Kent County

Your Partner, Your Place

Understanding Your Benefits

2025 Benefits Guide

All Employees (Elected Employees)

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2025 Benefits Guide

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

What This Guide Will Do For You

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

Where to Find More Details

By retrieving information on www.accesskent.com/benefits you have can access detailed plan documents and certificates of coverage that provide a more in-depth look at the benefits available to you. For specific coverage questions, our insurance carriers are the best resource to confirm coverage. If asking about a specific procedure or prescription, please make sure to have as many details as possible available, such as procedure and diagnosis codes, dosage, and quantity.

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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.

I. General Information

Introduction

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 submitted 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, 2025.

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 8.

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

Complete Your Open Enrollment Form ✓

- **Elect an FSA, or update your HSA**

Submit Non-Smoking Attestation to Personify Health ✓

Provide Supporting Documents for Dependents ✓

Submit Wellness Attestation to Personify Health ✓

I. General Information

What's Changing in 2025?

- NEW **Rx Contain** Specialty Carveout Program for eligible participants taking certain specialty medications.
- You can now carry over up to $640 from your 2024 Healthcare FSA account into your 2025 Healthcare FSA account.

2025 Highlights

- Kent County will make a **ONE TIME** contribution into your Health Savings Account (HSA) for those that NEWLY enroll in the Wellness High Deductible Health Plan for 2025.
    - Enroll in Employee Only medical coverage and receive $1,000!
    - Enroll in Two Party or Family medical coverage and receive $2,000!
- ALEX, a decision support tool, can assist you in choosing the right coverage for you and your family!
    - More information on page 7!

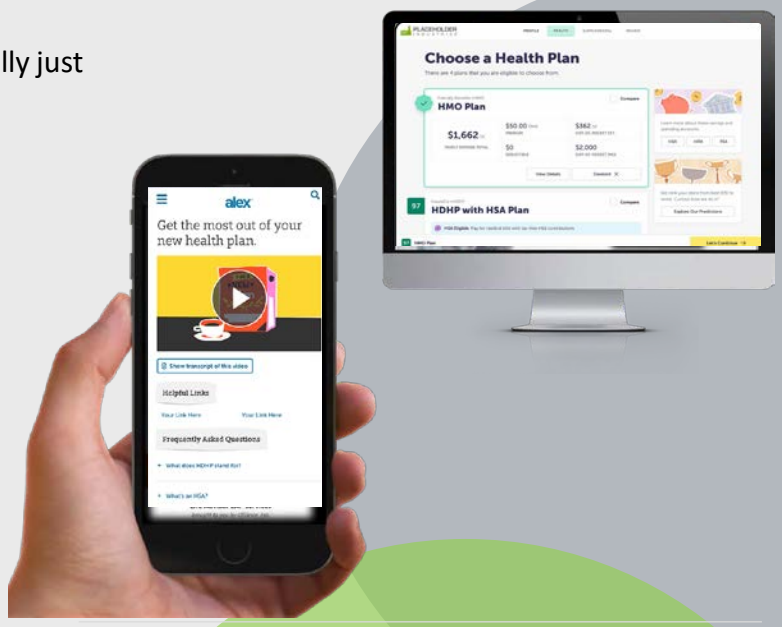
I. General Information

Meet ALEX

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

How long will this take?

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



Can I use ALEX on my phone?

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

Can I trust ALEX with my secrets?

Yes! Your ALEX experience is totally private and secure.

How should I prepare?

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

How does ALEX know what plan is best for me?

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

Get started at https://start.myalex.com/kent-county

I. General Information

Changing Your Elections and Eligibility Rules

Changing your elections

Benefits cannot be changed outside of the open enrollment period, except in the event of significant status changes (also know as a qualified event). These changes in circumstances include:

- Marriage, divorce, or legal separation,
- Birth or adoption of a child,
- A covered dependent reaching the limiting age (see Eligible Dependents section below),
- Death of a spouse or covered dependent,
- If you or your dependents have other coverage, but lose eligibility for that other coverage,
- Spouse's loss or gain of equivalent coverage through his/her employer, or
- Change in job status of employee or spouse.

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

Newborn Children

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

Eligible Dependents

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

Eligible Spouse:

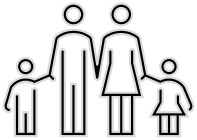
Your legally married spouse as defined by the State of Michigan.

Eligible Children:

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

Eligible Disabled Dependents:

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



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

Special Enrollment Rights

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

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

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

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

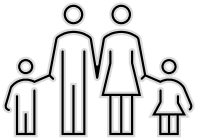
I. General Information

Changing Your Elections and Eligibility Rules

To Enroll Your…	1st Required Document – Must Provide	2nd Required Document – Must Also Provide
Spouse **Your legally married spouse**	A copy of your marriage certificate	Any document that lists both you and your spouse's name, mailing address, and is dated within the past 6 months (you may redact financial information). Examples: • A copy of your most recent filed federal income tax return confirming this dependent as a spouse, or • Any document dated within the past 6 months establishing your current relationship status, such as: o A joint household bill with both names o A joint bank or credit account with both names o Joint mortgage or lease with both names o An insurance policy with both names
Child(ren) **Your or your spouse's child are covered through the end of the month in which they turn age 26**	• A copy of the child's birth certificate, naming you or your spouse as the child's parent, or • A copy of a court order or adoption decree naming you or your spouse as the child's legal guardian, or • If applicable, a copy of a judgement of divorce granting full or joint custody (names of all parties must be included), or • If applicable, a copy of a court-issued Qualified Medical Support Order (QMSO), or • A copy of other court order where you or your spouse are required to provide healthcare (names of all parties must be included).	No additional documents are required to enroll child(ren).
Stepchild(ren) **Covered through the end of the month in which they turn 26**	• A copy of the child's birth certificate, naming you or your spouse as the child's parent, or • Appropriate court order or adoption decree naming you or your spouse as the child's legal guardian.	• A copy of your marriage certificate as proof of the dependent's relationship to the employee. • Any document that lists both you and your spouse's name, mailing address, and is dated within the past 6 months. See Examples listed above for Spouse.
Dependent with Disability	• A copy of the child's birth certificate, naming you or your spouse as the child's parent, or • Appropriate court order or adoption decree naming you or your spouse as the child's legal guardian.	• A copy of the front page of your most recent filed federal income tax return confirming that you claimed this dependent. You may redact any confidential financial information.

[1] A Dependent with a disability is 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 disability must have occurred by the end of the year in which the dependent turns 18.

NOTE: If the dependent with a disability is also a stepchild, the documents required for a spouse listed above will also be required.



I. General Information

Wellness Cash Incentives

Kent County Wellness 2025

The primary aim of Kent County's Wellness 2025 initiative is improved employee health. Here are the employee's options for Wellness Incentives in 2025:

PPO and HMO Cash Wellness Incentives

1. Employees enrolled in the PPO or HMO plan may earn a cash wellness incentive, payable in February 2026, by uploading their completed "Wellness Exam Attestation Form" by October 31, 2025 to the Kent County Personify Health (formerly Virgin Pulse) employee wellness platform. Note: the new Wellness Exam Attestation Form will now include reporting of employee cholesterol, blood sugar, blood pressure and BMI/circumference information.

Kent County Wellness Exam Incentives			
	Single	Two-Party	Family
BCBS PPO	$241.70	$507.58	$604.25
BCN HMO	$205.88	$477.71	$590.30

2. Employees enrolled in the PPO or HMO plan may earn an additional cash wellness incentive, payable in February 2026, by either:

   a. Accurately indicating on the Personify Health (formerly Virgin Pulse) system that they are a non-smoker and non-tobacco user by October 31, 2025 or,

   b. If they are a smoker and/or tobacco user, they will be required to complete the Personify Health (formerly Virgin Pulse) smoking or tobacco cessation program to earn the incentive.*

Kent County Non-Smoking Incentives			
	Single	Two-Party	Family
BCBS PPO	$241.70	$507.58	$604.25
BCN HMO	$205.88	$477.71	$590.30

Wellness High Deductible Health Plan (HDHP) 2025

In 2025 a Qualified High Deductible Health Plan (HDHP) with a Health Savings Account will be offered in addition to the current HMO and PPO plans. Eligible employees who newly enroll in the HDHP in 2025 will automatically receive a one-time County contribution to their Health Savings Account of $1,000 for single coverage or $2,000 for 2 person or family coverage upon enrollment.

Additionally, employees may earn an annual cash wellness incentive up to $1,000 for single coverage or $2,000 for 2 person or family coverage, payable in February 2026. The incentive may be earned as follows:

I. General Information

Wellness Cash Incentives

Required biometric data and award information for the Wellness High Deductible Health Plan:

Health Factor	Kent County Standard	Award if Standard Met	Alternatives to Receive Award
Cholesterol	• LDL less than 100mg/dl • HDL higher than 50mg/dl • Triglycerides less than 200mg/dl • Total Cholesterol less than 240 mg/dl *(HDL+LDL+20% Triglycerides)	$250 single or $500 family	Complete a County approved reasonable alternative program through Virgin Pulse.
Blood Sugar	• Fasting blood sugar level less than 125mg/dl	$250 single or $500 family	Complete a County approved reasonable alternative program through Virgin Pulse.
Blood Pressure	• Systolic: less than 140 mm Hg • Diastolic: less than 90 mm Hg	$250 single or $500 family	Complete a County approved reasonable alternative program through Virgin Pulse.
BMI / Body Circumference	• BMI less than 30 *(Weight in pounds/Height in inches x Height in inches) x 703 • Waist circumference o Male: less than 40 inches o Female: less than 35 inches	$250 single or $500 family	Complete a County approved reasonable alternative program through Virgin Pulse.
Tobacco Use	Attestation of no nicotine OR tobacco use	Employees enrolled in the HDHP will pay a bi-weekly surcharge equal to 10% of the healthcare premium if : 1. The employee is a tobacco user and fails to complete a County approved tobacco cessation program. 2. Any employee that does not smoke but fails to submit the non-smoking attestation form by the 10/31/25 deadline.	Complete a County approved tobacco cessation program through Virgin Pulse.

I. General Information

Wellness Cash Incentives

If employee does not meet the Center for Disease Control and Prevention (CDC) standard for any of the Biometric measurements, they will have to complete a County-approved health improvement plan. The health improvement plan only applies to the Wellness High Deductible Health Plan participants.

Important information:

- Wellness PPO and Wellness HMO plan participants only need to report Biometric data. They do not need to participate in a health improvement plan if they do not meet CDC standards.

- Only employees need to participate in the wellness program to benefit. Spouses and/or other dependents are not eligible to participate in the wellness incentives.

- The Wellness incentives earned in 2025 will be paid in February 2026 in a lump sum rather than throughout the year for all medical plans, Wellness High Deductible Health Plan, Wellness PPO & Wellness HMO.

- Employees must meet any applicable deadlines to complete required health improvement programs and/or submit information to the wellness vendor in the required timeframe to qualify for incentives.

- The information contained in this document does not, under any circumstances, supersede the terms and conditions outlined in any applicable Kent County Collective Bargaining Agreement (CBA), policy, procedure, benefit plan, instruction manual, or handbook. The above-described wellness incentives are subject to collective bargaining and will only apply if included in the current version of the collective bargaining agreement for any union represented employee.

You don't have to make these decisions on your own. We are offering a new tool called Alex to help. ALEX provides a hyper-personalized benefits experience to help employees choose, use and appreciate their benefits.

Medical Plan Options:

Kent County offers, to its full and part-time employees, 3 wellness medical plans to select from:

- Wellness Plan High Deducible Health Plan (HDHP) - Network coverage for this option is provided through Blue Cross Blue Shield of Michigan (BCBSM). The specific network is Blue Cross Blue Shield PPO.
- Wellness Plan Preferred Provider Organization (PPO) - Network coverage for this option is provided through Blue Cross Blue Shield of Michigan (BCBSM). The specific network is Blue Cross Blue Shield PPO.
- Wellness Plan Health Maintenance Organization (HMO) – Coverage for this option is provided by Blue Care Network (BCN)

Blue Cross Blue Shield of Michigan

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

The network, Blue Cross Blue Shield , is a preferred provider organization health care plan and consists of participating providers. These plans are designed to provide you the highest level of benefit payment and limit your out-of-pocket costs when you use physicians, hospitals and other health care specialists that are a part of the network. You may select any doctor or specialist of your choice, without a referral from your primary care physician. BCBSM Wellness Plan PPO and Wellness Plan High Deductible Health Plan give you the opportunity to receive care from either a network physician or an out-of-network physician. We suggest that you visit www.bcbsm.com for a list of Blue Cross Blue Shield PPO in-network providers.

Blue Care Network HMO

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

How to Choose a PCP: It is important to choose a PCP as soon as you become a member, so you can get the care you need. With thousands of qualified primary care physicians in network, how do you decide? Start with convenience. Search for physicians by county and city at www.bcbsm.com/find-a-doctor.

You can also search for a doctor by hospital affiliation and extended office hours. If you want more information, call the doctor's office or BCN Customer Service. Here are some questions to ask:

- Is the doctor in my plan?
- How many years has the doctor been in practice?
- What languages are spoken in the office?
- You can designate your PCP online or call customer service and tell BCN which PCP you selected.

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

Medical General Questions:

Blue Cross Online Visits

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

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

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

Diabetes Management:

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

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

II. Medical Coverage

Medical Plan Summary

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

II. Medical Coverage

Medical Plan Summary

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

II. Medical Coverage

Medical Plan Summary

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

II. Medical Coverage

Medical Plan Summary

	Wellness High Deductible Health Plan		Wellness PPO		Wellness HMO
	In Network	Out of Network	In Network	Out of Network	In Network
Preventative Services					
PCP Office Visits **Specialist Office Visits**	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 100% after $25 co-pay* Includes: Primary care and specialist physicians Presurgical consultations Initial visit to determine pregnancy	Covered - 65% after deductible	Covered - 100% after $20 co-pay Covered – 100% after $40 co-pay
Online Visits	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 100% after $25 co-pay	Covered - 65% after deductible	Covered – 100% after $20 co-pay
Outpatient and Home Visits	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 100% after $25 co-pay	Covered - 65% after deductible,	Covered – 100% after $20 co-pay for a PCP; $40 co-pay for a specialist
			One co-pay applies per visit. Deductibles may apply to services performed (e.g., lab, x- rays, etc.)		
Diagnostic Services					
Laboratory and Pathology Test	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Covered – 100%
Diagnostic Tests and X-rays	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Covered – 90% after deductible
Advanced Imaging	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Covered 100% following $150 co-pay after deductible
Radiation Therapy	Covered - 100% after deductible	Covered - 80% after deductible	Covered - 85% after deductible	Covered - 65% after deductible	Covered – 90% after deductible

II. Medical Coverage

Medical Plan Summary

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

II. Medical Coverage

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

II. Medical Coverage

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

III. Prescription Coverage
Prescription Summary

Capital Rx

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

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

- Generic – these drugs provide the most affordable way for you to obtain quality medications at the lowest co-payment. The U. S. Food and Drug Administration (FDA) requires that generic drugs have the same active chemical composition, same potency and be offered in the same form as their brand-name equivalents.

- Formulary (Preferred) brand-name – a list of medicines prepared by Capital Rx that helps identify products that are clinically appropriate and cost effective. These are brand-name drugs that generally have no generic equivalent and are commonly prescribed by physicians. The cost for preferred drugs is generally lower than non- preferred drugs.

- Non-formulary (Non-Preferred) brand-name – these are brand name drugs that have either equally effective or less costly generic alternatives or one or more preferred brand options. If you choose a drug in this tier, you are covered at a higher coinsurance level, which still represents a significant savings compared to the full retail cost.

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

Rx Cap Program – for those eligible, Capital Rx will maximize the value of manufacturer-sponsored patient assistance programs for commonly prescribed specialty drugs to drive plan savings without impacting member access or out-of-pocket obligation.
Rx Contain Program - for those eligible, Capital Rx will help members access enhanced patient assistance funding, making it easier to afford certain specialty medications.

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

III. Prescription Coverage
Prescription Summary

Value Investment Prescription Plan

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

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

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

Women's Preventive Services

To comply with Patient Protection and Affordable Care Act (PPACA), generics will be provided without cost share for contraceptive medicines and devices.
Additionally, under certain conditions, generic medications that reduce the risk of breast cancer may be covered by your Kent County pharmacy benefit plan at $0 cost-share if you meet the following conditions:

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

III. Prescription Coverage
Prescription Summary

Step Therapy

The cost of prescription drugs continues to rise, for both you and the County. To help control costs and make sure you get the proper medicine, Kent County has implemented a step therapy program.
The step therapy program helps flatten rising prescription costs by encouraging you to use formulary medications as the first step in your treatment plan. Some medications deliver similar value, safety, and effectiveness, but cost less than others. Step therapy identifies those cost saving medications for you and your pharmacy benefit plan. By trying first-line therapies, you actively help to manage the cost of your pharmacy benefit

What is Step Therapy?

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

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

How Does it Work?
Medications included in our step therapy program fall into two categories:

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

Step 2 Medications- brand medications that are typically more expensive than a step 1 medication.

Understanding Step Therapy

Capital Rx

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

↓

Pharmacy processes member's new step 2 prescription

↓

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

↓

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

↓

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

↓

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

III. Prescription Coverage
Prescription Summary

Kent County Prescription Plan Schedule of Prescription Drug Benefits

CO-PAYMENTS

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

PLAN PARAMETERS

- Maximum days' supply at the pharmacy window: 90-days
- Maximum days' supply when you use mail order: 90-days
- When you fill a prescription at the pharmacy window, you must consume 75% of the supply before a refill is authorized
- When you fill a prescription through mail order, you must consume 50% of the supply before a refill is authorized
- Pre-Authorization may apply for certain medications.
- NOTE: For non-covered medications, please refer to "Exclusions" in the Plan Document.

Dental Care Services:

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.

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)

IV. Other Benefit Information

Vision

VSP Coverage:

The vision plan offers additional value-added enhancements to the services it provides to Kent County employees. Full Time employees are encouraged to review those additional benefits on the internet at www.accessKent.com/Benefits.

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.
With private practice doctors and Visionworks retail locations to choose from nationwide, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

vsp PREMIER edge — 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:
01/01/2025

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**

BENEFIT	DESCRIPTION	COPAY
YOUR COVERAGE WITH A VSP PROVIDER		
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening • Every 12 months	$0 Up to $39
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • 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 network doctor for details. • Available as needed	$20 per exam
PRESCRIPTION GLASSES		**$20**
FRAME+	• $225 Featured Frame Brands allowance • $225 Visionworks frame allowance on any frame • $175 frame allowance • 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	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Anti-glare coating • Impact-resistant lenses • UV protection • Average savings of 30% on other lens enhancements • Every 24 months	$0 $95 - $105 $150 - $175 $25 $0 $0
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 24 months	Up to $60
VSP 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
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last 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.		

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

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

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

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102886 VCCM

Classification: Restricted

V. Plan Cost

Wellness High Deductible Health Plan Monthly Coverage Rates

NOTE: Commissioners pay the entire premium cost for medical and prescription benefits associated with the Wellness High Deductible Health Plans.

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.

Wellness High Deductible Health Plan (BCBSM)			
	Employee Cost (Full-Time)	County Cost	Total Cost
Single	$517.28		$517.28
Two-Party	$1,086.30		$1,086.30
Family	$1.293.21		$1,293.21

Prescription Plan with Wellness High Deductible Health Plan (Capital Rx)			
	Employee Cost (Full-Time)	County Cost	Total Cost
Single	$168.72		$168.72
Two-Party	$354.32		$354.32
Family	$431.81		$431.81

V. Plan Cost

Wellness PPO and Wellness HMO Plan Monthly Coverage Rates

NOTE: Commissioners pay the entire premium cost for medical and prescription benefits associated with the Wellness PPO and Wellness HMO Plans.

Wellness PPO (BCBSM)	Employee Cost (Full-Time)	County Cost	Total Cost
Single	$623.33		$623.33
Two-Party	$1,308.99		$1,308.99
Family	$1,558.32		$1,558.32

Wellness HMO (BCN)	Employee Cost (Full-Time)	County Cost	Total Cost
Single	$503.93		$503.93
Two-Party	$1,209.44		$1,209.44
Family	$1,511.80		$1,511.80

Prescription Plan with PPO and HMO Medical Plans (Capital Rx)	Employee Cost (Full-Time)	County Cost	Total Cost
Single	$182.35		$182.35
Two-Party	$382.93		$382.93
Family	$455.86		$455.86

Kent County Dental Plan (Full-Time Only)	Employee Cost	County Cost	Total Cost
Single	$96.26		$96.26
Two-Party	$96.26		$96.26
Family	$96.26		$96.26

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

V. Plan Cost

Wellness High Deductible Health Plan Monthly Coverage Rates

NOTE: Elected Officials and Judges pay 15% premium cost for medical and prescription benefits associated with the Wellness High Deductible Health Plans.

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.

Wellness High Deductible Health Plan (BCBSM)	Employee Cost (Full-Time)	County Cost	Total Cost
Single	$77.59	$439.69	$517.28
Two-Party	$162.94	$923.36	$1,086.30
Family	$193.98	$1,099.23	$1,293.21

Wellness High Deductible Health Plan (BCBSM) with Smoking Surcharge	Employee Cost (Full-Time)	County Cost	Total Cost
Single	$129.32	$387.96	$517.28
Two-Party	$214.67	$871.63	$1,086.30
Family	$245.70	$1,047.51	$1,293.21

Prescription Plan with Wellness High Deductible Health Plan (Capital Rx)	Employee Cost (Full-Time)	County Cost	Total Cost
Single	$25.30	$143.42	$168.72
Two-Party	$53.14	$301.18	$354.32
Family	$63.27	$358.54	$421.81

V. Plan Cost

Wellness PPO and Wellness HMO Plan Monthly Coverage Rates

NOTE: Elected Officials and Judges pay 20% premium cost for medical and prescription benefits associated with the Wellness PPO and Wellness HMO Plans.

Wellness PPO (BCBSM)	Employee Cost (Full-Time)	County Cost	Total Cost
Single	$124.66	$498.67	$623.33
Two-Party	$261.79	$1,047.20	$1,308.99
Family	$311.66	$1,246.66	$1,558.32

Wellness HMO (BCN)	Employee Cost (Full-Time)	County Cost	Total Cost
Single	$100.78	$403.14	$503.93
Two-Party	$241.88	$967.55	$1,209.44
Family	$302.36	$1,209.44	$1,511.80

Prescription Plan with PPO and HMO Medical Plans (Capital Rx)	Employee Cost (Full-Time)	County Cost	Total Cost
Single	$36.47	$145.88	$182.35
Two-Party	$76.58	$306.35	$382.93
Family	$91.17	$364.69	$455.86

Kent County Dental Plan (Full-Time Only)	Employee Cost	County Cost	Total Cost
Single	$0.00	$96.26	$96.26
Two-Party	$0.00	$96.26	$96.26
Family	$0.00	$96.26	$96.26

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

VI. Pre-Tax Accounts
Health Savings Account

Health Savings Account:

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

HSA Advantages

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

Financial Institution

- Health Equity will administer your account and provide you with a debit card.
- The 2025 HSA contribution maximums are $4,300 if enrolled in single coverage, or $8,550 if enrolled with one or more dependents. There is an additional $1,000 catch up contribution that can be added for individuals aged 55 or older. You must include (count) any employer contributions in the annual contribution maximum.

Using your HSA

At the Physician's Office

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

At the Pharmacy

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

Eligible Expenses

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

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

VI. Pre-Tax Accounts
Flexible Spending Accounts

Flexible Spending Accounts:

There are two Flexible Spending Accounts (FSA) options available to you. Both are administered by **Varipro.**

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.

Use It or Lose It

It's important to consider your expenses for the year. Both the Health Care FSA and Dependent Care FSA have a "use it or lose it" rule. This means if there are unused funds in the account(s) at the end of the year, funds are forfeited and not returned to you.

You are allowed the maximum carry-over amount determined the by IRS from your 2025 Healthcare FSA account into your 2026 Healthcare FSA account. Leftover funds beyond the maximum carry-over amount in the Health Care FSA will be forfeited.

Your payroll deductions will be from January 1, 2025 through December 31, 2025.

You are allowed 14 1/2 months, instead of 12 months, to receive reimbursement from your Dependent Care FSA for Plan Year 2025. Your payroll deductions were from January 1, 2025 through December 31, 2025 but Kent County has established a two-and-a- half-month grace period until March 15, 2026 for you to use your 2025 contributions. All claims must be reimbursed by March 31, 2026.

Health Care Flexible Spending Account

A Health Care Flexible Spending Account is a pre-tax account funded through employee elected payroll deductions to pay for health care expenses including medical, dental and vision. **The maximum annual HCFSA election allowed is $3,200** and funds are available to right away. You may not enroll in the Health Care FSA if you are enrolled in the Kent County Wellness High Deductible Health Plan with HSA. Instead, you would contribute pre-tax funds into your Health Savings Account.

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.

Dependent Care Flexible Spending Account

A Dependent Care Flexible Spending Account is a pre-tax account funded through employee elected payroll deductions to pay for dependent care expenses. To qualify, the dependent care must be essential for you and your spouse to work, look for work, or attend school full time. **The maximum annual DCFSA election allowed is $5,000 per household**. Funds are only accessible as they are deposited with each payroll deduction.

Qualified Dependents

- Children under the age of 13
- A spouse who is physically or mentally unable to care for him/herself
- Any adult you can claim as a dependent on your tax return that is physically or mentally unable to care for him/herself

VII. Other Benefit Information

Life Insurance

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 and in $50,000 increments from $200,000 to $450,000. Supplemental coverage is subject to the insurance carrier's underwriting and approval process.

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

VII. Other Benefit Information

Life Insurance

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:

$ of Desired Insurance x **Rate** / **$1,000** = **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.

$50,000 ($ of Desired Insurance) x **0.209** (Rate) / **$1,000** = **$10.45** 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, with the exception of those enrolling in coverage during the 2024 open enrollment window for coverage effective in 2025.

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.

VII. Other Benefit Information

Life Insurance

Dependent Life

Judges, Elected Officials and Commissioners 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.

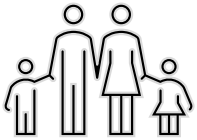
Dependents are defined as follows:

- Spouse means your current lawful spouse.
- Dependent Child means your unmarried child if he or she meets the following requirements:
    - A child from live birth to 19 years old;
    - 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;
    - 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 dependent life coverage is provided.



IX. General Information

Contact Information

	Carrier	Contact
Medical	Blue Cross Blue Shield of Michigan Blue Care Network	Customer Service: (888) 890-5754 Blue Cross Blue Shield of Michigan Customer Service: (800) 662-6667 Blue Care Network
Prescription Drugs	Capital Rx	(844) 532-2779 www.cap-rx.com Capital Rx
Dental	Varipro	(616) 285-2480 www.varipro.com
Vision	Vision Service Plan (VSP)	(800) 877-7195 www. vsp.com
Health Savings Account	Health Equity	(866) 735-8195 www.healthequity.com
Flexible Spending Account	Varipro	(616) 285-2480 www.varipro.com
Life Insurance/ Long Term Disability	New York Life	For Claims (888) 842-4462 For Converting (800) 423-1282 myNYLGBS.com Claims Pghlif2@newyorklife.com
Wellness	Virgin Pulse	More Information Coming in 2024!
Insurance Agent	Advantage Benefits Group	(616) 458-3597 Mike Cutlip (Agent): mcutlip@advantageben.com Steve Miller (Agent): smiller@advantageben.com

X. Employee Important Information
FAQs

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 Form
- Supporting Document(s) for New Spouse or 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. Yes. Everyone must complete the open enrollment form even if you are not making any changes to your benefit coverages.

Q. How do I return my enrollment form?
A. The Open Enrollment form should be completed in Onbase. HR will automatically receive a copy of the completed form

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, your 2024 flexible spending elections will not carry over into the new year. Changes to your open enrollment form submitted after the open enrollment deadline will not be processed.

X. General Information

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

X. Employee Information
FAQs

Medical Benefits

Q. What are my medical plan options?
A. Blue Cross/Blue Shield Wellness High Deductible Health Plan, Wellness PPO Plan and Blue Care Network Wellness HMO.

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 for in-network services. The co-pay applies as many times as you access services requiring an office, urgent care, or emergency room visit or fill a prescription up to the applicable out-of-pocket maximum. The co-pay does not apply to the deductible.

Q. I brought my dependent 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.

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.

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

Q. How does the out-of-pocket maximum work on a high deductible health plan?
A. All in-network services track towards your plan out of pocket maximum, with the exception of preventive care. Once you reach your out-of-pocket maximum, the plan will pay 100% of all covered in-network services copays no longer apply once you've satisfied your out-of-pocket maximum.

X. Employee Information
FAQs

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 $4,500 for an individual and $9,000 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. What are our 2025 prescription drug copays?

A. If enrolled in Wellness PPO or Wellness HMO:

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

If enrolled in Wellness High Deductible Health Plan:

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

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

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

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

X. Employee Information
FAQs

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. Depends on which plan you enroll in. Capital Rx will provide you with a prescription drug ID card to fill prescriptions (separate from your medical coverage card) if you're enrolled in the Wellness PPO or Wellness HMO plans. If you enroll in the Wellness High Deductible Health Plan, you only receive 1 ID card, this card will come from BCBSM but will have Capital Rx's detail on the back of the ID card.

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? Reminder to use ALEX
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 a certain ACA mandated percentage 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 username 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*** .

X. Employee Information
FAQs

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 if you enroll in the Wellness PPO or Wellness HMO. If you enroll in the Wellness High Deductible Health Plan you will pay 15% of the monthly rate. Part-time employees will continue to pay the total premium cost for medical and prescription benefits, less a $35.00 per pay period credit.

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.

X. Employee Information
FAQs

Life Insurance

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

A. 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.

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 tab at www.accesskent.com/benefits

X. Employee Information
FAQs

General Questions

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

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

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

*Documentation of proof is required to make changes such as a copy of a marriage certificate, finalized divorce decree, proof of loss of other coverage, etc. You may, however, make changes to your beneficiaries at any time during the year.

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

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

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.

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

Medicare Information:

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan and drop your County of Kent prescription drug coverage, be aware that your current prescription drug coverage is part of your medical coverage from County of Kent. You cannot drop your County of Kent prescription drug coverage unless you also drop your County of Kent medical coverage. If you enroll in a Medicare Part D plan and drop your creditable coverage with County of Kent, you may not be able to return to the same plan through County of Kent until the next enrollment period.

Medicare Information:

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

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

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

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

Contact 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).

XI. Medicare

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, 2025
Name of Entity/Sender:	Kent County
Contact--Position/Office:	Human Resources
Address:	300 Monroe Ave NW Grand Rapids, MI 49503
Phone Number:	616-632-7440

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

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

Our Pledge Regarding Your Protected Health Information

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

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

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

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

Patient Protection Disclosure

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

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

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

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

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

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

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

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

Special Situations

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

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

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

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

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

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

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

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

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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.

XII. Other Information

Wellness Plan Disclosures

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.

XII. Other Information

Wellness Plan Disclosures

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.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

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

XIV. Medicaid

Medicaid & Children's Health Insurance Program

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

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

XIV. Medicaid

Medicaid & Children's Health Insurance Program

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

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

XIV. Medicaid

Medicaid & Children's Health Insurance Program

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

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

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

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

XIV. No Surprise Billing

Your Right and Protections Against Surprise Medical Bills

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

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

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

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

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

You're protected from balance billing for:

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

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

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

XIV. No Surprise Billing

Your Right and Protections Against Surprise Medical Bills

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

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

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

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

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

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

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

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

XV. Laws and Regulations

General Information

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

County of Kent:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

Qualified sign language interpreters
Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

Qualified interpreters
Information written in other languages
If you need these services, contact Darius Quinn. If you believe that County of Kent has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Darius Quinn, 3000 Monroe Avenue NW, Grand Rapids, MI 49503, P: 1- 616-632-7468, F: 1-616-632-7445, E: darius.quinn@kentcountymi.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Darius Quinn is available to help you.

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

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

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-616-632-7468
注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。請致電 1-616-632-7468
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-616- 632-7468
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-616-632-7468번으로 전화해 주십시오.
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-616-632-7468
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-616-632-7468
7468-632-616-1ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-616-632-7468

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

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

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

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

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

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

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.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

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

Notes

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Kent
County
Your Partner, Your Place