub to make sure that the correct amount is being deducted and all of the benefits you elected are included.

IMPORTANT NOTE – Tax Considerations

If your employer's plan provides for coverage for domestic partners (including child(ren) of domestic partners) and/or coverage for dependents beyond age 26, the IRS requires that the value of the coverage be a post tax deduction. (Exception: mentally or physically handicapped child).



Medical Insurance

Community Care Plan is our exclusive medical healthcare provider.

The Community Care Plan requires a Primary Care Physician (PCP) election. The Plan does not require a referral to seek care from a contracted specialist. You may seek care directly from any contracted Community Care Plan physician. Before scheduling an appointment with a physician, you should confirm his/her current participation status with the Community Care Plan network. For Community Care Plan customer service, please call 954.622.3400, option 4.

You can locate a physician by contacting Community Care Plan Member Services, or you can go to Community Care Plan's directory on the BRHPC Portal. If you are enrolling in the HMO Plan, you will need to select a primary care physician from the network and provide the physician's full name and the Provider ID #. Provider directory can also be found at providerdirectory.ccpcares.org/brhpc.

Explanation of Calendar Year Deductible and Calendar Year Out-of-Pocket Maximum

Calendar Year Deductible

The Calendar Year Deductible is a specified dollar amount that you must pay for certain covered services per calendar year. There are individual and family deductibles. Once an individual or a family deductible has been satisfied, then coinsurance applies, if applicable. Coinsurance is your share of the costs of a health care service. It is the amount a member pays after the deductible has been met.

Calendar Year Out-of-Pocket Maximum

The Calendar Year Out-of-Pocket Maximum is the amount of covered expenses, (including deductible, coinsurance, and copayments) that must be paid by you, either individually or combined as a covered family member.

After the individual/family out-of-pocket maximum has been satisfied in a calendar year, payment for in-network covered services requiring copayment and coinsurance for that covered individual/family will be payable by Community Care Plan at 100% for the remainder of the calendar year, subject to any other terms, limitations, and exclusions.

Medical Plan Comparison

	Community Care Plan
Primary Care Physician (PCP) Election Needed	Yes
Specialist Referral	No
Network Access	In-Network Only
Calendar Year Deductible (CYD)	Your Responsibility
Individual / Family	$1,000 / $2,000
Out-of-Pocket Maximum	Your Responsibility
Individual/Family	$3,500 / $7,000
Professional Services	
Coinsurance	20% after CYD
Primary Office Visit	$20 copay
Specialist Office Visit	$40 copay
Preventive	No charge
Hospital and Facility Services	
Inpatient Hospital	$75 copay CCP Network Facilities/per day, 5 day max after CYD, $200 per day after CYD all others
Outpatient Hospital	$200 copay per visit after CYD
Surgical Facility	$200 copay per visit after CYD
Urgent Care Center	$50 copay in-network/$75 out-of-network, $20 CVS
Emergency Room (waived if admitted)	$125 copay after CYD
Independent Lab / Independent X-Ray	Laboratory $0 / X-ray $50
MRI, MRA, CT , PET Scans	$125 per test

**Includes CYD, Copays, Coinsurance, and Prescriptions

Please refer to your Plan document for more detailed information on your medical benefits; including limitations, restrictions and exclusions. These documents are located on the BRHPC intranet under Employee Benefits. The CCP network consists of the Broward Health and Memorial Healthcare System

Semi-Monthly Payroll Deduction (24 pay period)

Benefit Plan	CCP 2020
Medical Coverage	
Employee	$0.00
Employee + Spouse	$315.38
Employee + Child(ren)	$231.50
Family	$618.03

Pharmacy Benefits

Pharmacy benefits are administered by Southern Scripts.

- First Choice Pharmacies - Southern Scripts First Choice retail network of pharmacies includes CVS, Publix and Walmart, and provides you with the lowest cost plus the ability to have up to a 60-day fill at retail.
- Walgreens and Costco pharmacies will no longer be part of the Pharmacy Benefit.
- Variable Copay Program™: The Southern Scripts pharmacy program uses coupons provided by the manufacturer to greatly reduce costs for eligible Brand and Specialty medications; over 2,000 medications currently qualify. A list of the qualified medications may be found on the Southern Scripts website or call the Specialty Solutions Pharmacy (CRx) Customer Care Specialist at 800.710.9341 or visit: www.southernscripts.net/members.php.
  - If your medicine qualifies for the Variable Copay Program and you try to fill at a retail pharmacy, the pharmacy will get a rejection message stating "Variable Copay Opportunity Available. Please call 800.710.9341. The pharmacy should call the number and they will be provided with instructions on how to transfer your prescription to CRx Specialty Solutions, where it will filled by mail at a significantly lower cost to you.

Pharmacy	CCP Employee In-Network Plan
Network Access	First Choice
Generic (Retail)	
Up to 30 days	$10 copay
31-60 days	$20 copay
Preferred Brand (Retail)	
Up to 30 days	$40 copay
31-60 days	$80 copay
Non-Preferred Brand (Retail)	
Up to 30 days	40% ($60 min. / $200 max)
31-60 days	40% ($100 min. / $380 max)
Specialty Medications	
Up to 30 day supply	40% ($150 min. / $300 max)
Mail Order Pharmacy* (90 Day Supply)	
Generic	$10
Preferred Brand	$40
Non-Preferred Brand	40% ($70 min/$210 max)

Mail order available through Postal Prescription. More information is available at: www.southernscripts.net or call 800.710.9341.

Maximizing Benefits

Emergency Rooms (ER)

Going to an ER is appropriate in cases of severe or life-threatening illnesses or injuries. In the ER, patients with serious conditions are treated before those with less threatening problems. As a result, people can wait for hours before being seen by an ER physician.

Conditions typically treated at the ER:

- Severe bleeding or large, gaping wounds
- Sudden weakness or difficulty talking
- Chest pain or upper abdominal pain and pressure
- Sudden change in vision
- Major burns
- Spinal injuries
- Severe head trauma or injury
- Difficulty breathing

Urgent Care and Minute Clinics

Urgent Care centers and Minute Clinics often are open after hours and on weekends, and do not require an appointment. Urgent Care centers provide treatment for injuries and illnesses that require immediate attention, but are not life-threatening. First, try to schedule an appointment with your doctor; if he or she cannot see you that same day, go to an Urgent Care center or a Minute Clinic.

Aside from reduced time in the waiting room, using Urgent Care and Minute Clinic facilities saves you money because the copayments for treatment at those facilities are much less expensive than receiving treatment at an Emergency Room.

*CVS Minute Clinic

**CCP Network Urgent Care Facilities:

Broward Health Urgent Care, Memorial 24/7 Care Center, MD Now Medical Centers

Conditions typically treated at Urgent Care centers include:

- Sprains and strains
- Minor broken bones
- Mild asthma attacks
- Upper respiratory infections
- Rashes
- Minor cuts or wounds that may require stitches

Conditions typically treated at Minute Clinics

- Fever (<72 Hours)
- Swimmer's Ear
- Pink Eye
- Ear Infections
- Common Colds/Flu
- Camp/Sports Physicians

Dental Insurance

Lincoln Financial is our exclusive dental provider offering employees a Dental Preferred Provider Dental Plan (DPPO).

The DPPO plan provides coverage for both In-Network (contracted PPO dentist) and Out-of-Network (non-contracted dentist) coverage. You will maximize your benefits and minimize your out of pocket expenses when you seek care from a contracted dentist.

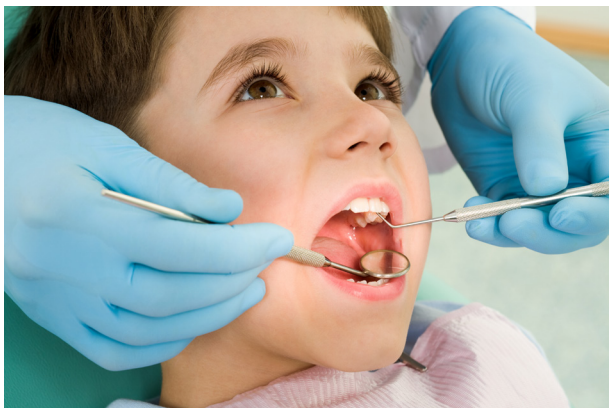
When you choose a dentist outside of the Lincoln Financial PPO network, your out-of-pocket costs will be higher and you may be subject to "balance billing" for provider fees that exceed the contracted or Usual, Customary, and Reasonable Allowances (UCR) allowed by Lincoln Financial 's contract. You can locate participating (In-Network) dental providers by visiting Lincoln Financial 's website at www.lfg.com.

	Lincoln
	Dental Guard Preferred
Network Access	In-Network
Calendar Year Maximum	$2,000
Calendar Year Deductible (Individual/Family)	$50/$150 (waived for preventive services)
Dental Description	
Routine Office Visits – 9430	No charge
Teeth Cleaning – 110	No charge
Full Mouth/Panoramic X-ray – 0330	No charge
Amalgam Fillings – 2140	20% after CYD
Extraction–Simple per Tooth – 7140	20% after CYD
Endodontics – 330	20% after CYD
Periodontal Scaling – 4341	20% after CYD
Full or Partial Dentures – 5110	40% after CYD
Crowns – 2752	40% after CYD

Late entrant waiting periods may apply if enrolling in the dental plan for the first time with a break in dental coverage of more than 63 days over the last 12 months. (6 months for fillings, 12 months on all other basic services)

Semi-Monthly Payroll Deduction (24 pay period)

Benefit Plan	Lincoln Financial PPO
Dental Coverage	
Employee	$0.00
Employee + One	$27.11
Employee + 2 or more	$53.37



Vision Program

EyeMed is our exclusive provider. Your vision is important to your health. Whether your vision is 20/20 or less than perfect, everyone needs to take good care of their eyes. The EyeMed vision program is being offered as a part of BRHPC's commitment to your well-being. The EyeMed vision program provides affordable, quality vision care nationwide. Through EyeMed's provider network, you can obtain a comprehensive vision examination, as well as eyeglasses (lenses and frames), or contact lenses in lieu of eyeglasses.

Carefully review the vision care program summary provided and take advantage of this very important benefit. You can call EyeMed's Customer Service Center for any questions you may have regarding contracted providers or coverage or by visiting the website at www.eyemedvisioncare.com.

	EyeMed	
Network Access	In-Network	Out-of-Network*
Eyecare Wellness Copay		
Routine Eye Exam	$10 copay	Reimbursed up to $40
Frequency	Once every 12 months	
Materials Copay		
Lenses (Standard Plastic)		
Single Vision	$25 copay	Reimbursed up to $30
Bifocals		Reimbursed up to $50
Trifocals		Reimbursed up to $70
Frequency	Once every 12 months	
Frames		
Selected Frames	$130 allowance + 20% off balance	Reimbursed up to $91
Frequency	Once every 24 months	
Contacts (In lieu of frame and lenses)		
Elective Conventional Lenses	$130 allowance + 15% off balance	Reimbursed up to $130
Medically Necessary Contacts	No charge	Reimbursed up to $210
Frequency	Once every 12 months	

Contact Lenses allowance applies to professional services (evaluation and fitting fees) and materials.

*Out-of-Network Benefits are subject to Balance Billing for charges over the EyeMed reimbursement schedule.

Semi-Monthly Payroll Deduction (24 pay period)

Benefit Plan	EyeMed
Vision Coverage	
Employee	$3.45
Employee + Spouse	$6.56
Employee + Child(ren)	$6.91
Family	$10.15

Basic Life Insurance and AD&D

BRHPC provides you with a $50,000 basic life insurance benefit at no cost to you. The plan will also provide you with Accidental Death & Dismemberment (AD&D). The AD&D benefit will provide your beneficiary with an additional amount equal to the life insurance in-force amount if death is due to an accident. If the employee is dismembered (such as loss of an eye or limb), benefits will be paid to the employee as a percentage of the AD&D amount.

BRHPC also provides, at no cost to you, basic life coverage for your spouse in the amount of $2,000 (terminates at 70 years old) and $1,000 for your child(ren) over 6 months to 19 years, (26 years old if a full-time student).

The benefit for a child(ren) that is 14 days to 6 months is $100.

The plan will also provide your dependents with Accidental Death & Dismemberment (AD&D). The AD&D benefit will provide your beneficiary with an additional amount equal to the life insurance in-force amount if death is due to an accident. If the dependent is dismembered (such as loss of an eye or limb), benefits will be paid to the dependent as a percentage of the AD&D amount.

The life insurance benefit amounts begin reducing at age 65. Please refer to Symetra's benefit summary and certificate of coverage for further information regarding the reduction schedule and other benefit limitations.

Beneficiary Information

Please make sure that your beneficiary information is up to date and correct. Please contact the Human Resources department for a beneficiary form if you need to make changes.

Supplemental Life Insurance and AD&D

BRHPC offers an excellent opportunity to purchase additional life insurance on yourself, your spouse and/or your dependent children. If you or your dependents enroll after your initial eligibility period, you are considered a late entrant. As a late entrant, you must submit a health questionnaire to Symetra. Coverage does not go into effect until you receive approval from Symetra.

Employee Benefit Amount

Employees may apply for the lesser of 5x annual salary or $200,000 in $10,000 increments. Evidence of Insurability will be required if applying for any amount over the guaranteed issue. Guaranteed Issue: $50,000.

Spouse Benefit Amount

The Employee must be enrolled to obtain coverage for their spouse. Benefit Options are available in increments of $5,000 up to $100,000 not to exceed 50% of the employee's elected benefit amount. Guaranteed Issue: $10,000.

Dependent Children Benefit Amount

The Employee must be enrolled to obtain coverage for their children. Benefit Options are available for children over the age of 6 months to 19 years old (26 years old if a full-time student) for a flat amount of $10,000 ($250 for children 14 days to 6 months old).

Accidental Death & Dismemberment –

You can also purchase supplemental voluntary AD&D coverage for yourself and your dependents through Symetra. In order to elect coverage for your spouse and/or child(ren), you must elect coverage for yourself. Employee rates vary by age and benefit amount.

Evidence of Insurability –

If you elected to waive the voluntary supplemental life insurance or supplemental voluntary AD&D at your original eligibility date, and decide to apply for coverage, or increase your amount of coverage at a later date, you will be required to answer medical questions by completing an evidence of insurability form to determine if Symetra will approve the requested amount.

You can obtain an Evidence of Insurability form from Human Resources.

Supplemental Life Insurance and AD&D

Premium - per $1,000	Employee	Spouse	Child(ren)
0-19	$0.080	$0.080	$0.200
20-24	$0.080	$0.080	
25-29	$0.080	$0.080	
30-34	$0.090	$0.090	
35-39	$0.120	$0.120	
40-44	$0.200	$0.200	
45-49	$0.330	$0.330	
50-54	$0.490	$0.490	
55-59	$0.740	$0.740	
60-64	$1.210	$1.210	
65-69	$2.190	$2.190	
70-74	$3.100	$3.100	
75-79	$6.690	$6.690	
80+	$6.690	$6.690	
AD&D Rate (per $1,000)	$0.020	$0.020	$.0020

Short-Term Disability (STD) Benefits

You can purchase Voluntary Short-Term Disability (STD) insurance for yourself through payroll deductions. In the event you become disabled due to either illness or off-the-job injury and are unable to perform the duties of your job. STD benefits provide you with coverage that supplements your lost wages on the 1st day for an accident and 8th day for an illness. The plan will reimburse you up to 60% of lost income to a maximum of $1,000 per week, up to 26 weeks.

If you elected to waive Short-Term Disability (STD) insurance at your original eligibility date, and later decide to apply for coverage, you will be required to answer medical questions by completing an evidence of insurability form to determine if Symetra will approve the requested election.

Long-Term Disability (LTD) Benefits

You can purchase Voluntary Long-Term Disability (LTD) benefit through Symetra. LTD insurance helps to replace your income if you are sick or injured and cannot work, and is designed to begin after you have been disabled for 180 days. The LTD benefit pays 60% of your monthly earnings up to a maximum of $5,000 per month.

If you elected to waive Long-Term Disability (LTD) insurance at your original eligibility date, and later decide to apply for coverage, you will be required to answer medical questions by completing an evidence of insurability form to determine if Symetra will approve the requested election.

Annual Disclosures

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance or group health 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 health coverage).

In addition, if you have a new dependent as a result 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.

To request special enrollment or obtain more information, contact Human Resources.

Michelle's Law – The law allows for continued coverage for dependent children who are covered under your group health plan as a student if they lose their student status because of a medically necessary leave of absence from school. This law applies to medically necessary leaves of absence that begin on or after January 1, 2010.

If your child is no longer a student, as defined in your Certificate of Coverage, because he or she is on a medically necessary leave of absence, your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges, universities, some trade schools and certain other post-secondary institutions).

Your employer will require a written certification from the child's physician that states that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

Section 111 – Effective January 1, 2009 Group Health Plans are required by Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extension of 2007's new Medicare Secondary Payer regulations. The mandate is designed to assist in establishing financial liability of claim assignments. In other words, it will help establish who pays first. The mandate requires Group Health Plans to collect additional information, more specifically Social Security Numbers for all enrollees, including dependents six months of age or older. Please be prepared to provide this information on your Benefit Enrollment Form when enrolling into benefits.

Women's Health and Cancer Rights Act of 1998 – If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

The Newborn's and Mother's 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 insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

Patient Protection: If the Group Health Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the 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, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website.

It is your responsibility to ensure that the information provided on your application for coverage is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

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 **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 **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, 2019. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPPcom Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711
FLORIDA – Medicaid
http://flmedicaidtplrecovery.com/hipp 877.357.3268
GEORGIA – Medicaid
https://medicaid.georgia.gov/ health-insurance-premium-payment-program-hipp 678.564.1162, ext. 2131
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid http://www.indianamedicaid.com | 800.403.0864
IOWA – Medicaid
http://dhs.iowa.gov/Hawki 800.257.8563
KANSAS – Medicaid
http://www.kdheks.gov/hcf 785.296.3512
KENTUCKY – Medicaid
http://chfs.ky.gov 800.635.2570
LOUISIANA – Medicaid
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 888.695.2447
MAINE – Medicaid
http://www.maine.gov/dhhs/ofi/public-assistance/index.html 800.442.6003 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
http://www.mass.gov/eohhs/gov/departments/masshealth 800.862.4840
MINNESOTA – Medicaid
http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/ programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084

NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/oii/hipp.htm 603.271.5218 | Toll-Free:800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpa ymenthippprogram/index.htm 800.692.7462
RHODE ISLAND – Medicaid
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427

VIRGINIA – Medicaid and CHIP
Medicaid: http://www.coverva.org/programs_premium_assistance.cfm 800.432.5924 CHIP: http://www.coverva.org/programs_premium_assistance.cfm 855.242.8282
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022, ext. 15473

WEST VIRGINIA – Medicaid
http://mywvhipp.com/ 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf 800.362.3002
WYOMING – Medicaid
https://wyequalitycare.acs-inc.com/ 307.777.7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/19)

Medicare D Notice

Important Notice from BRHPC about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with BRHPC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not 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 a minimum standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. BRHPC has determined that the prescription drug coverage administered by Southern Scripts 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 through 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, your current BRHPC coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

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 your employer 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 have 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 leave 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) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Important Notice from BRHPC about Your Prescription Drug Coverage and Medicare (continued)

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

Contact the person listed below for further information.

NOTE: This notice will be updated each year. You will receive it before the next period you can join a Medicare drug plan and if this coverage through your employer 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 will receive a copy of the handbook in the mail from Medicare every year. 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 or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2020
Name of Entity / Sender:	Broward Regional Health Planning Council, Inc.
Contact / Position-Office:	Yolanda M. Falcone / Manager of Administrative Services
Address:	200 Oakwood Lane, Suite 100 Hollywood, FL 33020
Phone Number:	954.561.9681, ext. 1202

The information in this guide is a summary of the benefits available to you and should not be intended to take the place of the official carriers' Member Certificates or Benefit Summaries. This guide contains a general description of the benefits to which you and your eligible dependents may be entitled as a full-time employee. This guide does not change or otherwise interpret the terms of the official plan documents. To the extent that any of the information contained in this guide is inconsistent with the official plan documents, the provisions of the official documents will govern in all cases and the plan documents and carrier certificates will prevail.

This guide highlights recent plan design changes and is intended to fully comply with the requirements under the Employee Retirement Income Security Act ("ERISA") as a Summary of Material Modifications and should be kept your most recent Summary Plan Description.

BRHPC reserves the right, in its sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of the benefit plans.

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting