County of Dakota County Employee Benefit Plan
Amendment #1
Effective: March 1, 2022

The following changes, clarifications, revisions and/or updates will become part of the County of Dakota County Employee Benefit Plan.

SUMMARY OF MEDICAL, PRESCRIPTION, & DENTAL BENEFITS

Summary of Medical Benefits

	In-Network	Out-of-Network	Limitations & Exceptions
Annual Calendar Year Maximum Paid Benefit Per Participant	**Unlimited** Except for certain services See Limitations & Exceptions		
Annual Calendar Year Medical Deductible	$1,500.00 / individual $3,000.00 / family (Embedded)	$4,000.00 / individual $8,000.00 / family (Embedded)	Annual medical deductible does not include: • Copayments • Any expenses not covered under the Plan • Penalties for failing to follow precertification procedures • Amounts in excess of the Maximum Allowable Charge
	Deductible Accumulation: Embedded Each individual must meet the individual deductible before benefits are payable unless any combination of family members have satisfied the family deductible then the deductible is satisfied for all family members.		
Annual Calendar Year Medical Out-of-Pocket Limit Includes Deductible, Copayments and Coinsurance	$2,500.00 / individual $5,000.00 / family (Embedded)	$4,400.00 / individual $8,800.00 / family (Embedded)	Medical out-of-pocket limit does not include: • Any expenses not covered under the Plan • Penalties for failing to follow precertification procedures • Amounts in excess of the Maximum Allowable Charge
	Out-of-Pocket Accumulation: Embedded Each individual must satisfy the individual out-of-pocket limit unless any combination of family members have satisfied the family out-of-pocket limit then the out-of-pocket limit is satisfied for all family members.		

Service	In-Network	Out-of-Network	Limitations & Exceptions
• **All benefits are subject to the deductibles, copayments and/or coinsurance & maximums unless otherwise stated**			
• **Limitations & Exceptions apply to In-Network and Out-of-Network benefits combined**			
Ambulance Service	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	
Breast Pumps Manual	Plan pays 100% Deductible Waived	Plan pays 60% of Maximum Allowable Charge	
Chemotherapy / Radiation	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	
Chiropractic Services Spinal Manipulation Treatment	Plan pays 100% after $30.00 copay Deductible Waived	Plan pays 60% of Maximum Allowable Charge	• Limited to 24 visits per calendar year
Curaquick Hy-Vee stores only	Plan pays 100% after $15.00 copay Deductible Waived	N/A	
Diabetic Services	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	
Diagnostic X-rays and Lab Services performed outside of physician's office Includes advanced radiological imaging	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	
Dialysis	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	
Durable Medical Equipment	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	• Rental up to purchase price
Emergency Care – Hospital Emergency Room	Plan pays 100% after $150.00 copay Deductible Waived	Plan pays 100% after $150.00 copay Deductible Waived	• Refer to the Plan Document for the definition of Emergency Care
Home Health Care	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	• Limited to 100 visits per calendar year
Hospice Care	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	• Limited to 180 days per occurrence or 360 days per lifetime
Hospital Services – Inpatient	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	

Service	In-Network	Out-of-Network	Limitations & Exceptions
• **All benefits are subject to the deductibles, copayments and/or coinsurance & maximums unless otherwise stated** • **Limitations & Exceptions apply to In-Network and Out-of-Network benefits combined**			
Hospital Services – Outpatient Includes hospital outpatient physician visits	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	
Infertility Diagnosis	Plan pays 100% after $30.00 copay Deductible Waived	Plan pays 60% of Maximum Allowable Charge	• Includes services for the diagnosis only
Mental Health Inpatient, Outpatient & Partial Hospitalization	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	
Physician Office Visit For injury or sickness including allergy testing, serum & injections, or other medical services and supplies performed in the office. Includes X-rays and lab work sent out of the physician's office for interpretation. Excludes preventive care	Plan pays 100% after $30.00 copay Deductible Waived	Plan pays 60% of Maximum Allowable Charge	
Physician / Professional Services Includes fees for surgical procedures and other medical care received in a hospital, skilled nursing facility, inpatient rehabilitation facility or alternate facility. Includes office surgery. Includes all other services rendered outside the office.	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	
Pregnancy For Inpatient / Birthing Center including services for labor and delivery	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	

Service	In-Network	Out-of-Network	Limitations & Exceptions
• **All benefits are subject to the deductibles, copayments and/or coinsurance & maximums unless otherwise stated** • **Limitations & Exceptions apply to In-Network and Out-of-Network benefits combined**			
Preventive Care	Plan pays 100% Deductible Waived	Plan pays 60% of Maximum Allowable Charge	• Out-of-network colonoscopy is not covered
Prosthetics	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	
Skilled Nursing Facility	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	• Limited to 100 days per calendar year
Telemedicine Teladoc	Plan pays 100% after $10.00 copay Deductible Waived	Plan pays 60% of Maximum Allowable Charge	• Available through Teladoc by calling: 1-800-Teladoc (1-800-835-2362)
Telemedicine All Other Providers	Plan pays 100% after $30.00 copay Deductible Waived	Plan pays 60% of Maximum Allowable Charge	• Telemedicine / Virtual Visit during the COVID-19 Public Health Emergency period defined under section 319 of the Public Health Service Act. Benefits under this provision may end earlier, at the Plan Administrator's discretion.
Therapy Services Cardiac, Occupational, Physical, Pulmonary, Speech	Plan pays 80%	Cardiac, Occupational, Pulmonary, Speech: Plan pays 60% of Maximum Allowable Charge Physical: Plan pays 60% of the Maximum Allowable Charge up to a maximum of $20.00 per visit	• Occupational, Physical & Speech – benefits are available only for rehabilitation services that are expected to result in significant physical improvement in the condition within 2 months of the start of treatment. • Physical – limited to 24 visits per calendar year • Speech – only covered for injury, illness, or congenital anomaly
Transplants	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	
Urgent Care Center	Plan pays 100% after $30.00 copay Deductible Waived	Plan pays 60% of Maximum Allowable Charge	
Wig after Chemotherapy or Radiation	Plan pays 80%	Plan pays 60% of Maximum Allowable Charge	• Limited to $500.00 lifetime benefit

Summary of Prescription Benefits

	In-Network	Limitations & Exceptions
Annual Calendar Year Prescription Out-of-Pocket Limit	$5,950.00 / individual $11,900.00 / family (Embedded) **Out-of-Pocket Accumulation: Embedded** Each individual must satisfy the individual out-of-pocket limit unless any combination of family members have satisfied the family out-of-pocket limit then the out-of-pocket limit is satisfied for all family members.	Prescription out-of-pocket limit does not include: • Any expenses not covered under the Plan

	You Pay	Plan Pays	Limitations & Exceptions
• **All benefits are subject to the deductibles, copayments and/or coinsurance & maximums unless otherwise stated**			
Retail Pharmacy (30-Day Supply) (participating pharmacy)			
Generic Medications	$10.00 copay Deductible Waived	100% after copay	
Formulary Brand Name Medications	$25.00 copay Deductible Waived	100% after copay	
Non-Formulary Brand Name Medications	$45.00 copay Deductible Waived	100% after copay	
High Dollar Prescription Medications (Prescriptions costing more than $500.00)	20% coinsurance	100% after coinsurance	• Maximum paid benefit per participant per calendar year is $20,000.00
Mail Order Prescription Medication Option (90-Day Supply)			
Generic Medications	$20.00 copay Deductible Waived	100% after copay	
Formulary Brand Name Medications	$50.00 copay Deductible Waived	100% after copay	
Non-Formulary Brand Name Medications	$90.00 copay Deductible Waived	100% after copay	
High Dollar Prescription Medications (Prescriptions costing more than $1,500.00)	20% coinsurance	100% after coinsurance	• Maximum paid benefit per participant per calendar year is $20,000.00
Over-the-Counter Medications (30-day supply)			
Claritin, Alavert, Loratidine, Prilosec, Pepcid AC, Zantac, Tagamet HP, and Axid AR	$5.00 copay Deductible Waived	100% after copay	

MEDICAL BENEFITS

Eligible Medical Expenses

- Telemedicine (Teladoc) – charges for a Teladoc phone or video consultation with a physician. Available through Teladoc by calling 1-800-Teladoc (1-800-835-2362).
- Telemedicine / Virtual Visit (All Other Providers) - During the COVID-19 Public Health Emergency period defined under section 319 of the Public Health Service Act. Benefits under this provision may end earlier, at the Plan Administrator's discretion.

Medical Expenses Not Covered

- Hospital Services
  - Any hospital stay that is not for the diagnosis or treatment of a sickness or injury
  - Deafness or blindness
  - Non-emergency hospital admissions on a Friday or Saturday unless surgery is performed within 24 hours of admission
  - Senility, mental deficiency, or retardation

PRESCRIPTION MEDICATION BENEFITS

Value Max Program

You are eligible to participate in the Value Max program through Magellan Rx if you are currently taking or if you begin taking certain specialty drugs. Drugs included in this program will have a coinsurance without a maximum member responsibility. The program will help you enroll in copay assistance programs offered by the manufacturer for your eligible drug, with the goal of helping you avoid most out-of-pocket expense for your therapy.

If you are eligible to participate in the program, the Magellan Rx specialty pharmacy will contact you to help you enroll in the applicable copay assistance program for your medication if you are not already enrolled. As a first step, participants are required to send specialty medication prescriptions to Magellan Rx Management by calling 800-424-0472 or logging onto www.magellanrx.com.

If you are eligible for a copay assistance program, and choose to dis-enroll in the program, you will be responsible for the entire cost of the drug.

Eligibility and participation in the Value Max program is subject to the **$20,000.00 High Dollar Prescription Drug Program Maximum Per Person Per Plan Year Limit.**

The Plan Document and Summary Plan Description will be amended to reflect this change. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Accepted: County of Dakota County

Signature: _____

Printed Name: Robert Giese

Title: Board Chair

Date: 3/21/2022