Understanding Your Benefits

2023 Benefit Book
Kent County

All Employees (Non-Elected)

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If you (and /or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 59 for more details.

VALUES

- Act with integrity
- Serve as responsible stewards of County resources
- Provide high-quality service to internal and external customers
- Work collaboratively
- Embrace diversity, equity, and inclusion

VISION

Kent County is where individuals and families choose to live, work, and play because we are a forward-looking, intentional, and inclusive community that serves as the economic engine of West Michigan.

MISSION

Through responsible budgeting and thoughtful planning, Kent County government is committed to providing resources and services that promotes high quality of life for the community.

Your benefits are an important part of your total employee compensation package. The County provides you with a broad range of medical, prescription, dental, vision, retirement, and other benefits to meet your individual needs. Please take the time to review the benefits available to you and select those options which best fit your needs. This booklet provides brief descriptions of the various plans available and the respective costs to you if you have elected to participate. Should you have any questions, please reach out to Human Resources. We are here to help you and your family address any benefit related questions you might have.

Each year, as your benefit needs change due to changing situations and responsibilities, you will have the opportunity to change your coverage. This opportunity for change is called "Open Enrollment." During this event, visit the Human Resources website at www.accesskent.com/benefits where you will find enrollment forms, costs and available options. These forms **must** be returned to Human Resources, prior to the end of open enrollment, even if no changes are being made. Your benefit coverage elections will become effective January 1, 2023.

You will **not** have the opportunity to change your benefit elections again until the next open enrollment period, unless you experience a specific life event change as outlined on page five.

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 on the Kent County internet site at www.accesskent.com/benefits or from Human Resources.

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

To ensure you're ready for open enrollment, below is a handy checklist for your reference.

My Checklist

Open Enrollment Form	☐	Non-Smoking Attestation	☐
Flexible Spending Election	☐	Supporting Document(s) for New Dependents	☐
Wellness Exam Attestation Form	☐		

The Human Resources Department is using technology tools to make your elections quicker and easier. Open enrollment material will no longer be mailed to your home.

OPEN ENROLLMENT INFORMATION & FORMS

- The enrollment form will be available online at (www.accesskent.com/benefits). The newly combined Open Enrollment Form and Non-Smoking Attestation form will need to be filled out in DocuSign. Once you click on "Submit", Human Resources will receive your form immediately.
- If you have completed a Wellness Exam Attestation Form for a 2021 wellness exam, and have not already submitted your form, you can download the form from www.accesskent.com/benefits. You can fax or email the form to hrbenefits@kentcountymi.gov

CURRENT BENEFITS ELECTIONS

- Your current elections can be found on A360.
- Log into A360 at https://myadvantagecloud.cgi.com/PROD/portal/Advantage360Home
- Click **Employee Self Service**
- Click the **Benefits** tab
- In the Enrollment Widget, view **Benefits Enrollment**
- Dependent information can be found using the **Dependent Benefits widget**

Vision Coverage Enhancements

- Increase in the Walmart and Costco frame allowance to match the VSP provider frame allowance of $175.

- Adding the Light Care enhancement to cover frames for non- prescription lenes such as blue light or sunglasses.

Cost Sharing Limitations

Cost-sharing limitations have been imposed under Health Care Reform. **For prescription drug coverage, a member's out-of-pocket maximums are increasing to $5,950 for an individual and $11,900 for a family.**

During Open Enrollment in October 2022 ONLY: You have the option of increasing your supplemental life to $100,000 worth of coverage without having to complete medical underwriting and will be automatically approved by the carrier

CHANGING YOUR ELECTIONS

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

- Marriage, divorce, or legal separation,
- Birth or adoption of a child,
- A covered dependent reaching the limiting age (see Eligible Dependents section below),
- Death of a spouse or covered dependent,
- 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.

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 ELIGIBLITY DOCUMENT REQUIREMENTS

The County reserves the right to require proof of eligibility. To <u>add</u> dependents to your plan, documentation is required for proof of eligibility. See requirements below. To ensure 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 ***<u>AND</u>***
- A copy of the front page of your most recently filed federal tax return confirming this dependent as a spouse, ***<u>OR</u>*** documentation dated within the last 6 months establishing current relationship status such as a joint household bill, joint bank/credit account, joint mortgage/lease, or insurance policies. The document must list you and your spouse's name, the date, and mailing address.

FOR CHILDREN: *Provide documentation listed below.*

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

FOR STEPCHILDREN: *Provide documentation listed below.*

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

FOR DISABLED DEPENDENTS: *Provide documentation listed below.*

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

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

WELLNESS EXAM CASH INCENTIVE:

Employees may receive a cash wellness incentive equivalent to 2.5% of their medical and prescription premiums. To receive this cash, you must complete an annual physical, and you and your physician must complete the "Wellness Exam Attestation Form".

Annual physicals screen for health issues that patients may not have noticed yet. Doctors may screen for several conditions during a physical, including cholesterol levels, diabetes, and high blood pressure. Physicians may also screen for a number of common cancers, including breast, cervical, prostate and skin.

Annual physicals find and help treat problems; early intervention helps cure and even prevent diseases and disorders. During a physical, physicians can answer any health questions a patient might have. Doctors may give recommended immunizations that protect the patient from communicable diseases.

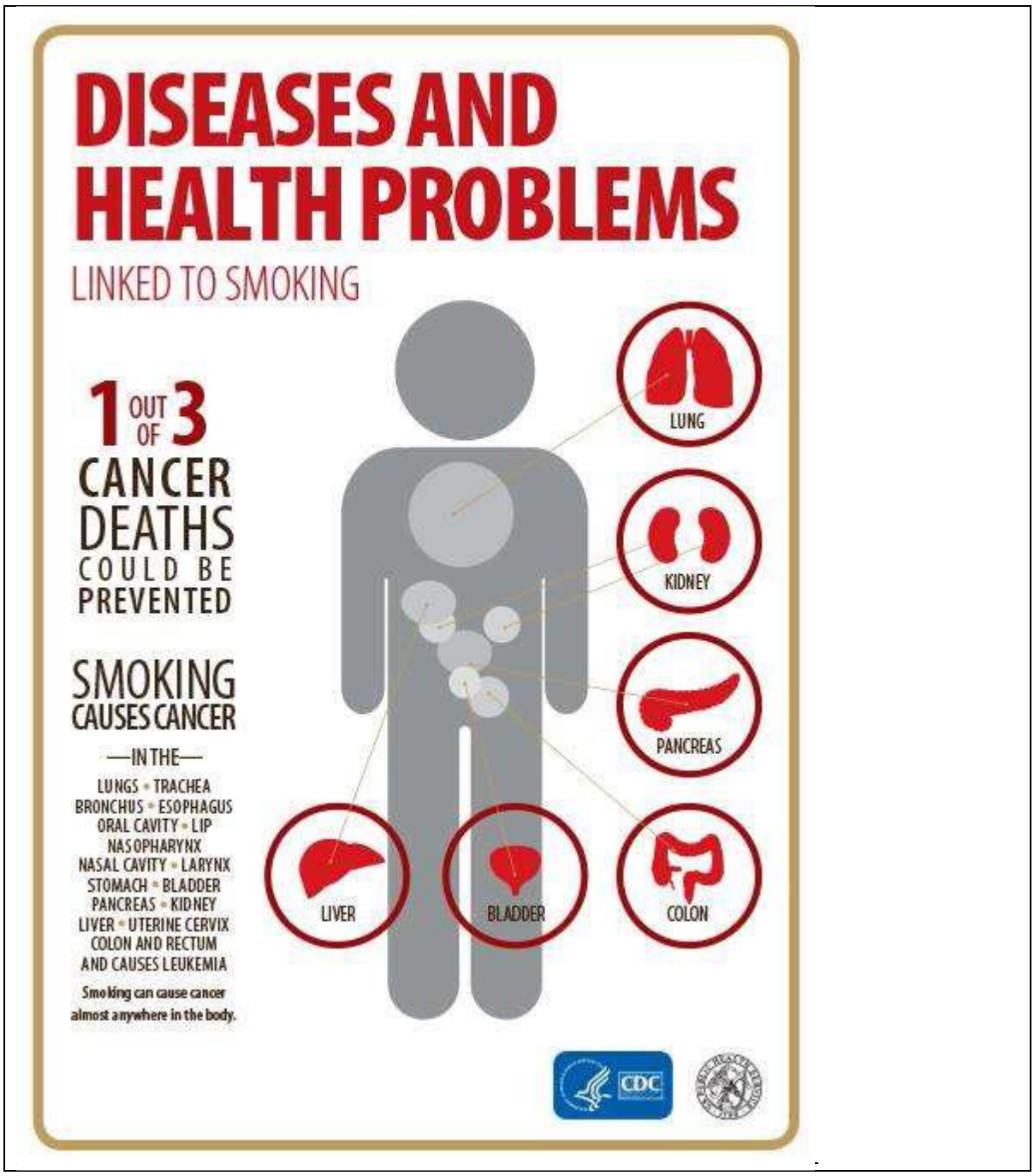
NON-SMOKER/ATTEMPTING TO QUIT WELLNESS INCENTIVE

Employees may receive a cash wellness incentive equivalent to 2.5% of their medical and prescription premiums by returning the "Non-Smoking Attestation Form". To receive this wellness cash, you must accurately indicate on the form that you are a non-smoker or, if you are a smoker that you will participate in a smoking cessation program.

Kent County has teamed with our health care claim administrator to offer no-cost programs designed to **help you quit** smoking.

Blue Cross Wellness PPO and Blue Care Network HMO Participants:

The Tobacco Cessation Coaching, powered by WebMD program offers a specialized program for employees ready to quit using tobacco products. Those who are ready to quit work with a health coach to set a quit date which includes 5 calls over a 12-week period, and optional two rounds of Nicotine Replacement Therapy. This has been proven to help eliminate barriers and support members in quitting. Inbound calls are also available on an unlimited basis. To enroll in the program, call toll-free 1-855-326-5102.


DISEASES AND HEALTH PROBLEMS
LINKED TO SMOKING
1 OUT OF 3 CANCER DEATHS COULD BE PREVENTED
SMOKING CAUSES CANCER
—IN THE—
LUNGS • TRACHEA
BRONCHUS • ESOPHAGUS
ORAL CAVITY • LIP
NASOPHARYNX
NASAL CAVITY • LARYNX
STOMACH • BLADDER
PANCREAS • KIDNEY
LIVER • UTERINE CERVIX
COLON AND RECTUM
AND CAUSES LEUKEMIA
Smoking can cause cancer almost anywhere in the body.
LUNG
KIDNEY
PANCREAS
LIVER
BLADDER
COLON
CDC

Wellness Attestation Forms:

There are two different Wellness Attestation Forms available:

1. Wellness Exam Attestation Form
    - To be completed to receive wellness cash for having an annual physical.
2. Non-Smoking Attestation Form
    - To be completed to receive wellness cash for being a non-smoker or participating in a smoking cessation program.

Attestation forms are located on the Kent County internet site (www.accesskent.com/benefits) or can be obtained from the Human Resources Department.

Attestation forms may be turned in any time during the calendar year. Wellness incentives will be applied during the pay period following the date the form was received by Human Resources.

Examples of Wellness Exam Attestation Form Timelines				
Exam Incentive Previous Year?	Physical Exam Date	Attestation Form Received in HR	Incentive Begins	Incentive Ends
Yes	March 30, 2021	April 1, 2021	April 16, 2021	With Final Premium Payment for 2022
Yes	March 30, 2021	December 7, 2021	January 21, 2022	With Final Premium Payment for 2022
No	January 14, 2022	January 16, 2022	February 4, 2022	With Final Premium Payment for 2023
Yes	September 30, 2021	October 4, 2021	October 29, 2021	With Final Premium Payment for 2022

NOTE: Non-Smoking Attestation Forms must be updated and submitted annually during open enrollment to receive the incentive for the following year.

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at 616-632-7440 and we will work with you to develop another way to qualify for the reward.

Kent County offers, to its full and part-time employees, wellness medical plans with the option of choosing either:

- 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) medical plan. Claims will be processed and paid by BCBSM, and all questions regarding claims should be addressed to them.

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

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

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

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

Blue Care Network HMO

Blue Care Network is the insurance company and plan administrator for the County's 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.

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 though 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

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.

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

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

	Blue Care Network Wellness HMO	Blue Cross/Blue Shield Wellness PPO	
		In Network	Out-Of-Network
	Advanced Imaging, Covered – 100% following $150 co-pay after deductible		
Radiation Therapy	Covered - 90% after deductible	Covered - 85% after deductible	Covered - 65% after deductible
Maternity Services			
Pre-Natal and Post-Natal Care	Covered – 100%	Covered – 100%, after initial co-pay	Covered - 65% after deductible
Delivery and Nursery Care	Covered - 100% for professional services. 90% after deductible for facility charges	Covered - 85% after deductible	Covered - 65% after deductible
Hospital Care			
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 90% after deductible	Covered - 85% after deductible	Covered – 65% after deductible
Inpatient Consultations	Covered - Inpatient professional 100% after deductible; Inpatient facility 90% after deductible	Covered - 85% after deductible	Covered - 65% after deductible
Chemotherapy	Covered - 90% after deductible	Covered - 85% after deductible	Covered - 65% after deductible
Outpatient Hospital	Covered - 90% after deductible	Covered – 85% after deductible	Covered – 65% after deductible
Alternatives to Hospital Care			
Skilled Nursing Care	Covered - 90% after deductible. Maximum 45 days per contract year	Covered -85% after deductible. Limited to 120 days per calendar year	Covered - 65% after deductible. Limited to 120 days per calendar year
Hospice Care	Covered - 100% (when authorized) after deductible	Covered - 85% after deductible.	Covered - 65% after deductible.
Home Health Care	Covered - 100% following $40 co-pay after deductible, unlimited visits	Covered - 85% after deductible, unlimited visits	Covered - 65% after deductible, unlimited visits
Surgical Services			
Surgery – includes related surgical services	Covered - 90% after deductible	Covered - 85% after deductible	Covered - 65% after deductible
Human Organ Transplants			
Specified Human Organ	Covered - 90% after deductible	Covered - 85%	Covered - 65% after deductible
Bone Marrow, Kidney, Cornea and Skin	Covered - 90% after deductible	Covered - 85%	Covered - 65% after deductible
Behavioral Health Care and Substance Abuse Treatment			
Inpatient Behavioral Health Care and Substance Abuse Care	**Behavioral Health Care**: Covered - 90% after deductible **Substance Abuse Care**: Covered - 90% after deductible	**Behavioral Health Care:** Covered - 85% after deductible **Substance Abuse Care:** Covered - 85% after deductible	**Behavioral Health Care:** Covered - 65% after deductible **Substance Abuse Care:** Covered - 65% after deductible
Outpatient Mental Health Care	Covered – 100% after $20 co-pay	Covered - 85% after deductible	Covered - 65% after deductible
Outpatient Substance Abuse Care	Covered – 100% after $20 co-pay	Covered - 85% after deductible	Covered - 65% after deductible
Other Services			

	Blue Care Network Wellness HMO	Blue Cross/Blue Shield Wellness PPO	
		In Network	Out-Of-Network
Allergy Testing and Therapy	Covered – 50% after deductible	Covered - 85% after deductible	Covered - 65% after deductible
Allergy Injections	Covered – 100% after $5 co-pay	Covered - 85% after deductible	Covered - 65% after deductible
Chiropractic Office Visits	Covered – 100% after $40 co-pay when referred. Up to 30 visits per calendar year	Covered - 85% after deductible; one new patient visit per 36 months	Covered – 65% after deductible; one new patient visit per 36 months
Chiropractic Spinal Manipulation	Covered – 100% after $40 co-pay when referred. Up to 30 visits per calendar year	Covered - 85% after deductible; one per day, up to 24 visits per calendar year	Covered - 65% after deductible; one per day, up to 24 visits per calendar year
Chiropractic X-rays	Covered – 90% after deductible	Covered - 85% after deductible	Covered – 65% after deductible
Chiropractic Services – Hot/Cold Modalities etc.	Not Covered	Not Covered	Not Covered
Outpatient Physical, Speech and Occupational Therapy, Osteopathic, Pulmonary, Cardiac Rehabilitation	Covered – 100% following $40 co-pay after deductible. One period of treatment for any combination of therapies within 60 consecutive days per calendar year	Covered - 85% after deductible	Covered - 65% after deductible
		Limited to 60 combined visits per calendar year. Services are covered when performed in the outpatient department of the hospital or approved freestanding facility. Physical therapy is also covered in an independent therapist's office. Speech and language therapy limited to services that restore speech.	
Applied Behavioral Analyses (ABA treatment) Limited to 25 hours per week	Covered – 100% after $20 co-pay	Not Covered	
Outpatient Physical Therapy, Speech Therapy, Occupational Therapy, Nutritional Counseling for Autism Spectrum Disorder Through Age 18	Covered – 100% following $40 co-pay after deductible	Not Covered	
Other Covered Services, including mental health services, for Autism Spectrum Disorder	Covered – See other outpatient mental health benefit and medical office visit benefit	Not Covered	
Durable Medical Equipment	Covered - 100%	Covered - 85% after deductible	
Prosthetic Devices	Covered - 100%	Covered - 85% after deductible	
Orthotic Appliances	Covered - 100%	Covered - 85% after deductible	

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

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

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

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

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

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

Value Investment Prescription Plan

Kent County has established a value-based prescription design. For those 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 PPACA, generics will be provided without cost share for contraceptive medicines and devices.

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

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

Cost Sharing Limitations

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

Step Therapy

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

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

Kent County Prescription Plan
Schedule of Prescription Drug Benefits

CO-PAYMENTS

Generic medication and supplies used for the treatment of: ▪ diabetes ▪ hypertension Generic contraceptive medicines or devices Generic medication for women at increased risk for breast cancer Smoking cessation drugs	▪ $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
Formulary (Preferred)/ Brand Name	▪ $25.00 for one-month supply ▪ $50.00 for 90-day supply
Non-Formulary (Non-Preferred)/ Brand Name	▪ $45.00 for one-month supply ▪ $90.00 for 90-day supply

PLAN PARAMETERS

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

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

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

PRE-AUTHORIZATION

- Growth and biosynthetic hormones require prior authorization

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

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

Kent County offers a dental care reimbursement program to assist full-time employees, and their covered dependents, with dental care needs. Kent County pays the premiums for this benefit.

COINSURANCE PERCENTAGES

Type I (Preventative) Services

- Routine oral exams. This includes the cleaning and scaling of teeth. Limit of 2 per Covered Person each Calendar Year paid at 100%
- One bitewing x-ray series per Calendar Year covered at 100%
- One full mouth x-ray every Calendar Year covered at 100%

Type II (Basic) Services (e.g., fillings, oral surgery, root canals and extractions) covered at 50%

Type III (Major) Services (e.g., gold restorations, installation of crowns and periodontics) covered at 50%

Type IV (Orthodontic) Services covered at 50%

NOTE: Employees are not responsible for meeting a deductible.

PLAN LIMITS

Maximum Calendar Year Benefit per Family
$2,500 Per Calendar Year* Combined Type I, II, III and IV Services

*Only one annual family maximum will apply if multiple members of the household are eligible to participate in the County plan.

You may select the dental care provider(s) of your choice. The provider will be paid directly for eligible dental services they provide to you and your eligible dependents. Your provider will directly bill Varipro. In-Network Dental providers can be located using the DocFind search tool any time at www.aetna.com/docfind/custom/aetnadentalaccess.

Using the Dental DocFind Search Tool

- Find a doctor by zip, city, or county
- See a list of the network dentists (category defaults to “Dental Providers”)
- Pick a type of provider; primary or specialist.
- Select a dental plan (plan defaults to Aetna Dental Access® /Aetna Dental® Administrators)

A Look at your VSP Vision Coverage

vsp vision care

With VSP and KENT COUNTY, your health comes first.

As a member, you'll 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, including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

vsp PREMIER PROGRAM — Preferred private practice and retail in-network choices: private practice doctors; Visionworks

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.

PROVIDER NETWORK:
VSP Choice

EFFECTIVE DATE:
01/01/2023

Interim Benefits: If your lens prescription changes before you are eligible and if the prescription improves visual acuity and has a change in diopter, then lenses and frame will be eligible at a 12 month frequency instead of 24 months.

Create an account today.

Contact us at:
800.877.7195 or **vsp.com**

*Coverage with a retail chain may be different or not apply.

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

BENEFIT	DESCRIPTION	COPAY
YOUR COVERAGE WITH A VSP PROVIDER		
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Every 12 months	$0
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. • Available as needed	$0 per screening $20 per exam
PRESCRIPTION GLASSES		**$20**
FRAME*	• $175 frame allowance • $225 featured frame brands allowance • $225 Visionworks frame allowance on any frame • 20% savings on the amount over your allowance • $175 Walmart*/Sam's Club*/Costco* frame allowance • Every 24 months	Included in Prescription Glasses
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Every 24 months	Included in Prescription Glasses
LENS ENHANCEMENTS	• UV protection • Impact-resistant lenses • Anti-glare coating • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every 24 months	$0 $0 $25 $0 $95 - $105 $150 - $175
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 24 months	Up to $60
LIGHTCARE™	• $175 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts • Every 24 months	$20
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $50 to spend on featured frame brands. Go to **vsp.com/framebrands** 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	
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.		

Value-Added Benefit

The vision plan offers 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 .

MONTHLY HEALTH COVERAGE RATES

Kent County Wellness PPO (BCBSM)			
	Employee Cost (Full-Time)	County Cost	Total Cost
Single	$115.91	$463.68	$579.59
Two-Party	$243.42	$973.72	$1,217.14
Family	$289.79	$1,159.19	$1,448.98

Blue Care Network HMO			
	Employee Cost (Full-Time)	County Cost	Total Cost
Single	$89.52	$358.10	$447.62
Two-Party	$214.85	$859.42	$1,074.28
Family	$268.57	$1,074.28	$1,342.85

Kent County Prescription Plan			
	Employee Cost (Full-Time)	County Cost	Total Cost
Single	$28.91	$115.64	$144.55
Two-Party	$60.71	$242.85	$303.56
Family	$72.27	$289.11	$361.38

Kent County Dental Plan (Full-Time Only)			
	Employee Cost	County Cost	Total Cost
Single	$0.00	$92.64	$92.64
Two-Party	$0.00	$92.64	$92.64
Family	$0.00	$92.64	$92.64

Kent County Vision Plan (Full-Time Only)			
	Employee Cost	County Cost	Total Cost
Single	$0.00	$8.31	$8.31
Two-Party	$0.00	$12.04	$12.04
Family	$0.00	$21.83	$21.83

NOTE: **Full-time** employees pay 20% premium cost for medical and prescription benefits.

Part-time employees pay the total premium cost (far right column) for medical and prescription benefits, less a $35.00 per pay period credit. Part-time employees are not eligible for dental and vision coverage.

Deductions are taken from the first and second pay period of each month. If you want to calculate your deduction amount per pay period, take your monthly contribution and divide it by two.

A Flexible Spending Account (FSA) allows you to reduce your taxable income by setting aside pre-tax dollars for health care expenses that are not covered under the County's medical, prescription drug, dental and vision benefits, and certain dependent care expenses. An FSA is like a personal account in which you can set aside a predetermined amount of money to cover qualified expenses. Contributing to an FSA, through payroll deduction, helps you make the most tax-effective use of your salary.

You can elect to participate in the following FSAs:

- Health Care Reimbursement Account
- Dependent Care Reimbursement Account.

You *must* make an annual election for each year in which you wish to participate in the FSA. The only expenses eligible for reimbursement are those incurred following the effective date of your election. A list of qualified expenses may be obtained through Human Resources or through our third-party administrator, Varipro.

During open enrollment, you may elect to contribute a portion of your pay, to one or both reimbursement accounts, for the upcoming 2023 plan year. The minimum contribution is $130 per year for either plan. As to the maximum contributions, there is an annual maximum of $2,850 subject to change for the Health Care Reimbursement Account and a maximum of $5,000 subject to change for the Dependent Care Reimbursement Account.

Health Care Reimbursement Account
As you incur qualified health care expenses, you request reimbursement from your account by submitting a completed flex claim form, along with your itemized receipt(s) to Varipro, the claims administrator. The full amount pledged to the Health Care Reimbursement Account for the plan year is immediately available to you. The Health Care Reimbursement Account can be used to pay for a variety of uninsured expenses, including co-payments, deductibles and other health related expenses incurred by you or your covered family members, including vision, dental and prescription drug services not payable under your insurance coverage.

You are allowed 14 1/2 months, instead of 12 months, to receive reimbursement from your Flexible Spending Account(s) for Plan Year 2023. Your payroll deductions will be from January 1, 2023 through December 31, 2023 but Kent County has established a two-and-a-half-month grace period until March 15, 2024 for you to access medical services and to seek reimbursement from your 2023 contributions. You may submit claims through March 31, 2023.

If you have a balance in your 2021 Health Care Reimbursement Account as of January 1, 2024, any services received through March 15, 2024 and claims submitted by March 31, 2024 will be applied to the previous year's fund balance before claims are paid with the 2024 funds you elected.

Dependent Care Reimbursement Account

The Dependent Care Flexible Spending Account reimburses for eligible dependent care expenses such as child care **for children under age 13 or day care for anyone who you claim as a dependent on your Federal tax return who is physically or mentally incapable of self-care** so that you (and your spouse, if you are married) can work, look for work, or attend school full-time. The Dependent Care Flexible Spending Account does NOT pay for medical care for your dependents.

As you incur qualified dependent care expenses, you request reimbursement from your account by submitting a completed flex claim form, along with your itemized receipt(s) to Varipro, the claims administrator. You will be reimbursed up to the maximum in your account at the time of your request for the Dependent Care Reimbursement Account. You have 90 days following the end of the plan year to submit claims for reimbursement of services received during the plan year.

General Information Regarding Your FSA

If you enroll in both the Health and Dependent Care Spending Accounts, you **cannot** transfer or borrow funds from one account to the other. **The IRS requires that unused pre-tax funds be forfeited if claims are not submitted within the allotted time frame.** You will be allowed to change the amounts you are contributing during the plan year **only** in the event of a significant status change.

Please Note: Should you take an unpaid leave of absence during the year, payroll deductions for your FSA will change upon your return to work to ensure that your annual election for the year is deducted.

The Tax Savings Advantage for Flexible Spending Accounts

The following page shows how you can save on taxes and increase your take-home pay for the year by participating in an FSA.

Tax Savings Example

	Without Flex		With Flex
Annual Salary	**$30,000**		**$30,000**
Health Care FSA	$0		$1,000
Dependent Care FSA	$0		$5,000
Taxable Salary (W-2 Income)	**$30,000**	⟷	**$24,000**
Federal Tax (15%)	$4,500		$3,600
State Tax (4%)	$1,200		$960
Social Security Tax (7.65%)	$2,295		$1,836
Total Annual Taxes	**$7,995**		**$6,396**
After-tax Out-of-Pocket Medical	$1,000		$0
After-tax Dependent Care	$5,000		$0
Annual Take-Home Pay	**$16,005**	⟷	**$17,604**
Annual Tax Savings with Flex			**$1,599**

This employee saved approximately $1,599.00 annually by participating in the FSA Plan!

* Estimated amount used. Actual amount will depend on current tax year and filing status.

Dependent Care Account or Tax Credit?

You should be aware that Federal law provides a tax credit, called the "Credit for Child and Dependent Care Expenses" for those who incur dependent care expenses. When comparing the advantages of a Dependent Care Account to a tax credit, you should estimate the amount of tax savings available under each approach to determine which is more favorable for your personal circumstances.

Basic Life and AD&D

Kent County offers $50,000 Basic Life and Accidental Death and Dismemberment (AD&D) Insurance, through New York Life, to its full-time employees, at no cost to the employee.

Supplemental Life

Full-time employees may purchase, through payroll deduction, Supplemental Life coverage in addition to the Basic Life and AD&D coverage provided by the County. You may apply for Supplemental Life Insurance in multiples of $5,000 from $15,000 to $150,000. Supplemental coverage is subject to the insurance carrier's underwriting and approval process.

During Open Enrollment in October 2022 ONLY: You have the option of increasing your supplemental life to $100,000 worth of coverage without having to complete medical underwriting and will be automatically approved by the carrier

Value-Added Benefits

The life insurance carrier offers 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

The following schedule shows the rates for Supplemental Life coverage:

Age	Rate per $1000		Age	Rate per $1000
0-25	0.057		50-54	0.371
26-29	0.057		55-59	0.646
30-34	0.067		60-64	1.245
35-39	0.076		65-69	2.271
40-44	0.114		70 & over	2.271
45-49	0.209			

The formula for estimating your monthly contribution is as follows:

_____	X	_____	/	$1,000	=	_____
$ of Desired Insurance		**Rate**				**Monthly Contribution**

For example: Marilyn Jones is 47 years old. She has decided that she needs an additional $50,000 in life insurance because her 17-year-old son is ready to start college. She wants to ensure he will be able to finish school if something happens to her.

$50,000	X	**0.209**	/	$1,000	=	**$10.45**
$ of Desired Insurance		**Rate**				**Monthly Contribution**

If you waived coverage upon your hire date, then you must complete the medical underwriting process and be approved by the carrier before any Supplemental Life coverage is provided. If you have previously elected life insurance coverage of an amount less than $100,000 and choose to increase your coverage amount, you have the option to increase your election an additional $5,000 or $10,000 without having to complete a health questionnaire. If you increase your election by an amount greater than $10,000, you must complete the medical underwriting process and be approved by the carrier. Additionally, if you have previously elected life insurance in an amount of $100,000 or greater and you choose to increase your coverage by any amount, then you must complete the medical underwriting process and be approved by the carrier.

Imputed Income Tax – Imputed income is a term the Internal Revenue Service (IRS) applies when they feel that the value of a benefit or service should be considered as income for the purposes of calculating your federal taxes. In our case, only life insurance coverage in excess of $50,000 would be considered.

To determine if this applies to you simply add the amount of life insurance provided by the County to the amount of supplemental life insurance coverage you purchase. If the amount is greater than $50,000, the IRS will assess imputed income taxes according to a sliding scale based on your age and amount of life insurance coverage. The imputed income tax on life insurance is generally not a significant amount, but it does increase with your age or amount of coverage. Imputed income will be added to your pay for tax purposes. The additional taxes that you owe will be withheld from your paycheck. Imputed income is reported on Form W-2.

Dependent Life (MPP employees only)

MPP employees are eligible to purchase Dependent Life Insurance. The level of coverage is $25,000 for a spouse and $10,000 for each child. The premium for the Dependent Life Insurance is $3.75 per month.

Dependents are defined as follows:

Spouse means your current lawful spouse.

Dependent Child means your unmarried child if he or she meets the following requirements:

1. A child from live birth to 19 years old;
2. A child who is 19 or more years old to the end of the calendar month in which a child attains age 26 years old, and primarily supported by you;
3. A child who is 19 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical incapacity.

The term "child" means:

- your natural child;
- your legally adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of your Spouse provided the child is living with, and is financially dependent upon you;
- a stepchild born to your Spouse and who is living with and financially dependent upon you;
- a child less than 19 years old (unless the child otherwise satisfies the requirement of paragraph 3 above) for whom you are the court-appointed legal guardian and who resides with and is financially dependent upon you.

If you are newly electing dependent life insurance, you must complete the medical underwriting process and be approved by the carrier before any Supplemental Life coverage is provided.

Sickness and accident benefits will be provided for **full-time and regular part-time employees with the exception of TPOAM hired before July 1, 2016 and KCLEA hired before January 1, 2019.**

These benefits are payable from the first **(1st) day of disability due to accident, surgery (both inpatient and outpatient), and hospitalization.** A seven-day waiting period applies in cases of illness. Benefits may be received for not more than twenty-six (26) weeks for any one period of disability.

This coverage becomes effective after six months of employment. Employees receive weekly indemnity payments **equal to sixty-seven percent (67%)** of their normal gross straight time wages.

Employees are not entitled to S&A benefits for any disability for which they may be entitled to indemnity or compensation under the Kent County Retirement Plan, Social Security, Workers' Compensation, or any other disability benefit program.

An employee will be given pension service credit under the County retirement plan for the period of time during which S&A insurance benefits are received, provided that the employee pays the employee pension contribution on 100% of the employee's gross weekly wage for the entire period in which S&A benefits are paid.

An employee can use benefit time (vacation or personal time) or time from his or her reserve sick leave bank to supplement S&A payments. The sum of any such S&A benefits and supplemental payments shall not exceed one hundred percent (100%) of the employee's gross weekly wage.

If an employee is eligible for Family and Medical Leave, the employer portion of all insurance premiums will be paid while an employee is receiving S&A benefits, provided the employee pays the employee portion. Insurance payments while on disability shall not exceed twenty-six (26) weeks in a rolling twelve (12) month period. FMLA and S&A programs run concurrently.

An employee who is receiving S&A insurance benefits is eligible to return to his/her former or comparable position consistent with the Family and Medical Leave Act. The employee must present a proper medical release from the employee's health care provider to return to work.

Value-Added Benefits

The S&A carrier offers 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.

Long Term Disability benefits will be provided for **full-time and regular part-time employees with the exception of KCDSA hired before January 1, 2016, Captains and Lieutenants, and KCLEA.**

There is a 180 day wait period before this benefit begins to pay. This plan pays a benefit of up to 60% of your monthly covered earnings to a maximum of $5,000 per month.

Covered earnings mean your wage or salary, excluding bonuses, commissions, overtime pay or other extra compensation.

You are considered disabled if, solely because of injury or sickness, you are unable to perform the material duties of your regular occupation and you are unable to earn 80% or more of your indexed earnings from working in your regular occupation. After benefits have been payable for 24 months, you are considered disabled if, solely due to your injury or sickness, you are unable to perform the material duties of any occupation for which you are (or may reasonably become) qualified by education, training or experience, and you are unable to earn 60% or more of your indexed earnings.

Benefit Duration
Once you qualify for benefits under this plan, you will receive them until the end of the benefit period shown below, or until you no longer qualify for benefits, whichever is first.

Age at Disability	Age 62 or younger	63	64	65	66	67	68	69+
Duration of Payment (months)	To age 65 or the date the 42nd monthly benefit is payable, if later	36	30	24	21	18	15	12

Earnings While Disabled
During the first 24 months that benefits are payable, benefits will be reduced if benefits plus income from employment exceeds 100% of pre-disability covered earnings. After that, benefits will be reduced by 50% of earnings from employment.

Pre-existing Conditions
Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures) or for which a reasonable person would have consulted a physician during the 3 months just prior to the most recent effective date of insurance.

Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured for at least 12 months after your most recent effective date of insurance.

The Kent County Employees' Retirement Plan is a defined benefit retirement plan established by the Kent County Board of Commissioners. The Plan is funded by a combination of County and employee contributions.

Age and service requirements for retirement eligibility are negotiated benefits and based on bargaining unit or employee group. Refer to your bargaining unit agreement or handbook to determine how the retirement plan eligibility applies to you.

The retirement benefits received from the Plan will be in addition to any benefits from Social Security.

Participation in the Kent County Employees' Retirement Plan is mandatory after six (6) months of employment for all employees covered by a collective bargaining agreement and management pay plan. Employee contribution rates are determined by employee group or collective bargaining agreement; Kent County's contributions are determined annually by the pension plan's actuary.

The bi-weekly pre-tax deduction begins with the first full pay period following your six (6) month anniversary. Years of service credit, however, will commence with your first day of employment. You will be vested in the Kent County Employees' Retirement Plan when you have accumulated the years of credited service required by your employee group.

Contribution Rates for 2023

The variable employee contribution rate, as determined by the actuary of the retirement plan, is:

Employee Group	Rate
All Employees except the following	Variable Rate = 9.23%
Captains and Lieutenants	Variable Rate + 3.5%
KCDSA	Variable Rate + 1.38% + 0.37%
KCLEA	Variable Rate + 3.32%

Each employee group has negotiated specific provisions for the pension benefit and contribution rate; therefore, some employees' contribution rate will exceed the above variable rates. Please refer to your contract for additional information. Obligations to pay current and future benefits, investment performance of the plan's assets, funding status of the plan as well as other factors determine what the rates will be for any given year.

The Kent County Deferred Compensation Plan is authorized under Section 457 of the Internal Revenue Code and is a voluntary retirement plan maintained to provide supplemental retirement income for eligible employees. Participation in the Deferred Compensation Plan will allow you two choices to accumulate monies for your retirement.

- You can use the traditional pre-tax contributions to the Plan and enjoy the advantage of tax deferment until you are ready to retire; *or*
- You can designate your contributions to the Plan account as after-tax Roth 457 contributions. The Roth option allows after-tax contributions to the Plan with the goal of receiving tax-free income in retirement.

You can split deferrals between pre-tax and after-tax Roth contributions. You may enroll, increase, or decrease contributions in the Kent County Deferred Compensation plan on the first pay date of each month. You can stop contributions at any time. The Deferred Compensation Plan allows you to allocate your contributions to the plan in a variety of investment options available under contract with Nationwide Retirement Solutions.

What's the difference?	Traditional (pre-tax 457)	Roth 457
Contribution Limit	Refer to federal guidelines	
Catch-up contribution limit – for those age 50 and older	Refer to federal guidelines	
Contribution taxable in year **contributed**	No	Yes
Contribution taxable in year **distributed**	Yes	No
Contribution earnings taxable in year distributed	Yes	No
Your income determines your contribution amount	No	No

You cannot access your deferred compensation account balance, as an active Kent County employee, unless you experience an unforeseen event outside of your control that results in financial hardship. An unforeseen emergency withdrawal may be obtained only if you can show that all other available assets have been used and opportunities for loans or credit are not available. The amount of the unforeseen emergency withdrawal cannot exceed the amount required to alleviate your financial hardship after considering your other financial resources and your ability to obtain money from another source.

An unforeseen emergency is defined in the Internal Revenue Code as a severe financial hardship resulting from a sudden and unexpected accident or illness of the participant or of a dependent of the participant. It may be the loss of the participant's property due to casualty, or other similar extraordinary and unforeseeable circumstances. The loss must be because of events beyond the control of the participant. (IRS Reg. 1.457-2(h)(4). Contact the Human Resources Department to apply for an unforeseen emergency withdrawal.

Beneficiary Designation - It is recommended to review and update beneficiary(ies) from time to time; particularly if you have experienced a change in your status. Marriage, divorce, death of family members and birth of children are events that warrant a review of your beneficiary designation.

A Notification of Record Changes form is used to update beneficiary(ies) for the pension plan and it is available on the Kent County internet site under Forms / Human Resources / Pension Plan Notification of Record Changes.

A Deferred Compensation Beneficiary Changes form can update beneficiary(ies) for the deferred compensation plan and it is available on the Kent County internet site under Forms / Human Resources **/** Deferred Compensation Plan (457) – Nationwide.

Send completed forms via interoffice mail to: Human Resources Dept. / County Admin Bldg. / ATTN Retirement Services.

KENT COUNTY HOLIDAYS FOR YEAR 2023

ACTUAL DAY	ACTUAL DATE	DESCRIPTION	OBSERVED DAY	OBSERVED DATE
SUNDAY	1/01/2023	NEW YEAR'S DAY	MONDAY	1/02/2023
MONDAY	1/16/2023	MARTIN LUTHER KING DAY	MONDAY	1/16/2023
MONDAY	5/29/2023	MEMORIAL DAY	MONDAY	5/29/2023
TUESDAY	7/04/2023	INDEPENDENCE DAY	TUESDAY	7/04/2023
MONDAY	9/04/2023	LABOR DAY	MONDAY	9/04/2023
SATURDAY	11/11/2023	VETERANS DAY	FRIDAY	11/10/2023
THURSDAY	11/23/2023	THANKSGIVING DAY	THURSDAY	11/23/2023
FRIDAY	11/24/2023	DAY AFTER THANKSGIVING	FRIDAY	11/24/2023
SUNDAY	12/24/2023	CHRISTMAS EVE	FRIDAY	12/22/2023
MONDAY	12/25/2023	CHRISTMAS DAY	MONDAY	12/25/2023
MONDAY	1/01/2024	NEW YEAR'S DAY	MONDAY	1/01/2024

NOTE: ELIGIBILITY FOR REGULAR PART- TIME EMPLOYEES IS BASED ON COLLECTIVE BARGAINING UNIT OR EMPLOYEE GROUP

KENT COUNTY PAYROLL DATES FOR YEAR 2023

Pay Period	Pay Period Schedule		Pay Date	Timesheet Due Date
1	12/12/2022 to 12/18/2022 12/19/2022 to 12/25/2022	*	1/06/2023	12/26/2022
2	12/26/2022 to 1/01/2023 1/02/2023 to 1/08/2023	*	1/20/2023	1/09/2023
3	1/09/2023 to 1/15/2023 1/16/2023 to 1/22/2023	*	2/03/2023	1/23/2023
4	1/23/2023 to 1/29/2023 1/30/2023 to 2/05/2023		2/17/2023	2/06/2023
5	2/06/2023 to 2/12/2023 2/13/2023 to 2/19/2023		3/03/2023	2/20/2023
6	2/20/2023 to 2/26/2023 2/27/2023 to 3/05/2023		3/17/2023	3/06/2023
7	3/06/2023 to 3/12/2023 3/13/2023 to 3/19/2023		3/31/2023	3/20/2023
8	3/20/2023 to 3/26/2023 3/27/2023 to 4/02/2023		4/14/2023	4/03/2023
9	4/03/2023 to 4/09/2023 4/10/2023 to 4/16/2023		4/28/2023	4/17/2023
10	4/17/2023 to 4/23/2023 4/24/2023 to 4/30/2023		5/12/2023	5/01/2023
11	5/01/2023 to 5/07/2023 5/08/2023 to 5/14/2023		5/26/2023	5/15/2023
12	5/15/2023 to 5/21/2023 5/22/2023 to 5/28/2023		6/09/2023	5/29/2023
13	5/29/2023 to 6/04/2023 6/05/2023 to 6/11/2023	*	6/23/2023	6/12/2023
14	6/12/2023 to 6/18/2023 6/19/2023 to 6/25/2023	*	7/07/2023	6/26/2023

KENT COUNTY PAYROLL DATES FOR YEAR 2023

Pay Period	Pay Period Schedule		Pay Date	Timesheet Due Date
15	6/26/2023 to 7/02/2023 7/03/2023 to 7/09/2023	*	7/21/2023	7/10/2023
16	7/10/2023 to 7/16/2023 7/17/2023 to 7/23/2023		8/04/2023	7/24/2023
17	7/24/2023 to 7/30/2023 7/31/2023 to 8/06/2023		8/18/2023	8/07/2023
18	8/07/2023 to 8/13/2023 8/14/2023 to 8/20/2023		9/01/2023	8/21/2023
19	8/21/2023 to 8/27/2023 8/28/2023 to 9/03/2023		9/15/2023	9/04/2023
20	9/04/2023 to 9/10/2023 9/11/2023 to 9/17/2023	*	9/29/2023	9/18/2023
21	9/18/2023 to 9/24/2023 9/25/2023 to 10/01/2023		10/13/2023	10/02/2023
22	10/02/2023 to 10/08/2023 10/09/2023 to 10/15/2023		10/27/2023	10/16/2023
23	10/16/2023 to 10/22/2023 10/23/2023 to 10/29/2023		11/10/2023	10/30/2023
24	10/30/2023 to 11/05/2023 11/06/2023 to 11/12/2023	*	11/24/2023	11/13/2023
25	11/13/2023 to 11/19/2023 11/20/2023 to 11/26/2023	*	12/08/2023	11/27/2023
26	11/27/2023 to 12/03/2023 12/04/2023 to 12/10/2023		12/22/2023	12/11/2023
1	12/11/2023 to 12/17/2023 12/18/2023 to 12/24/2023	*	1/05/2024	12/25/2023

* Denotes a Payroll with a Holiday

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

	☎	
MEDICAL		
	Customer Service	Blue Cross Blue Shield of Michigan
Blue Cross Blue Shield of Michigan (BCBSM)	(888) 890-5754 Provider Locator (800) 810-2583	West Michigan Customer Service P.O. Box 230555 Grand Rapids, MI 49523-0555
	☎	
Blue Care Network (BCN)	(800) 662-6667	Blue Care Network P.O. Box 68767 Grand Rapids, MI 49516-8767
PRESCRIPTION DRUG	☎	
		www.cap-rx.com
Capital Rx	(844) 532-2779	Capital Rx 228 Park Avenue S, Suite 87234 New York, NY 10003
DENTAL	☎	
		www.varipro.com
Varipro, Inc.	(616) 285-2480	5300 Patterson Ave SE, Suite 150 Grand Rapids, MI 49512
VISION	☎	
		www.vsp.com
Vision Service Plan Insurance Company (VSP)	(800) 877-7195	3333 Quality Drive Rancho Cordova, CA 95670
FLEX SPENDING ACCOUNTS	☎	
	(616) 285-2480	www.varipro.com 5300 Patterson Ave SE, Suite 150
Varipro, Inc.	Claims Fax: (844) 902-4564	Grand Rapids, MI 49512
LIFE INSURANCE	☎	
	For Claims	myNYLGBS.com
New York Life (Formerly CIGNA)	(888) 842-4462	Claims.Pghlif2@newyorklife.com New York Life Group Benefit Solution
	For Converting (800) 423-1282	P.O. Box 22328 Pittsburgh, PA 15222-0328
LONG TERM DISABILITY	☎	
	For Claims	myNYLGBS.com
New York Life (Formerly CIGNA)	(888) 842-4462	Claims.Pghlif2@newyorklife.com New York Life Group Benefit Solution P.O. Box 709015 Dallas, TX 75370-9015
EMPLOYMENT ASSISTANCE PROGRAM	☎	
		www.encompass.us.com User Name: kentcounty
Encompass	(616) 459-9180 (800) 788-8630	4829 E. Beltline NE, Bldg. 1 Grand Rapids, MI 49525
FMLA	☎	
		https://mshonline.net/
LifeWorks (formerly MorningStar Health)	(616) 942-9088 (888) 674-3652	801 Broadway NW Suite 201Grand Rapids, MI 49504

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

BENEFITS STAFF Kent County Human Resources Department	☎ Mirela Ruiz (616) 632-7462 Nicole Joyce (616) 632-7464 Rebecca Hatfield (616) 632-7471	✉ mirela.ruiz@kentcountymi.gov nicole.joyce@kentcountymi.gov rebecca.hatfield@kentcountymi.gov Kent County Human Resources Dept 300 Monroe NW. 2nd Floor Grand Rapids, MI 49503
PAYROLL STAFF Kent County Fiscal Services Department	☎ Alesia Terry (616) 632-7710 Stacey Steffes (616) 632-7712	✉ alesia.terry@kentcountymi.gov stacey.steffes@kentcountymi.gov Payroll@kentcountymi.gov Kent County Fiscal Services Dept. Attn: Payroll 300 Monroe NW 2nd Floor Grand Rapids, MI 49503
RETIREMENT PLANS Kent County Pension Plan	☎ Tara Beatty (616) 632-7457 Mandy Lee (616) 632-7442	✉ tara.beatty@kentcountymi.gov mandy.lee@kentcountymi.gov kcretirement@kentCountymi.gov Kent County Human Resources Dept. 300 Monroe NW 2nd Floor Grand Rapids, MI 49503
Deferred Compensation (457) Plan	☎ Angia McGeorge, Retirement Specialist (231) 343-2506 a.mcgeorge@nationwide.com Customer Service (877) 677-3678	✉ www.kentcountydefcomp.org Nationwide Retirement Solutions P.O. Box 182797 Columbus, Ohio 43218-2797

LOCATING PLAN DOCUMENTS, CERTIFICATES AND NOTICES

Plan documents, Certificates of Coverage and Required Notices for County-sponsored benefit plans are available for downloading or reading on Kent County's internet site – https://www.accesskent.com/Benefits/ . If you do not have access to the County's internet site, you may call Kent County Human Resources at (616) 632-7440 and we will provide you with a copy.

Plan Documents, Certificates of Coverage and Required Notices

Kent County Employees and Retirees Benefits Plan Wrap Document	https://www.accesskent.com/Benefits/pdf/HR_Benefit_Employee_Retiree_Plan_Wrap.pdf
Wellness PPO Plan Handbook HMO Plan Handbook	https://www.accesskent.com/Benefits/medical.htm
Prescription Schedule of Benefits	https://www.accesskent.com/Benefits/prescription.htm
Dental Plan Document	https://www.accesskent.com/Benefits/dental.htm
Vision Plan Document	https://www.accesskent.com/Benefits/vision.htm
Flexible Spending Plan Document	https://www.accesskent.com/Benefits/fsa.htm
Deferred Compensation (457 Plan) Plan Document	http://kcintranet.kc.gov/forms/pdf/hr_ben_457_Plan_Document.pdf
Kent County Pension Plan	http://kcintranet.kc.gov/forms/pdf/hr_ben_Retirement_Plan_Summary_Description_.pdf
Life Insurance Certificate of Coverage	http://www.accessKent.com/Benefits/life_insurance.htm
Long Term Disability	www.accessKent.com/Benefits/ltd.htm
Sick and Accident Plan Certificate of Coverage (if eligible)	www.accessKent.com/Benefits/sad.htm
Genetic Information Non-Discrimination Act of 2008	https://www.accesskent.com/Benefits/required_notices.htm
Newborns' and Mothers' Health Protection Act	https://www.accessKent.com/Benefits/pdf/Newborns_Mothers_Health_Protection_Act.pdf
Notice of Privacy Practices (HIPAA)	https://www.accesskent.com/Benefits/pdf/Notice_Privacy_Practices_HIPAA.pdf
Premium Assistance Under Medicaid and the Children's Health Insurance Program	https://www.accesskent.com/Benefits/pdf/Premium_Assistance_Under_Medicaid_Childr en_Health_Insurance_Program.pdf
Prescription Drug Coverage and Medicare	https://www.accesskent.com/Benefits/pdf/Prescription_Drug_Coverage_Medicare.pdf
Women's Health and Cancer Rights Act of 1998	https://www.accesskent.com/Benefits/pdf/Women_Health_Cancer_Rights_Act_1998.pdf
Marketplace Exchange Notice	https://www.accesskent.com/Benefits/required_notices.htm
Summary of Benefits and Coverage	https://www.accesskent.com/Benefits/summary_benefits_coverage.htm

Open Enrollment Form

Q. What forms must I return to Human Resources?
A. To ensure that your elections are correctly entered and that you receive the wellness incentives for which you are eligible, return the following forms:

- Open Enrollment-Non Smoking Attestation Form in Docusign
- Wellness Exam Attestation Form
- Supporting Document(s) for New Dependents

Remember, previous year elections for flexible spending do not roll over to the next year.

Q. Do I need to return the open enrollment forms to Human Resources even if I do not have any changes?
A. No. Unless you need to return any of the forms mentioned under the first question above, it is not necessary to submit any open enrollment forms.

Q. How do I return my enrollment form?
A. The Open Enrollment/Non Smoking attestation form should be completed in DocuSign**.** HR will automatically receive a copy of the completed DocuSign form. The Wellness Exam Attestation form can be emailed to hrbenefits@kentcountymi.gov or faxed to 632-7455. Paper forms not accepted. Please do not interoffice your open enrollment forms to HR.

Q. What happens if I miss the open enrollment deadline?
A. If you do not return your open enrollment form on or before the open enrollment deadline, your medical, prescription, dental and vision benefits will remain as they are. **However, neither your flexible spending accounts nor your wellness incentives carry over into the new year.** Changes to your open enrollment form submitted after the open enrollment deadline **will not** be processed.

Health Plan Terminology

COINSURANCE. Reflected as a percentage of the benefit coverage you, as a participant, are responsible for paying. For example, under the Blue Cross/Blue Shield Wellness PPO Plan, the County contributes 85% coverage for in-network hospitalization. You, the participant, would then be responsible for the remaining 15% balance, up to the coinsurance maximum.

CO-PAY. Reflected as a flat dollar amount. For example, participants of Blue Care Network will pay a $20 co-pay for non-preventative doctor visits and a $40 co-pay to see a specialist. Participants of the Kent County prescription plan will pay a $15 co-pay for up to a one-month's supply of generic prescriptions or $30 co-pay for a 3-month supply of a generic prescription.

DEDUCTIBLE. The amount the participant is responsible to pay **before** the health plan starts to pay for services. Under the Blue Cross/Blue Shield Wellness PPO Plan, participants with family coverage have a $600 annual out-of-pocket deductible maximum but will pay no more than $300 per family member. For example, if the participant is scheduled for an in-network surgery and it is the first claim of the year, the participant must pay the first $300 before the County starts paying for any balance due. Coinsurance and co-pays do not apply to deductibles.

EMPLOYEE PREMIUM. The amount an employee contributes on a pretax basis for medical and prescription benefits. Full-time employees who participate in the County sponsored medical and prescription plan(s) will pay 20% of the total health plan cost in employee premiums. Premiums are deducted from the employee's paycheck on a bi-weekly basis.

OUT OF POCKET MAXIMUM. Cost-sharing limitations have been imposed under Health Care Reform. A member's out-of-pocket maximums for medical expenses under the Blue Cross/Blue Shield Wellness PPO are limited to $3,150 for an individual and $6,300 for family coverage. The out-of-pocket maximum as defined by the PPACA includes co-pays, deductibles, and coinsurance. For prescription drug coverage, a member's out-of-pocket maximums are limited to $5,500 for an individual and $11,900 for a family. Total combined employee cost for medical and prescriptions cannot exceed the federal annual limit of $8,700 for an individual and $17,400 for a family-adjusted annually.

VALUE-BASED BENEFIT DESIGN. In a value-based approach, an employer makes 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. Anticipated investment returns include productive, healthy employees and lower overall health care costs. A value-based prescription plan makes medication more affordable for those with chronic health conditions. For example, Kent County has designed a Value Investment Prescription (VIP) Plan that removes 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.

Medical Benefits

Q. What are my medical plan options?
A. Blue Care Network Wellness HMO or the Blue Cross/Blue Shield Wellness PPO Plan.

Q. I received an explanation of benefits statement from Blue Cross and they didn't pay the bill, why?
A. You may need to first meet deductibles and/or coinsurance before the plan begins paying for services. Check your Explanation of Benefits (EOB) for the reason.

Q. I went to my doctor for a routine physical and he did not charge a co-pay, will I be billed later?
A. All preventive services are covered 100% by the plan and you will not pay a co-pay, coinsurance, or deductible for these services.

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. 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. I brought my son into the Emergency Room with a sore throat; what will the plan pay?
A. Keep in mind that emergency room visits should only be used if there is a medical emergency. If you use the emergency room for anything other than a life-threatening injury or illness, you will be responsible for the entire cost of the bill. In this situation, the plan may not pay for all services.

For non-emergency situations, please consider visiting your primary care physician or urgent care center for a lower co-pay.

Q. I am a participant in Blue Cross Blue Shield's Wellness PPO Plan. Why is it an advantage to use physicians and facilities within the Blue Cross Blue Shield PPO Network?
A. Choosing in-network physicians and facilities can save you out-of-pocket expenses. Blue Cross Blue Shield negotiates discounted health care costs for its clients. Providers agree to accept Blue Cross Blue Shield payment for medical services covered under your health plan. If you visit a provider in the network, your claims will be processed as in-network, resulting in less out-of-pocket expenses.

Q. Can I only elect Medical Coverage and Waive Prescription Coverage?
A. No. If you are electing medical coverage, then you must also elect prescription coverage for yourself and any dependents you wish to be covered.

Medical Benefits (cont'd)

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.

Q. What is an HRA?

A. An HRA (Health Risk Assessment) is a wellness tool that will allow your doctor and you to identify any preventable health conditions you may have. The HRA evaluates information you submit online at www.bcbsm.com . Kent County will not receive any personal health information from either Blue Cross or BCN, nor will Blue Cross or BCN share your personal health information with anyone but you. We encourage you to take advantage of this assessment for your well-being.

Prescription

Q. Are there any changes regarding prescription coverage?

A. Yes. The out-of-pocket maximum for prescription drug coverage will be $5,950 for an individual and $11,900 for a family.

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. Have our co-pays changed?

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

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

Q. 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.

Prescription Benefits (cont'd)

Q. Can I only elect Prescription Coverage and Waive Medical Coverage?
A. No. If you are electing prescription coverage, then you must also elect medical coverage for yourself and any dependents you wish to be covered.

Q. Will I receive a separate prescription drug ID card?
A. Yes. Capital Rx will provide you with a prescription drug ID card to fill prescriptions (separate from your medical coverage card).

Health Care Reform

Q. Do I have to elect both Medical coverage and Prescription coverage?
A. Yes, if you are electing medical coverage, you must also elect prescription coverage and vice versa.

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

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

Health Care Reform (cont'd)

- 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.

Dental & Vision

Q. Are cards issued for the dental and vision plans?

A. Yes and No. A card is issued for the dental plan but not issued for the vision plan. However, our vision carrier, VSP, provides you the opportunity to print a card from its website, www.vsp.com. Just log-in or create a user name and follow the instructions to print a card. While you are there, you can review your and your dependents' benefit status and read informative articles regarding your vision.

Q. How do I use the Dental Plan?

A. The **Dental Plan** is administered by Varipro, Inc. 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 Varipro. You may give the information below to your dental provider:

County of Kent Dental Plan
c/o Varipro, Inc.
5300 Patterson Ave. SE, Ste. 150
Grand Rapids, MI 49512

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). Benefit information is available on the internet ***www.accesskent.com/benefits*** .

Premium Payments

Q. So, are there premium contribution changes this year?
A. No, full-time employees will continue to pay 20% of the monthly rate for medical and prescription coverage. Part-time employees will continue to pay the total premium cost for medical and prescription benefits, less a $35.00 per pay period credit.

Wellness Cash Incentives

Q. What do I need to do to receive my wellness cash incentives?
A. You'll need to comply with the following two steps:
- Physical Examination – You must complete an annual wellness examination to receive wellness cash. The payment will be applied after Human Resources receives the Wellness Exam Attestation form completed by both you and your physician.
- Non-smoker/Attempting to Quit Wellness Incentive – In order to receive the payment, you must return a Non-Smoking Attestation Form and indicate that you are a non-smoker or that you are enrolled in a smoking cessation program.

Q. When will the wellness incentives be applied to my paycheck?
A. You will not receive a 2.5% wellness cash incentive until you report that you have completed an annual physical exam. If you are a non-smoker or enrolled in a cessation program you will see the additional 2.5% wellness cash incentive applied after Human Resources has received your attestation form. If you return the completed attestation forms with your open enrollment form by the Open Enrollment Deadline, you will see the payment reflected on your second paycheck in January.

- **Attestation forms must be updated and submitted annually.**

Q. Where can I find information on smoking cessation programs?

A. Blue Cross Blue Shield and Blue Care Network participants may use the "Tobacco Cessation Coaching" program through WebMD. This is a 12-week program for individuals who are ready to quit using tobacco products. Over the 12-week period, individuals will receive 5 calls from a specially trained health coach and an optional two rounds of Nicotine Replacement Therapy.

Flexible Spending

Q. What is the difference between health care and dependent care reimbursement accounts?

A. Dependent care and health care reimbursement accounts are separate and are only used for specific expenses under IRS regulations.

Health Care: The funds in your health care reimbursement account (maximum of $2,850 subject to change) may be used to pay for many of your family's health care expenses that are not already covered by your health care plans, including deductibles, co-payments and expenses that exceed reasonable and customary limits.

Dependent Care: The Dependent Care Flexible Spending Account (maximum of $5,000) reimburses for childcare or adult dependent care expenses that are necessary to allow you or your spouse to work or attend school full-time. The Dependent Care Flexible Spending Account does NOT pay for medical care for your dependents.

Q. Does Flex Spending automatically roll over into 2023 if I elected it in 2022?

A. **No**. If you had a flexible spending account in 2022, you will need to re-elect these options for 2023 and specify the amount you are electing. Previous year elections for flexible spending do not roll over to the next year.

Q. What are the timelines for using my Flexible Spending contributions?

A. You will be allowed 14 1/2 months to receive reimbursement from your Health Care imbursement Account and Dependent Care Account. Your payroll deductions will be from January 1– December 31, but you will have until March 15, the following year to access medical services and be reimbursed. You may submit claims through March 31 of the following year.

If you have a balance in your Flexible Spending Account as of January 1, any services received through March 15, and claims submitted by March 31, will be applied to the previous year's fund balance before claims are paid with the current year's funds you elected.

Payroll deductions for your Dependent Care Reimbursement Account will be from January 1- December 31. The amount available for reimbursement at any time is limited to the amount in your account. The Flexible Spending Plan remains a use-or-lose benefit. Therefore, you would still LOSE any funds not used through the plan year.

Flexible Spending Accounts (cont'd)

Q. If I have someone come into my home to take care of my children instead of using a day care facility, do these expenses qualify for a dependent care FSA?

A. Yes. If the services are necessary for you (or, if you are married, you and your spouse) to work, you can include payments made to a babysitter or companion in or outside your home. Expenses will also qualify if you work and your spouse is a full-time student or is mentally or physically incapable of self-care. However, you *cannot* be reimbursed for payments made to:

- Your spouse
- A parent of your qualifying child
- Your child under age 19, even if that child is not your dependent
- Any person you claim as a dependent on your tax return

Q. Can I use the dependent care FSA for elder care? What if my elderly parent remains in his/her own home or a nursing home but is still my dependent?

A. You can use the dependent care FSA for elder care expenses so that you (or if you are married, you and your spouse) can work. To claim the expenses:

- Your parent must qualify as your dependent under the tax rules. Please see IRS Publication 503 at www.irs.gov for specifics.
- Your parent must be physically or mentally incapable of self-care.
- Your parent must reside in your home for at least half of the year.
- Your parent must usually spend at least eight hours a day in your home.

Q. Can I get reimbursed from my dependent care FSA as soon as I pay my childcare bill?

A. Under IRS guidelines, you can only be reimbursed for dependent care that has already taken place. Also, you can only be reimbursed for the amount that you have already contributed to your dependent care FSA. Unlike the health care FSA, the full amount of your dependent care election is not available January 1.

Life Insurance

Q. Are there any requirements to increase or newly elect supplemental life insurance?

A. During Open Enrollment in October 2021 ONLY: you have the option of increasing your election up to $100,000 without having to complete medical underwriting and be approved by the carrier.

After Open Enrollment in October 2021, you have the option of increasing your election up to $10,000 without having to complete medical underwriting and be approved by the carrier.

If you are:

- newly enrolling in the supplemental life plan; or
- electing to increase current coverage in an amount greater than $10,000; or
- if you have previously elected life insurance in an amount of $100,000 or greater and you choose to increase your coverage by any amount

then you will be required to complete medical underwriting and be approved by the carrier.

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Q. What do I need to do if I want to change my beneficiary(ies)?

A. You may change your beneficiaries at any time during the year. For example, you should review your beneficiary selections when you experience a life event such as marriage, divorce, or birth of a child. If you would like to make changes, please complete Part B of the Benefit Election Form. It is accessible on the internet at: www.accessKent.com/Benefits.

Remember that if you are designating a percentage rather than a flat amount to each beneficiary, the percentage needs to be in whole amounts (e.g. 33%, 33% and 34% for three beneficiaries).

Beneficiary changes to your pension and deferred compensation plans are different from life insurance. Please see the Retirement section of this booklet for more information.

Sickness and Accident (S&A) Plan

Q. What is a sickness and accident plan?

A. It is a short-term disability program. Administered by Morningstar, the plan pays you 67% of your weekly salary while you are ill or temporarily disabled.

Q. Is there a waiting period before the benefit is effective?

A. The benefit is effective on the first day if you are hospitalized, have an accident, or have in-patient or out-patient surgery. A waiting period of seven days applies in the case of a serious illness.

Q. Why do I need a sickness and accident plan?

A. To ensure financial security and a safety net for you and your family by paying a portion of your salary because of illness or injury

Sickness and Accident (S&A) Plan (cont'd)

Q. What is the advantage of the S & A Plan compared to a sick leave policy?

A. The advantages are:

- Provides financial security for you and your family
- More flexibility for time off – you can use your personal time for a variety of reasons; you are not restricted to your own illness

Q. What if I am injured at home and break my leg? What if I break my arm playing on a sports league?

A. Both injuries would be covered from the day of the accident with your doctor's verification.

Q. What if I'm pregnant and give birth to my baby? When is the benefit effective?

A. The benefit would be effective on the day you were hospitalized to give birth.

Q. Is outpatient surgery considered the same as a hospital stay?

A. If you are unable to work following outpatient surgery, your disability may be covered under the plan. Benefits begin the day of surgery.

Q. If I call into work for illness, and the illness becomes a long-term illness, when will I begin to receive benefits?

A. Following a waiting period – normally the eighth calendar day of illness.

Q. If the doctor admits me to the hospital in the above instance, when would my benefits begin?

A. If you are still within your waiting period, the benefits would begin on the day you are admitted to the hospital.

Q. May I use time from my old sick bank to fulfill the waiting period?

A. No. The "reserve" sick leave bank can only be used to supplement S&A. You cannot use the reserve sick bank for time off for an occasional sick day.

Q. How long can I collect benefits?

A. Benefits can be collected for up to 26 weeks for each injury/illness.

Q. How often is payment made?

A. Checks are issued once a week.

Q. Is there any way that I can earn more than 67% of my salary? I have bills to pay.

A. Yes. You can supplement the additional 33% with time from your reserve sick leave bank, or from other benefit time that you have available. You would receive that payment on your regularly scheduled County pay day.

Sickness and Accident (S&A) Plan (cont'd)

Q. Will I receive pension service credit for the period of time I'm on S&A?
A. If you make the required employee's portion of the pension contribution, you will receive pension service credit.

Q. If I have an illness for 2 days, can I receive benefits with the S&A plan?
A. No, you would use time from your personal time bank.

Q. If I do not have enough personal days to cover my time, can I use vacation time?
A. Yes, under County policy you must use available benefit time.

Q. How do I apply for S&A benefits?
A. Call the Human Resources Department at 632-7440 to be directed to a Benefits Specialist.

Long Term Disability Plan

Q. Are there any pre-existing condition limitations?
A. Yes. Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received treatment, care or services (including diagnostic measures) or for which a reasonable person would have consulted a physician during the 3 months just prior to the most recent effective date of insurance. Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured for at least 12 months after your most recent effective date of insurance.

Q. How will long term disability payments affect my pay from the County?
A. During the first 24 months that benefits are payable, benefits will be reduced if benefits plus income from employment exceeds 100% of pre-disability covered earnings. After that, benefits will be reduced by 50% of earnings from employment.

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. Is my social security number required to access my benefits?

A. For security reasons, it is best to use your Privacy ID number. This number starts with 9909 plus your employee ID# (e.g. 990998000) and is located on your medical and prescription cards. However, except for your prescription benefits, you can use your social security number, if necessary, to access your benefits.

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.

Q. Am I eligible for the payment in-lieu of insurance if I elect medical and prescription coverage with another plan that is not sponsored by Kent County?

A. Full-time employees can receive $35 per pay period when both medical and prescription coverage is waived and they are not enrolled in another Kent County Plan as a spouse or dependent.

Q. How do I ensure that I receive the $35 per pay period in-lieu of medical and prescription coverage?

A. If you are a full-time employee and waive medical and prescription coverage, and if you are eligible to receive the payment in-lieu of insurance, you must elect to waive medical and prescription coverage on your open enrollment form. You will begin receiving the $35 per pay period payment beginning with the second pay period of January, if you have insurance not sponsored by Kent County.

General Questions (cont'd)

Q. Where can I find information about my benefits?

A. Information about your benefits is located on the Kent County internet site (www.accesskent.com/Benefits/) under Forms-Human Resources, or you may contact Human Resources or your benefits carrier.

Kent County Benefit Department Contacts:

Rebecca Hatfield	Human Resources Specialist I	(616) 632-7471
Nicole Joyce	Human Resources Specialist I	(616) 632-7464
Mirela Ruiz	Human Resources Specialist I	(616) 632-7462
Holly Hartley	Benefits/Compensation Manager	(616) 632-7459

Retirement Services

Q. Where can I find information about the pension plan and deferred compensation plan?

A. The pension plan is a defined benefit plan with mandatory participation and is administered by Kent County. Employee contributions are made on a pre-tax basis via payroll deduction.

The deferred compensation plan (457) is a voluntary pre-tax retirement plan sponsored by Kent County with investment options and recordkeeping provided by Nationwide.

You can find information regarding the pension plan and deferred compensation plan on the Kent County internet site https://www.accesskent.com/Benefits/retirement.htm .

You may find contact information in the Employees' Retirement Plans section of this benefit book.

Also remember, when you experience a status change, such as a divorce or death, you will want to consider updating your elected beneficiaries on your pension, deferred compensation, and life insurance policies.

Q. How do I change my beneficiary election for my pension plan and/or deferred compensation plan?

A. You may download forms from the Kent County internet site by going to https://www.accesskent.com/Benefits/retirement.htm , or you may contact Human Resources to obtain these forms. You may elect to change beneficiaries and submit the forms directly to Human Resources to process your change.

IMPORTANT NOTICE FROM KENT COUNTY ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan and drop your County of Kent prescription drug coverage, be aware that **your current prescription drug coverage is 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.

IMPORTANT NOTICE FROM KENT COUNTY ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

IMPORTANT NOTICE FROM KENT COUNTY ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

Date:	September 23, 2022
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.

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.

County of Kent is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of 2.5% of the Medical and Prescription Premium for completing the Wellness Exam Attestation Form. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive 2.5%.

Additional incentives of up to 2.5% of the Medical and Prescription Premium may be available for employees who participate in the Non-smoking Attestation Form or participate in the Smoking Cessation Program. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources at 616-632-7440.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and County of Kent may use aggregate information it collects to design a program based on identified health risks in the workplace, County of Kent will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive.

WELLNESS PLAN DISCLOSURE

Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at 616-632-7440.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM

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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health- plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
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	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
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – 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: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.asp x 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	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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	SOUTH DAKOTA - 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: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462	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)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

1-866-444-EBSA (3272) 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 that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

DISCRIMINATION IS AGAINST THE LAW

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

County of Kent:

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

If you need these services, contact Darius Quinn. If you believe that County of Kent has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Darius Quinn, 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
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-616-632-7468
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-616-632-7468

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-616-632-7468
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-616-632-7468
AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-616-632-7468
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-616-632-7468 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-616-632-7468).
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-616-632-7468
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-616-632-7468

NO SURPRISE BILLING NOTICE

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

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

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

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

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

- Your health plan generally must:

  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

  - Cover emergency services by out-of-network providers.

  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

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

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

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

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

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