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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 53 for more details.
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 returned to Human Resources, prior to the end of open enrollment, even if no changes are being made. Your benefit coverage elections will become effective January 1, 2018.

Following the end of the open enrollment period, Human Resources will post your confirmation statement to your Digital PayStub account. In the event that the confirmation statement does not accurately reflect your benefit elections, contact Human Resources. The confirmation statement is only for making corrections to processing errors; it is not an opportunity to change or make new elections. Otherwise, benefits will be administered for the plan year as detailed on your confirmation statement. You will not have the opportunity to change your benefit elections again until the next open enrollment period, unless you experience a specific life event change as outlined on page five.

The following plan descriptions are brief and are not intended to give you all of the details about the available plans. You should refer to, and rely on, the actual plan documents for complete information. Summary Plan Descriptions are available on the Kent County internet site at www.accesskent.com/benefits or from Human Resources.

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

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

**My Checklist**

- Open Enrollment Form
- Flexible Spending Election
- Wellness Exam Attestation Form
- Non-Smoking Attestation Form
- Supporting Document(s) for New Dependents
The Human Resources Department is using technology tools to make your elections quicker and easier. Open enrollment material will no longer be mailed to your home.

OPEN ENROLLMENT INFORMATION & FORMS

- The enrollment form will be available online at www.accesskent.com/benefits. Electronically complete the form. Enroll in or change plans. Ensure your dependents are covered. Click “Save As” and keep a copy.
- Print the enrollment form and sign it.
- Be sure you include (or have already submitted) the necessary attestation forms and, if you’re adding dependents, the appropriate supporting documentation.
- Scan your completed, signed form(s), attach to an e-mail, and send to:

  HRBenefits@kentcountymi.gov; or
  Mail to Kent County Human Resources
  300 Monroe Ave.
  Grand Rapids, MI 49503; or
  Interoffice to HR / Benefits; or
  Hand deliver to Human Resources/Admin Bldg., 2nd Floor

CURRENT BENEFITS ELECTIONS

- Your current elections are outlined on the Confirmation of Benefits Form. This form is available on-line in Digital Paystub. If you haven’t already set-up a password, directions to do so can be found on the internet. If you need assistance, the IT Help Desk is available to assist you.
- When you enter Digital Paystub, click the “benefit election” tab. Follow the instructions at the top of the page.
WHAT’S CHANGING IN 2018?

Enhancement to Medical Plans:

Blue Cross Online Visits™

Effective January 1, 2018, employees and their families with Blue Cross Blue Shield of Michigan or Blue Care Network can get fast, affordable online medical and behavioral health care by accessing the BCBSM Online Visits™ app, by visiting the web or via phone. This service allows you to simply use your smartphone, tablet or computer to meet face-to-face online with a U.S. board-certified doctor.

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

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

Changes because of PPACA (Patient Protection and Affordable Care Act)

Plans Must Continue Cost Sharing Limitations

Cost-sharing limitations have been imposed under Health Care Reform. In 2018, a member’s out-of-pocket maximums for medical expenses are limited to $3,150 for an individual and $6,300 for family coverage. The out-of-pocket maximum as defined by the PPACA includes co-pays, deductibles and coinsurance. For prescription drug coverage, a member’s out-of-pocket maximums are limited to $4,200 for an individual and $8,400 for a family. Total combined employee cost for medical and prescriptions cannot exceed the federal annual limit of $7,350 for an individual and $14,700 for a family-adjusted annually.

Changes to Statins Coverage due to ACA Requirement

ACA will require statins to be covered at $0 cost-share effective Nov. 1, 2017 for members who meet specific coverage criteria:

• Being age 40-75 and
• Having one or more cardiovascular risk factors such as dyslipidemia, diabetes, hypertension, or smoking, and
• Having a calculated 10-year risk of a cardiovascular event of 10% or greater. This will require universal lipid screening for this age group.
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. 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 in order 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, as long as the County is timely notified. If you submit a completed Benefit Election Form and copy of Birth Certificate more than 30-days after the birth, you will not be able to add your newborn to your health insurance until the next open enrollment period. In that case, benefits would not be effective until January 1st of the next calendar year.

ELIGIBLE DEPENDENTS

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

Eligible SPOUSE:
- Your legally married spouse as defined by the State of Michigan.

Eligible CHILDREN:
- Your or your spouse’s child through the end of the month in which they turn 26.

Eligible DISABLED DEPENDENTS:
- An unmarried child 26 years of age or older who depends on you or your spouse for support as they are unable to support themselves due to a mental or physical condition. The child must depend on you or your spouse for financial support. The disability must have occurred by the end of the year in which the dependent turns 26.
A child is defined as your or your spouse’s natural child, stepchild, legally adopted child, a child placed with you for adoption, a child for whom you are required to provide health insurance by a Qualified Medical Child Support Order, or a child for whom you or your spouse have legal guardianship.

<table>
<thead>
<tr>
<th><strong>Special Enrollment Rights</strong></th>
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<tr>
<td>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).</td>
</tr>
<tr>
<td>In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30-days after the marriage, birth, adoption, or placement for adoption.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>To request special enrollment or obtain more information, contact HR.</td>
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PROOF OF ELIGIBILITY DOCUMENT REQUIREMENTS

The County reserves the right to require proof of eligibility. In order to add dependents to your plan, documentation is required for proof of eligibility. See requirements below. To ensure confidentiality, please write “NOT FOR OFFICIAL USE” and BLOCK OUT all social security numbers or income information on all documents. Intentionally providing false information is a violation of County policy and could result in disciplinary action.

FOR SPOUSE: Provide documentation listed below.

- A copy of your marriage certificate \textbf{AND}
- A copy of the front page of your most recently filed federal tax return confirming this dependent as a spouse, \textbf{OR} documentation dated within the last 6 months establishing current relationship status such as a joint household bill, joint bank/credit account, joint mortgage/lease, or insurance policies. The document must list you and your spouse’s name, the date, and mailing address.

FOR CHILDREN: Provide documentation listed below.

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

FOR STEPCHILDREN: Provide documentation listed below.

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

FOR DISABLED DEPENDENTS: Provide documentation listed below.

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

\textbf{Note: If this disabled dependent is a stepchild, the documentation required for a spouse listed above will also be required.}
WELLNESS CASH INCENTIVES

WELLNESS EXAM CASH INCENTIVE:

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

Your 2017 annual physical counts towards the 2018 wellness cash incentive. An employee will receive the wellness cash when the physical has been completed and the employee and his/her physician complete and submit the “Wellness Exam Attestation Form”. Wellness cash incentives will be applied to the employee’s paycheck going forward from the date the form was received by Human Resources for the balance of the plan year.

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

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

NON-SMOKER/ATTEMPTING TO QUIT WELLNESS INCENTIVE

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

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

Blue Cross Wellness PPO and Blue Care Network HMO Participants:

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

1 OUT OF 3 CANCER DEATHS COULD BE PREVENTED

SMOKING CAUSES CANCER

IN THE
LUNGS • TRACHEA
BRONCHUS • ESOPHAGUS
ORAL CAVITY • LIP
NASOPHARYNX
NASAL CAVITY • LARYNX
STOMACH • BLADDER
PANCREAS • KIDNEY
LIVER • UTERINE CERVIX
COLON • RECTUM
AND CAUSES LEUKEMIA

Smoking can cause cancer almost anywhere in the body.
Wellness Attestation Forms:

There are two different Wellness Attestation Forms available:

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

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

Properly completed attestation forms received by the end of the open enrollment period (October 18, 2017) will result in your receiving the appropriate wellness cash incentive starting with the first deduction for the 2018 plan year. (December 2017)

Attestation forms may be turned in any time during the calendar year. Wellness incentives will be applied to your paycheck going forward from the date the form was received by Human Resources for the balance of the plan year.

Attestation forms must be updated and submitted annually.

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at 616-632-7440 and we will work with you to develop another way to qualify for the reward.
Kent County offers, to its full and part-time employees, wellness medical plans with the option of choosing either:

- Wellness Plan Preferred Provider Organization (PPO) - Network coverage for this option is provided through Blue Cross Blue Shield of Michigan (BCBSM). The specific network is Blue Cross Blue Shield PPO.

- Wellness Plan Health Maintenance Organization (HMO) – Coverage for this option is provided by Blue Care Network (BCN), a fully-funded HMO.

**Blue Cross Blue Shield of Michigan**

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

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

BCBSM Wellness Plan PPO gives you the opportunity to receive care from either a network physician or an out-of-network physician. We suggest that you visit [www.bcbsm.com](http://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 fully-funded 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?

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

- Is the doctor in my plan?
- How many years has the doctor been in practice?
- What languages are spoken in the office?

You can designate your PCP online or call customer service and tell BCN which PCP you selected.

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

**Blue Cross Online Visits™**

Effective January 1, 2018, 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 service it provides to Kent County employees. Employees are encouraged to review those additional benefits on the internet at [www.accesskent.com/benefits](http://www.accesskent.com/benefits).
**Patient Protection Disclosure**

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

You do not need prior authorization from BCN or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in 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](http://www.bcbsm.com).
## MEDICAL PLANS COMPARISON OF BENEFITS

<table>
<thead>
<tr>
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<th>Blue Care Network Wellness HMO</th>
<th>Blue Cross/Blue Shield Wellness PPO</th>
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<tr>
<td><strong>In Network</strong></td>
<td></td>
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<tr>
<td>Flat Dollar Co-Pays</td>
<td>$20 for Office visits</td>
<td>$25 co-pay for:</td>
</tr>
<tr>
<td></td>
<td>$20 for Online visits</td>
<td>• Office visits</td>
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<tr>
<td></td>
<td>$40 for Specialist visits</td>
<td>• Online visits</td>
</tr>
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<td></td>
<td>$100 for Emergency Room</td>
<td>• Urgent care</td>
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<tr>
<td></td>
<td>$20 Urgent Care</td>
<td>• Emergency Room Services</td>
</tr>
<tr>
<td>Deductible</td>
<td>$250 per individual, $500 per two-party/family</td>
<td>$300 per individual, $600 per two-party/family</td>
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<tr>
<td></td>
<td>$600 per individual, $1,200 per two-party/family</td>
<td>In-Network and Out-Of-Network deductibles accumulate separately per calendar year.</td>
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<tr>
<td>Coinsurance</td>
<td>10% unless otherwise noted</td>
<td>15%, unless otherwise noted</td>
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<td></td>
<td>50% for private duty nursing</td>
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<tr>
<td></td>
<td></td>
<td>35%, unless otherwise noted</td>
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<td></td>
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<td>50% for private duty nursing</td>
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<tr>
<td><strong>Out-Of-Network</strong></td>
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<tr>
<td>Flat Dollar Co-Pays</td>
<td>Does not apply</td>
<td>Does not apply</td>
</tr>
<tr>
<td>Coinsurance Maximums – Excludes Deductibles</td>
<td>Does not apply</td>
<td>Does not apply</td>
</tr>
<tr>
<td>Deductible</td>
<td>$3,150 per individual, $6,300 per two-party/family</td>
<td>$3,150 per individual, $6,300 per two-party/family</td>
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<td></td>
<td>$6,300 per individual, $12,600 per two-party/family</td>
<td>$6,300 per individual, $12,600 per two-party/family</td>
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<tr>
<td>Co-Insurance Co-Insurance / Dollar Maximums</td>
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<tr>
<td>Flat Dollar Co-Pay</td>
<td>Does not apply</td>
<td>Does not apply</td>
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<tr>
<td>Preventive Services</td>
<td></td>
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<tr>
<td>Health Maintenance Exam</td>
<td>Covered - 100%</td>
<td>Covered - 100%</td>
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<td>One per calendar year - beginning age 16, includes related X-rays, EKG, and lab procedures performed as part of the physical exam.</td>
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<tr>
<td>Annual Gynecological Exam</td>
<td>Covered - 100%, one per calendar year</td>
<td>Covered - 100%, one per calendar year</td>
</tr>
<tr>
<td>Pap Smear Screening – laboratory services only</td>
<td>Covered - 100%, one per calendar year</td>
<td>Covered - 65% after deductible, one per calendar year</td>
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<tr>
<td>Well Baby and Well Child Visit</td>
<td>Covered - 100%</td>
<td>Covered - 100%, through age 15</td>
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<td></td>
<td>8 visits, birth through 12 months</td>
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<td>6 visits, 13 months through 23 months</td>
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<td></td>
<td>6 visits, 24 months through 35 months</td>
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<td></td>
<td>2 visits, 36 months through 47 months</td>
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<tr>
<td></td>
<td>visits beyond 47 months are limited to one per member per calendar</td>
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<tr>
<td>Immunizations, Adult and Pediatric</td>
<td>Covered - 100%</td>
<td>Covered - 100%</td>
</tr>
<tr>
<td>Fecal Occult Blood Screening</td>
<td>Covered - 100%, one per calendar year</td>
<td>Covered - 65% after deductible, one per calendar year</td>
</tr>
<tr>
<td>Service</td>
<td>Blue Care Network Wellness HMO</td>
<td>Blue Cross/Blue Shield Wellness PPO</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Endoscopic Exam (includes colonoscopy)</td>
<td>Covered - 100%, one per calendar year</td>
<td>Covered - 100%, one per calendar year</td>
</tr>
<tr>
<td>Preventive Services (Cont’d)</td>
<td><strong>In Network</strong></td>
<td><strong>Out-Of-Network</strong></td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) Screening</td>
<td>Covered - 100%, one per calendar year</td>
<td>Covered - 65% after deductible, one per calendar year</td>
</tr>
<tr>
<td>Mammography Screening</td>
<td>Covered - 100%, one per calendar year – no age restrictions</td>
<td>Covered - 65% after deductible, one per calendar year</td>
</tr>
<tr>
<td>Voluntary Sterilization</td>
<td>Female – Covered – 100%</td>
<td>Covered - 65% after deductible</td>
</tr>
<tr>
<td>Contraceptive Devices</td>
<td>Approved devices covered – 100%</td>
<td>All FDA-approved devices covered – 65% after deductible</td>
</tr>
<tr>
<td>Physician Office Services</td>
<td><strong>In Network</strong></td>
<td><strong>Out-Of-Network</strong></td>
</tr>
<tr>
<td>PCP Office Visits</td>
<td>Covered - 100% after $20 co-pay</td>
<td>Covered - 100% after $25 co-pay*</td>
</tr>
<tr>
<td>Specialist Office Visits</td>
<td>Covered – 100% after $40 co-pay</td>
<td>Includes:</td>
</tr>
<tr>
<td>Online Visits</td>
<td>Covered – 100% after $20 co-pay</td>
<td>- Primary care and specialist physicians</td>
</tr>
<tr>
<td>Outpatient and Home Visits</td>
<td>Covered – 100% after $20 co-pay for a PCP; $40 co-pay for a specialist</td>
<td>- Presurgical consultations</td>
</tr>
<tr>
<td>Emergency Medical Care</td>
<td><strong>In Network</strong></td>
<td><strong>Out-Of-Network</strong></td>
</tr>
<tr>
<td>Hospital Emergency Room –</td>
<td>Covered – 100% following $100 co-pay after deductible; co-pay does not apply if admitted</td>
<td>Covered – 100% following $125 co-pay*; co-pay waived if admitted</td>
</tr>
<tr>
<td>Ambulance Services – Medically Necessary</td>
<td>Covered – 90% after deductible</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Urgent Care Visits</td>
<td>Covered – 100% after $20 co-pay</td>
<td>Covered - 65% after deductible</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td><strong>In Network</strong></td>
<td><strong>Out-Of-Network</strong></td>
</tr>
<tr>
<td>Laboratory and Pathology Test</td>
<td>Covered – 100%</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Diagnostic Tests and X-rays</td>
<td>Covered - 90% after deductible Advanced Imaging,</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td></td>
<td>Covered – 100% following</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Service</td>
<td>Blue Care Network Wellness HMO</td>
<td>Blue Cross/Blue Shield Wellness PPO</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td></td>
<td>In Network</td>
<td>Out-Of-Network</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Maternity Services</td>
<td>Covered – 100%</td>
<td>Covered – 100%, after initial co-pay</td>
</tr>
<tr>
<td>Pre-Natal and Post-Natal Care</td>
<td>Covered - 100% for professional services. 90% after deductible for facility charges</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Delivery and Nursery Care</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Hospital Care</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Inpatient Consultations</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>Covered - 90% after deductible</td>
<td>Covered – 85% after deductible</td>
</tr>
<tr>
<td>Alternatives to Hospital Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Care</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Covered - 100% (when authorized) after deductible</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Covered - 100% following $40 co-pay after deductible, unlimited visits</td>
<td>Covered - 85% after deductible, unlimited visits</td>
</tr>
<tr>
<td>Surgical Services</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Human Organ Transplants</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 85%</td>
</tr>
<tr>
<td>Bone Marrow, Kidney, Cornea and Skin</td>
<td>Covered - 90% after deductible</td>
<td>Covered - 85%</td>
</tr>
<tr>
<td>Behavioral Health Care and Substance Abuse Care</td>
<td>Behavioral Health Care: Covered - 90% after deductible</td>
<td>Behavioral Health Care: Covered - 85% after deductible</td>
</tr>
<tr>
<td>Inpatient Behavioral Health Care and Substance Abuse Care</td>
<td>Behavioral Substance Abuse Care: Covered - 90% after deductible</td>
<td>Behavioral Substance Abuse Care: Covered - 85% after deductible</td>
</tr>
<tr>
<td>Outpatient Mental Health Care</td>
<td>Covered – 100% after $20 co-pay</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Outpatient Substance Abuse Care</td>
<td>Covered – 100% after $20 co-pay</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Other Services</td>
<td>Covered – 50% after deductible</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Allergy Testing and Therapy</td>
<td>Covered – 50% after deductible</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Service</td>
<td>Blue Care Network Wellness HMO</td>
<td>Blue Cross/Blue Shield Wellness PPO</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>Covered – 100% after $5 co-pay</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td></td>
<td>Covered - 65% after deductible</td>
<td>Covered - 65% after deductible</td>
</tr>
<tr>
<td>Chiropractic Office Visits</td>
<td>Covered – 100% after $40 co-pay when referred. Up to 30 visit per calendar year</td>
<td>Covered - 85% after deductible; one new patient visit per 36 months</td>
</tr>
<tr>
<td>Chiropractic Spinal Manipulation</td>
<td>Covered – 100% after $40 co-pay when referred. Up to 30 visit per calendar year</td>
<td>Covered - 85% after deductible; one per day, up to 24 visits per calendar year</td>
</tr>
<tr>
<td>Chiropractic X-rays</td>
<td>Covered – 90% after deductible</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td></td>
<td>Covered - 65% after deductible</td>
<td>Covered - 65% after deductible</td>
</tr>
<tr>
<td>Chiropractic Services – Hot/Cold Modalities etc.</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Outpatient Physical, Speech and Occupational Therapy, Osteopathic, Pulmonary, Cardiac Rehabilitation</td>
<td>Covered – 100% following $40 co-pay after deductible. One period of treatment for any combination of therapies within 60 consecutive days per calendar year</td>
<td>Covered - 85% after deductible; one per day, up to 24 visits per calendar year</td>
</tr>
<tr>
<td>Applied Behavioral Analyses (ABA treatment) Limited to 25 hours per week</td>
<td>Covered – 100% after $20 co-pay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Outpatient Physical Therapy, Speech Therapy, Occupational Therapy, Nutritional Counseling for Autism Spectrum Disorder Through Age 18</td>
<td>Covered – 100% following $40 co-pay after deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Other Covered Services, including mental health services, for Autism Spectrum Disorder</td>
<td>Covered – See other outpatient mental health benefit and medical office visit benefit</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Covered - 100%</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>Covered - 100%</td>
<td>Covered - 85% after deductible</td>
</tr>
<tr>
<td>Orthotic Appliances</td>
<td>Covered - 100%</td>
<td>Covered - 85% after deductible</td>
</tr>
</tbody>
</table>

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

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

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

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

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

To start:

- Ask your doctor to write a prescription for a 90-day supply of medicine.
- Complete the mail service order form - available in the Human Resources Department or on-line at: www.accesskent.com/benefits.
- Mail your order form along with your prescription(s) and payment to the OptumRx mail order pharmacy printed on the form.

NOTE: Drugs classified as controlled substances cannot be purchased through the mail.
Value Investment Prescription Plan

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

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

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

Women’s Preventive Services

To comply with PPACA, generics will be provided without cost share for contraceptive medicines and devices.

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

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

Cost Sharing Limitations

Cost-sharing limitations have been imposed under Health Care Reform. In 2018, a member’s out-of-pocket maximums for prescription drug coverage are limited to $4,200 for an individual and $8,400 for a family. Total combined employee cost for medical and prescriptions cannot exceed the federal annual limit of $7,350 for an individual and $14,700 for a family - adjusted annually.
**Step Therapy**

The cost of prescription drugs continue 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.

The next page describes the mapping process when you are filling a medicine identified as part of the step therapy program.
**Kent County Prescription Plan**

**Schedule of Prescription Drug Benefits**

**CO-PAYMENTS**

<table>
<thead>
<tr>
<th>Generic medication and supplies used for the treatment of:</th>
<th>$0.00 Prescription Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ diabetes</td>
<td></td>
</tr>
<tr>
<td>▪ hypertension</td>
<td></td>
</tr>
<tr>
<td>Generic contraceptive medicines or devices</td>
<td></td>
</tr>
<tr>
<td>Generic medication for women at increased risk for breast cancer</td>
<td></td>
</tr>
<tr>
<td>Smoking cessation drugs</td>
<td></td>
</tr>
<tr>
<td><strong>Generic medication not listed above</strong></td>
<td>$15.00 for one-month supply</td>
</tr>
<tr>
<td>Insulin on the formulary (preferred) list</td>
<td>$30.00 for a 90-day supply</td>
</tr>
<tr>
<td><strong>Formulary (Preferred)/Brand Name</strong></td>
<td>$25.00 for one-month supply</td>
</tr>
<tr>
<td></td>
<td>$50.00 for 90-day supply</td>
</tr>
<tr>
<td><strong>Non-Formulary (Non-Preferred)/Brand Name</strong></td>
<td>$45.00 for one-month supply</td>
</tr>
<tr>
<td></td>
<td>$90.00 for 90-day supply</td>
</tr>
</tbody>
</table>

**PLAN PARAMETERS**

- Individual out-of-pocket maximum - $4,200
- Family out-of-pocket maximum - $8,400
- Maximum dollar amount per fill at the pharmacy window without over-ride - $5,000
- Maximum dollar amount per fill through mail order without over-ride - $10,000
- Maximum days supply at the pharmacy window – 90-days
- Maximum days supply when you use mail order – 90-days
- When you fill a prescription at the pharmacy window, you must consume 75% of the supply before a refill is authorized
- When you fill a prescription through mail order, you must consume 50% of the supply before a refill is authorized

**PRE-AUTHORIZATION**

- Growth and biosynthetic hormones require prior authorization

For non-covered medications, please refer to “Exclusions” in the Plan Document.

This prescription summary is intended as an easy-to-read document. It is not a contract. An official description of benefits can be found in the Plan Document.
Kent County offers a dental care reimbursement program to assist full-time employees, and their covered dependents, with dental care needs. Kent County pays the premiums for this benefit.

**COINSURANCE PERCENTAGES**

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

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

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

**Type IV (Orthodontic) Services** covered at 50%

Employees are not responsible for meeting a deductible.

**PLAN LIMITS**

<table>
<thead>
<tr>
<th>Group</th>
<th>Maximum Calendar Year Benefit per Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPOAM</td>
<td>$2,500 Per Calendar Year* &lt;br&gt; Combined Type I, II, III and IV Services</td>
</tr>
</tbody>
</table>

*Only one annual family maximum will apply if both 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](http://www.aetna.com/docfind/custom/aetnadentalaccess).

Dental DocFind page
- 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)
Value Added Benefits

The vision plan offers additional value-added enhancements to the services it provides to Kent County employees. Employees are encouraged to review those additional benefits on the internet at www.accessKent.com/Benefits.
### MONTHLY HEALTH COVERAGE RATES

#### Kent County Wellness PPO (BCBSM)

<table>
<thead>
<tr>
<th></th>
<th>Employee Cost (Full-Time)</th>
<th>County Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$103.71</td>
<td>$414.86</td>
<td>$518.57</td>
</tr>
<tr>
<td>Two-Party</td>
<td>$217.80</td>
<td>$871.20</td>
<td>$1,089.00</td>
</tr>
<tr>
<td>Family</td>
<td>$259.29</td>
<td>$1,037.14</td>
<td>$1,296.43</td>
</tr>
</tbody>
</table>

#### Blue Care Network Wellness HMO (BCN)

<table>
<thead>
<tr>
<th></th>
<th>Employee Cost (Full-Time)</th>
<th>County Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$86.98</td>
<td>$347.92</td>
<td>$434.90</td>
</tr>
<tr>
<td>Two-Party</td>
<td>$208.74</td>
<td>$835.02</td>
<td>$1,043.76</td>
</tr>
<tr>
<td>Family</td>
<td>$260.94</td>
<td>$1,043.75</td>
<td>$1,304.69</td>
</tr>
</tbody>
</table>

#### Kent County Prescription Plan

<table>
<thead>
<tr>
<th></th>
<th>Employee Cost (Full-Time)</th>
<th>County Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$32.64</td>
<td>$130.57</td>
<td>$163.21</td>
</tr>
<tr>
<td>Two-Party</td>
<td>$68.55</td>
<td>$274.19</td>
<td>$342.74</td>
</tr>
<tr>
<td>Family</td>
<td>$81.60</td>
<td>$326.42</td>
<td>$408.02</td>
</tr>
</tbody>
</table>

#### Kent County Dental Plan (Full-Time Only)

<table>
<thead>
<tr>
<th></th>
<th>Employee Cost</th>
<th>County Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$0.00</td>
<td>$89.77</td>
<td>$89.77</td>
</tr>
<tr>
<td>Two-Party</td>
<td>$0.00</td>
<td>$89.77</td>
<td>$89.77</td>
</tr>
<tr>
<td>Family</td>
<td>$0.00</td>
<td>$89.77</td>
<td>$89.77</td>
</tr>
</tbody>
</table>

#### Kent County Vision Plan (Full-Time Only)

<table>
<thead>
<tr>
<th></th>
<th>Employee Cost</th>
<th>County Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$0.00</td>
<td>$9.23</td>
<td>$9.23</td>
</tr>
<tr>
<td>Two-Party</td>
<td>$0.00</td>
<td>$13.38</td>
<td>$13.38</td>
</tr>
<tr>
<td>Family</td>
<td>$0.00</td>
<td>$24.25</td>
<td>$24.25</td>
</tr>
</tbody>
</table>

**Notes:**
- **Full-time** employees pay 20% premium cost for medical and prescription benefits.
- **Part-time** employees pay the total premium cost (far right column) for medical and prescription benefits, less a $35.00 per pay period credit. Part-time employees are not eligible for dental and vision coverage.

Deductions are taken from the first and second pay period of each month. If you want to calculate your deduction amount per pay period, take your monthly contribution and divide it by two.
A Flexible Spending Account (FSA) allows you to reduce your taxable income by setting aside pre-tax dollars for health care expenses that are not covered under the County’s medical, prescription drug, dental and vision benefits and certain dependent care expenses. An FSA is like a personal account in which you can set aside a predetermined amount of money to cover qualified expenses. Contributing to an FSA, through payroll deduction, helps you make the most tax-effective use of your salary.

You can elect to participate in the following FSAs:

- Health Care Reimbursement Account
- Dependent Care Reimbursement Account.

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

During open enrollment, you may elect to contribute a portion of your pay, to one or both of the reimbursement accounts, for the upcoming 2018 plan year. The minimum contribution is $130 per year for either plan. As to the maximum contributions, there is an annual maximum of $2,600 subject to change for the Health Care Reimbursement Account and a maximum of $5,000 subject to change for the Dependent Care Reimbursement Account.

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

You are allowed 14 1/2 months, instead of 12 months, to receive reimbursement from your Healthcare Reimbursement Account for Plan Year 2018. This benefit applies only to the Health Care Reimbursement Account. Your payroll deductions will be from January 1, 2018 through December 31, 2018 but Kent County has established a two and a half month grace period until March 15, 2019 for you to access medical services and to seek reimbursement from your 2018 contributions. You may submit claims through March 31, 2019.
As a reminder, PPACA changed the rules regarding over-the-counter medicines. Effective January 1, 2011, over-the-counter drugs are **NOT** reimbursable through the Health Care Reimbursement Account **without a prescription**. You will still be able to receive reimbursement for insulin, blood sugar testing kits and supplies “to alleviate or treat personal injuries or sickness,” such as crutches, wheelchairs, and contact lens solution.

**Dependent Care Reimbursement Account**

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

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

**General Information Regarding Your FSA**

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

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

**The Tax Savings Advantage for Flexible Spending Accounts**

The following page shows how you can save on taxes and increase your take-home pay for the year by participating in an FSA.
SECTION 125 - FLEXIBLE SPENDING

Tax Savings Example

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

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

Dependent Care Account or Tax Credit?

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

This employee saved approximately $1,599.00 annually by participating in the FSA Plan!
Basic Life and AD&D

Kent County offers Basic Life and Accidental Death and Dismemberment (AD&D) Insurance, through CIGNA, to its full-time employees, at no cost to the employee. The Life and AD&D benefit varies by employment group or bargaining unit, and in some cases may change annually based on your earnings as of January 1st each year. Your life insurance coverage amount is explained in the following table:

<table>
<thead>
<tr>
<th>Employment Group</th>
<th>Coverage Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPOAM</td>
<td>$50,000 annually, after 6 months of employment</td>
</tr>
</tbody>
</table>

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. The level of coverage for Supplemental Life varies by employment group or collective bargaining agreement. Coverage levels are as follows:

<table>
<thead>
<tr>
<th>Employment Group</th>
<th>Coverage Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPOAM</td>
<td>You may apply for Life Insurance in multiples of $5,000, from $15,000 to $150,000</td>
</tr>
</tbody>
</table>

Value-Added Benefits

The life insurance carrier offers additional value-added enhancements to the services it provides to Kent County employees. Employees are encouraged to review those additional benefits on the internet at www.accessKent.com/Benefits.
The following schedule shows the rates for Supplemental Life coverage:

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate per $1000</th>
<th>Age</th>
<th>Rate per $1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-25</td>
<td>0.057</td>
<td>50-54</td>
<td>0.371</td>
</tr>
<tr>
<td>26-29</td>
<td>0.057</td>
<td>55-59</td>
<td>0.646</td>
</tr>
<tr>
<td>30-34</td>
<td>0.067</td>
<td>60-64</td>
<td>1.245</td>
</tr>
<tr>
<td>35-39</td>
<td>0.076</td>
<td>65-69</td>
<td>2.271</td>
</tr>
<tr>
<td>40-44</td>
<td>0.114</td>
<td>70 &amp; over</td>
<td>2.271</td>
</tr>
<tr>
<td>45-49</td>
<td>0.209</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The formula for estimating your monthly contribution is as follows:

\[
\frac{\text{\$ of Desired Insurance}}{\text{Rate}} \times \frac{1}{1,000} = \text{Monthly Contribution}
\]

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.

\[
\frac{\text{\$50,000}}{0.209} \times \frac{1}{1,000} = \$10.45
\]

If you waived coverage upon your hire date, then you must complete a health questionnaire 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 a health questionnaire. 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 a health questionnaire.

**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.
SICKNESS AND ACCIDENT (S&A) PLAN

Sickness and accident benefits will be provided for full-time and regular part-time employees hired on or after July 1, 2016.

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

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

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

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

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

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

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

Value-Added Benefits

The S&A carrier offers additional value-added enhancements to the services it provides to Kent County employees. Employees are encouraged to review those additional benefits on the internet at www.accessKent.com/Benefits.
LONG TERM DISABILITY (LTD) PLAN

Long Term Disability benefits will be provided for full-time and regular part-time employees.

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

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

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

**Benefit Duration**

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

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

**Earnings While Disabled**

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

**Pre-existing Conditions**

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

Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured for at least 12 months after your most recent effective date of insurance.
The Kent County Employees’ Retirement Plan is a defined benefit retirement plan established by the Kent County Board of Commissioners. The Plan is funded by a combination of County and employee contributions.

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

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

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

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

Contribution Rates for 2017

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

<table>
<thead>
<tr>
<th>Employee Group</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>TPOAM</td>
<td>8.63%</td>
</tr>
</tbody>
</table>

Each employee group has negotiated specific provisions for the pension benefit and contribution rate; therefore, some employees’ contribution rate will exceed the above variable rates. Please refer to your contract for additional information. The employer contribution rate will be 9.22% of payroll in 2018. Obligations to pay current and future benefits, investment performance of the plan’s assets, funding status of the plan as well as other factors determine what the rates will be for any given year.
The Kent County Deferred Compensation Plan is authorized under Section 457 of the Internal Revenue Code and is a voluntary retirement plan maintained to provide supplemental retirement income for eligible employees. Participation in the Deferred Compensation Plan will allow you two choices to accumulate monies for your retirement.

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

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

<table>
<thead>
<tr>
<th>What’s the difference?</th>
<th>Traditional (pre-tax 457)</th>
<th>Roth 457</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018 Contribution Limit</td>
<td>Refer to Federal Guidelines</td>
<td></td>
</tr>
<tr>
<td>2018 catch-up contribution limit – for those age 50 and older</td>
<td>Refer to Federal Guidelines</td>
<td></td>
</tr>
<tr>
<td>Contribution taxable in year contributed</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Contribution taxable in year distributed</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Contribution earnings taxable in year distributed</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Your income determines your contribution amount</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

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

An unforeseen emergency is defined in the Internal Revenue Code as a severe financial hardship resulting from a sudden and unexpected accident or illness of the participant or of a dependent of the participant. It may be the loss of the participant’s property due to casualty, or other similar extraordinary and unforeseeable circumstances. The loss must be as a result of events beyond the control of the participant. (IRS Reg. 1.457-2(h)(4). Contact the Human Resources Department to apply for an unforeseen emergency withdrawal.
**Beneficiary Designation** - It is recommended to review and update beneficiary(ies) from time to time; particularly if you have experienced a change in your status. Marriage, divorce, death of family members and birth of children are events that warrant a review of your beneficiary designation.

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

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

Send completed forms via interoffice mail to: Human Resources Dept. / County Admin Bldg / ATTN Retirement Services.
## Kent County Holidays for Year 2018

<table>
<thead>
<tr>
<th>Actual Day</th>
<th>Actual Date</th>
<th>Description</th>
<th>Observed Day</th>
<th>Observed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>1/1/2018</td>
<td>New Year's Day</td>
<td>Monday</td>
<td>1/1/2018</td>
</tr>
<tr>
<td>Monday</td>
<td>1/15/2018</td>
<td>Martin Luther King Day</td>
<td>Monday</td>
<td>1/15/2018</td>
</tr>
<tr>
<td>Monday</td>
<td>5/28/2018</td>
<td>Memorial Day</td>
<td>Monday</td>
<td>5/28/2018</td>
</tr>
<tr>
<td>Wednesday</td>
<td>7/4/2018</td>
<td>Independence Day</td>
<td>Wednesday</td>
<td>7/4/2018</td>
</tr>
<tr>
<td>Sunday</td>
<td>11/11/2018</td>
<td>Veterans Day</td>
<td>Monday</td>
<td>11/12/2018</td>
</tr>
<tr>
<td>Thursday</td>
<td>11/22/2018</td>
<td>Thanksgiving Day</td>
<td>Thursday</td>
<td>11/22/2018</td>
</tr>
<tr>
<td>Friday</td>
<td>11/23/2018</td>
<td>Day After Thanksgiving</td>
<td>Friday</td>
<td>11/23/2018</td>
</tr>
<tr>
<td>Monday</td>
<td>12/24/2018</td>
<td>Christmas Eve</td>
<td>Monday</td>
<td>12/24/2018</td>
</tr>
<tr>
<td>Tuesday</td>
<td>12/25/2018</td>
<td>Christmas Day</td>
<td>Tuesday</td>
<td>12/25/2018</td>
</tr>
</tbody>
</table>

Note: Eligibility for regular part-time employees is based on collective bargaining unit or employee group.
### KENT COUNTY PAYROLL DATES FOR YEAR 2018

<table>
<thead>
<tr>
<th>Pay Period</th>
<th>Pay Run ID</th>
<th>Pay Period Schedule</th>
<th>Pay Date</th>
<th>Time Report Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>18A</td>
<td>12-18-17 to 12-24-17 12-25-17 to 12-31-17</td>
<td>1-12-18</td>
<td>1-02-18</td>
</tr>
<tr>
<td>2</td>
<td>18B</td>
<td>1-01-18 to 1-07-18 1-08-18 to 1-14-18</td>
<td>1-26-18</td>
<td>1-16-18</td>
</tr>
<tr>
<td>3</td>
<td>18C</td>
<td>1-15-18 to 1-21-18 1-22-18 to 1-28-18</td>
<td>2-09-18</td>
<td>1-29-18</td>
</tr>
<tr>
<td>4</td>
<td>18D</td>
<td>1-29-18 to 2-04-18 2-05-18 to 2-11-18</td>
<td>2-23-18</td>
<td>2-12-18</td>
</tr>
<tr>
<td>5</td>
<td>18E</td>
<td>2-12-18 to 2-18-18 2-19-18 to 2-25-18</td>
<td>3-09-18</td>
<td>2-26-18</td>
</tr>
<tr>
<td>6</td>
<td>18F</td>
<td>2-28-18 to 3-04-18 3-05-18 to 3-11-18</td>
<td>3-23-18</td>
<td>3-12-18</td>
</tr>
<tr>
<td>7</td>
<td>18G</td>
<td>3-12-18 to 3-18-18 3-19-18 to 3-25-18</td>
<td>4-06-18</td>
<td>3-26-18</td>
</tr>
<tr>
<td>8</td>
<td>18H</td>
<td>3-26-18 to 4-01-18 4-02-18 to 4-08-18</td>
<td>4-20-18</td>
<td>4-09-18</td>
</tr>
<tr>
<td>9</td>
<td>18I</td>
<td>4-09-18 to 4-15-18 4-16-18 to 4-22-18</td>
<td>5-04-18</td>
<td>4-23-18</td>
</tr>
<tr>
<td>10</td>
<td>18J</td>
<td>4-23-18 to 4-29-18 4-30-18 to 5-06-18</td>
<td>5-18-18</td>
<td>5-07-18</td>
</tr>
<tr>
<td>11</td>
<td>18K</td>
<td>5-07-18 to 5-13-18 5-14-18 to 5-20-18</td>
<td>6-01-18</td>
<td>5-21-18</td>
</tr>
<tr>
<td>12</td>
<td>18L</td>
<td>5-21-18 to 5-27-18 5-28-18 to 6-03-18</td>
<td>6-15-18</td>
<td>6-04-18</td>
</tr>
<tr>
<td>13</td>
<td>18M</td>
<td>6-04-18 to 6-10-18 6-11-18 to 6-17-18</td>
<td>6-29-18</td>
<td>6-18-18</td>
</tr>
<tr>
<td>14</td>
<td>18N</td>
<td>6-18-18 to 6-24-18 6-25-18 to 7-01-18</td>
<td>7-13-18</td>
<td>7-02-18</td>
</tr>
<tr>
<td>15</td>
<td>18O</td>
<td>7-02-18 to 7-08-18 7-09-18 to 7-15-18</td>
<td>7-27-18</td>
<td>7-16-18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pay Schedule 2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>18P</td>
<td>7-16-18 to 7-22-18  7-23-18 to 7-29-18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>18Q</td>
<td>8-10-18  7-30-18 to 8-05-18  8-06-18 to 8-12-18  8-24-18  8-13-18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>18R</td>
<td>9-07-48  8-27-18 to 9-02-18  8-20-18 to 8-26-18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>18S</td>
<td>9-10-18 to 9-16-18  9-17-18 to 9-23-18  9-10-18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>18U</td>
<td>10-15-18 to 10-21-18  11-02-18  10-22-18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>18X</td>
<td>11-16-18  11-05-18 to 11-11-18  11-12-18 to 11-18-18  11-19-18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>18Y</td>
<td>12-14-18  11-19-18 to 11-25-18  11-26-18 to 12-02-18  12-03-18  12-02-18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>18Z</td>
<td>12-17-18  12-03-18 to 12-09-18  12-09-18 to 12-15-18  12-17-18</td>
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<td>1-11-19  12-17-18 to 12-23-18  12-24-18 to 12-30-18  12-31-18</td>
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</table>

*Pay week with a County Holiday - Time reports are due by these dates, as the Payroll Department may be operational on a holiday.*
| WHERE TO CALL ☏, OR WRITE ✉️, OR ACCESS INFORMATION ☑️ |

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>☏</th>
<th>✉️</th>
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<tr>
<td>Blue Cross Blue Shield of Michigan (BCBSM)</td>
<td>Customer Service</td>
<td>(888) 890-5754</td>
<td>Blue Cross Blue Shield of Michigan Customer Service</td>
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<tr>
<td>Blue Care Network</td>
<td>(800) 662-6667</td>
<td>Blue Care Network</td>
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<tr>
<td>OptumRx</td>
<td>(800) 797-9791</td>
<td>OptumRx</td>
<td>P.O. Box 29077</td>
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<tbody>
<tr>
<td>Varipro, Inc.</td>
<td>(616) 285-2480</td>
<td>5300 Patterson Ave SE, Suite 150</td>
<td>Grand Rapids, Michigan 49512</td>
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<tr>
<th>VISION</th>
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<tr>
<td>Vision Service Plan Insurance Company (VSP)</td>
<td>(800) 877-7195</td>
<td>3333 Quality Drive</td>
<td>Rancho Cordova, CA 95670</td>
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<tr>
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<tr>
<td>Varipro, Inc.</td>
<td>(616) 285-2480</td>
<td>Claims Fax: (855) 296-1026</td>
<td>5300 Patterson Ave SE, Suite 150</td>
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<tr>
<th>LIFE INSURANCE</th>
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<tr>
<td>CIGNA</td>
<td>1-800-36-CIGNA (24462)</td>
<td>900 Cottage Grove Road</td>
<td>Bloomfield, CT 06002</td>
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<tr>
<td>For Converting</td>
<td>1-800-423-1282</td>
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<tr>
<td>Encompass</td>
<td>(616) 459-9180</td>
<td>4829 E. Beltline NE, Bldg. 1</td>
<td>Grand Rapids, MI 49525</td>
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<tr>
<td>(800) 788-8630</td>
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<tr>
<td>MorningStar Health</td>
<td>(616) 942-9088</td>
<td>801 Broadway NW</td>
</tr>
<tr>
<td>(888) 672-3652</td>
<td>Grand Rapids, MI 49504</td>
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### WHERE TO CALL ☎️, OR WRITE 📧, OR ACCESS INFORMATION

<table>
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<tr>
<th></th>
<th>Name</th>
<th>Phone Number</th>
<th>Email/Website</th>
</tr>
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<tbody>
<tr>
<td><strong>RETIREMENT PLANS</strong></td>
<td>Tara Beatty</td>
<td>(616) 632-7457</td>
<td><a href="mailto:tara.beatty@kentcountymi.gov">tara.beatty@kentcountymi.gov</a></td>
</tr>
<tr>
<td>Kent County Pension Plan</td>
<td></td>
<td></td>
<td>Kent County Human Resources Dept. County Admin Bldg., 2nd Floor 300 Monroe NW</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Grand Rapids, MI 49503</td>
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<tr>
<td>Deferred Compensation</td>
<td>Brian Wanless,</td>
<td>(616) 304-8417</td>
<td><a href="http://www.kentcountydefcomp.org">www.kentcountydefcomp.org</a></td>
</tr>
<tr>
<td>(457) Plan</td>
<td>Retirement Specialist</td>
<td></td>
<td>Nationwide Retirement Solutions P.O. Box 182797</td>
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<td></td>
<td></td>
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<td>Columbus, Ohio 43218-2797</td>
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<tr>
<td></td>
<td>Customer Service</td>
<td>(877) 677-3678</td>
<td></td>
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<tr>
<td><strong>BENEFITS STAFF</strong></td>
<td>Shanna Christie</td>
<td>(616) 632-7462</td>
<td><a href="mailto:shanna.scott@kentcountymi.gov">shanna.scott@kentcountymi.gov</a></td>
</tr>
<tr>
<td>Kent County Human</td>
<td>Nicole Joyce</td>
<td>(616) 632-7464</td>
<td><a href="mailto:nicole.joyce@kentcountymi.gov">nicole.joyce@kentcountymi.gov</a></td>
</tr>
<tr>
<td>Resources Department</td>
<td>Mandy Lee</td>
<td>(616) 632-7478</td>
<td><a href="mailto:mandy.lee@kentcountymi.gov">mandy.lee@kentcountymi.gov</a></td>
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<td></td>
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<td>Kent County Human Resources Dept. County Admin Bldg., 2nd Floor 300 Monroe NW</td>
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<td>Grand Rapids, MI 49503</td>
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<tr>
<td><strong>PAYROLL STAFF</strong></td>
<td>Linda Quinn</td>
<td>(616) 632-7710</td>
<td><a href="mailto:linda.quinn@kentcountymi.gov">linda.quinn@kentcountymi.gov</a></td>
</tr>
<tr>
<td>Kent County Fiscal</td>
<td>Stacey Steffes</td>
<td>(616) 632-7712</td>
<td><a href="mailto:stacey.steffes@kentcountymi.gov">stacey.steffes@kentcountymi.gov</a></td>
</tr>
<tr>
<td>Services Department</td>
<td></td>
<td></td>
<td>Kent County Fiscal Services Dept. Attn: Payroll County Admin Bldg., 2nd Floor</td>
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<tr>
<td></td>
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<td></td>
<td>300 Monroe NW</td>
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<td>Grand Rapids, MI 49503</td>
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PLAN DOCUMENTS, CERTIFICATES AND NOTICES

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

### Plan Documents, Certificates of Coverage and Required Notices

<table>
<thead>
<tr>
<th>Plan Document</th>
<th>Link</th>
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<tr>
<td>Kent County Pension Plan</td>
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</tr>
<tr>
<td>Sick and Accident Plan Certificate of Coverage (if eligible)</td>
<td><a href="https://www.accessKent.com/Benefits/sad.htm">https://www.accessKent.com/Benefits/sad.htm</a></td>
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<tr>
<td>Summary of Benefits and Coverage</td>
<td><a href="https://www.accessKent.com/Benefits/summary_benefits_coverage.htm">https://www.accessKent.com/Benefits/summary_benefits_coverage.htm</a></td>
</tr>
</tbody>
</table>
FREQUENTLY ASKED QUESTIONS

Open Enrollment Form

Q. What forms must I return to Human Resources?
A. In order 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
- Flexible Spending Election
- Non-Smoking Attestation Form
- Wellness Exam Attestation Form
- Working Spouse Attestation Form
- Supporting Document(s) for New Dependents

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

Q. Do I need to return the open enrollment forms to Human Resources even if I do not have any changes?
A. Yes. Return the open enrollment and attestation forms to Human Resources to confirm your benefit elections, even if you choose to keep your elections the same.

Q. How do I return my enrollment form?
A. You may return your enrollment form in one of the following ways:
   - Scan and/or Save your completed form, attach it to an e-mail, and send it to HRBenefits@kentcounty.mi.gov
   - Mail your form to Kent County Human Resources
     300 Monroe Ave.
     Grand Rapids, MI 49503
   - Interoffice your form to HR / Benefits
   - Hand deliver your form to Human Resources/Admin Bldg., 2nd Floor

Q. What happens if I miss the open enrollment deadline?
A. If you do not return your open enrollment form on or before the October 18, 2017 deadline, your medical, prescription, dental and vision benefits will remain as they are. However, neither your flexible spending accounts nor your wellness incentives carry over into the new year. Changes to your open enrollment form submitted after the October 18, 2017 deadline will not be processed.
Health Plan Terminology

COINSURANCE. Reflected as a percentage of the benefit coverage you, as a participant, are responsible for paying. For example, under the Blue Cross/Blue Shield Wellness PPO Plan in 2018, the County contributes 85% coverage for in-network hospitalization. You, the participant, would then be responsible for the remaining 15% balance, up to the coinsurance maximum.

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

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

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

OUT OF POCKET MAXIMUM. Cost-sharing limitations have been imposed under Health Care Reform. In 2018, a member’s out-of-pocket maximums for medical expenses under the Blue Cross/Blue Shield Wellness PPO are limited to $3,150 for an individual and $6,300 for family coverage. The out-of-pocket maximum as defined by the PPACA includes co-pays, deductibles and coinsurance. For prescription drug coverage, a member’s out-of-pocket maximums are limited to $4,200 for an individual and $8,400 for a family. Total combined employee cost for medical and prescriptions cannot exceed the annual limit of $7,350 for an individual and $14,700 for a family-adjusted annually.

VALUE-BASED BENEFIT DESIGN. In a value-based approach, an employer makes a strategic investment in its health management practice that improves the health of employees, especially those at high risk for chronic illness or costly major medical events. Anticipated investment returns include productive, healthy employees and lower overall health care costs. A value-based prescription plan makes medication more affordable for those with chronic health conditions. For example, Kent County has designed a Value Investment Prescription (VIP) Plan that removes the co-pay for generic drugs used in the treatment of diabetes and hypertension. By making these medications available with no co-pay, Kent County is supporting members who must take their medication correctly and consistently to avoid developing more serious health problems.
FREQUENTLY ASKED QUESTIONS

Medical Benefits

Q. What are my medical plan options for 2018?
A. Blue Care Network Wellness HMO or the Blue Cross/Blue Shield Wellness PPO Plan.

Q. I received an explanation of benefits statement from Blue Cross and they didn’t pay the bill, why?
A. You may need to first meet deductibles and/or coinsurance before the plan begins paying for services. Check your explanation of benefits 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 preventative 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?
A. The out-of-pocket maximum as defined by the PPACA is $7,350 for an individual and $14,700 for family coverage. The co-pay applies as many times as you access services requiring an office, urgent care, or emergency room visit or fill a prescription up to the applicable out-of-pocket maximum. The co-pay does not apply to the deductible.

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

For non-emergency situations, please consider visiting your primary care physician or urgent care center for a lower co-pay.
Medical Benefits (cont’d)

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. 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-preventative 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 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. For 2018, the out-of-pocket maximum for prescription drug coverage will be $4,200 for an individual and $8,400 for a family.

Q. Are there any prescription drugs that are not covered under the prescription plan?
A. Yes. For example all of the erectile dysfunction drugs are not covered under the plan. Examples of these types of drugs are Viagra and Cialis. You are responsible for the entire cost of the medication. For a list of other non-covered prescription drugs, please refer to the summary plan description.

Q. Have our co-pays changed?
A. No. The 2018 co-pays for a 30-day supply remain:
   $15 – Generics
   $25 – Formulary
   $45 – Non-Formulary
When you get a 90-day supply, you will pay two times the prescription co-pay ($30/$50/$90). In other words, you are paying for 2 months and getting one month free.
FREQUENTLY ASKED QUESTIONS

Prescription (cont’d)

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.

Health Care Reform

Q. Do I have to elect both Medical coverage and Prescription coverage?
A. You have a separate election right for medical and prescription under the County plan. However, employees who do not elect both medical and prescription may be out of compliance with the Affordable Care Act.

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 of 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. The federal and state health insurance marketplaces will begin enrollment on November 1, 2017 for coverage starting January 1, 2018.
FREQUENTLY ASKED QUESTIONS

Health Care Reform (cont’d)

Q. What if I have health insurance options through my employer?
A. You’ll have the options to get insurance through your employer or a health insurance exchange. The choice is yours. Before you choose a plan:
  • Think about your health care needs.
    o Do you see the doctor fairly 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?
    o The answer to these questions can help you decide which option presents the best coverage and value for you and your family.
  • Review all the options that are available to you.
    o Depending on your situation, you may also be eligible for coverage through Medicare or Medicaid. Or your children may be eligible for coverage through the Children’s Health Insurance Program (CHIP) in your state.

If, after reviewing all your options, you decide to buy coverage through an exchange, you may qualify for financial help if your income is low or modest. However, you will not qualify for financial help if you choose to buy insurance through an exchange and your employer offers you coverage that is:
  • Considered “affordable” (how much you pay for coverage is less than 9.5% of your income); and
  • Meets coverage standards as required by law.

Dental & Vision

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

Q. How do I use the Dental Plan?
A. The Dental Plan is administered by Varipro, Inc. You may select the dental care provider(s) of your choice. If you choose an in-network provider, discounts for services will be provided. 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 below listed address to your dental provider:

  County of Kent Dental Plan
c/o Varipro, Inc.
5300 Patterson Ave. SE, Ste. 150
Grand Rapids, MI 49512
Dental & Vision (cont’d)

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 [vsp.com](http://vsp.com)). Benefit information is available on the internet under Forms / Human Resources.

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 a health questionnaire.

   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 a health questionnaire.

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](http://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 dependents).

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

Premium Payments

Q. Are there premium contribution changes this year?
A. No, full-time employees will continue to pay 20% of the monthly rate in 2018 for medical and prescription coverage. Part-time employees will continue to pay the total premium cost for medical and prescription benefits, less a $35.00 per pay period credit.

Wellness Cash Incentives

Q. What do I need to do to receive my wellness cash incentives?
A. You'll need to comply with the following two steps:
   ▪ Physical Examination – You must complete an annual wellness examination in 2017 in order to receive wellness cash for 2018. The payment will be applied after Human Resources receives the Wellness Exam Attestation form completed by both you and your physician.
   ▪ Non-smoker/Attempting to Quit Wellness Incentive – In order to receive the payment you must return a Non-Smoking Attestation Form and indicate that you are a non-smoker or that you are enrolled in a smoking cessation program.

Q. When will the wellness incentives be applied to my paycheck?
A. You will not receive a 2.5% wellness cash incentive until you report that you have completed an annual physical exam. If you are a non-smoker or enrolled in a cessation program you will see the additional 2.5% wellness cash incentive applied after Human Resources has received your attestation form. If you return the completed attestation forms with your open enrollment form by October 18, 2017, you will see the payment reflected on your first paycheck in December.

   ▪ Attestation forms must be updated and submitted annually.

Q. Where can I find information on smoking cessation programs?
A. Blue Cross Blue Shield and Blue Care Network participants may use the “Tobacco Cessation Coaching” program through WebMD. This is a 12 week program for individuals who are ready to quit using tobacco products. Over the 12 week period, individuals will receive 5 calls from a specially trained health coach and an optional two rounds of Nicotine Replacement Therapy.
FREQUENTLY ASKED QUESTIONS

Flexible Spending

Q. What is the difference between health care and dependent care reimbursement accounts?
A. Dependent care and health care reimbursement accounts are separate and are only used for specific expenses under IRS regulations.

Health Care: The funds in your health care reimbursement account (maximum of $2,600 subject to change) may be used to pay for many of your family’s health care expenses that are not already covered by your health care plans, including deductibles, co-payments and expenses that exceed reasonable and customary limits. Effective January 1, 2011 over-the-counter medications could no longer be reimbursed from your health care reimbursement account without a doctor’s written prescription.

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

Q. Does Flex Spending automatically roll over into 2018 if I elected it in 2017?
A. No. If you had a flexible spending account in 2017, you will need to re-elect these options for 2018 and specify the amount you are electing. Previous year elections for flexible spending do not roll over to the next year.

Q. What are the timelines for using my Flexible Spending contributions?
A. You will be allowed 14 1/2 months to receive reimbursement from your Health Care Reimbursement Account. This benefit applies only to the Health Care Reimbursement Account. Your payroll deductions will be from January 1, 2018 – December 31, 2018 but you will have until March 15, 2019 to access medical services and be reimbursed. You may submit claims through March 31, 2018.

If you have a balance in your 2017 Health Care Reimbursement Account as of January 1, 2018, any services received through March 15, 2018 and claims submitted by March 31, 2018 will be applied to the previous year’s fund balance before claims are paid with the 2018 funds you elected. Remember, over-the-counter medication cannot be reimbursed without a doctor’s written prescription.

Payroll deductions for your Dependent Care Reimbursement Account will be from January 1, 2018 - December 31, 2018 and only reimbursable within that 12 month period. The amount available for reimbursement at any time is limited to the amount in your account. The Flexible Spending Plan remains a use-or-lose benefit. Therefore, you would still LOSE any funds not used through the plan year (12 months for Dependent Care and 14 1/2 months for Health Care).
Q. If I have someone come into my home to take care of my children instead of using a day care facility, do these expenses qualify for a dependent care FSA?
A. Yes. If the services are necessary in order for you (or, if you are married, you and your spouse) to work, you can include payments made to a babysitter or companion in or outside your home. Expenses will also qualify if you work and your spouse is a full-time student or is mentally or physically incapable of self-care. However, you cannot be reimbursed for payments made to:
   - Your spouse
   - A parent of your qualifying child
   - Your child under age 19, even if that child is not your dependent
   - Any person you claim as a dependent on your tax return

Q. Can I use the dependent care FSA for elder care? What if my elderly parent remains in his/her own home or a nursing home but is still my dependent?
A. You can use the dependent care FSA for elder care expenses so that you (or if you are married, you and your spouse) can work. To claim the expenses:
   - Your parent must qualify as your dependent under the tax rules. Please see IRS Publication 503 at www.irs.gov for specifics.
   - Your parent must be physically or mentally incapable of self-care.
   - Your parent must reside in your home for at least half of the year.
   - Your parent must usually spend at least eight hours a day in your home.

Q. Can I get reimbursed from my dependent care FSA as soon as I pay my child care bill?
A. Under IRS guidelines, you can only be reimbursed for dependent care that has already taken place. Also, you can only be reimbursed for the amount that you have already contributed to your dependent care FSA. Unlike the health care FSA, the full amount of your dependent care election is not available January 1.
FREQUENTLY ASKED QUESTIONS

General Questions

Q. Can I make changes to my benefits at any time during the year?
A. Changes during the year can only be made within 30 days of the event based on the following status changes:
   - Marriage*
   - Birth / Adoption*
   - Divorce*
   - Death*
   - Loss of Other Coverage

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

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

Q. Can I add an adult child to my insurance at this time?
A. Your dependent child can be covered through the end of the month in which he/she turns 26. If you want to add an adult child to your insurance for 2018, 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.

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 first pay period in 2018, 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) under Forms-Human Resources, or you may contact Human Resources or your benefits carrier.
FREQUENTLY ASKED QUESTIONS

General Questions (cont’d)

Kent County Benefit Department Contacts:

Mandy Lee  Human Resources Technician  (616) 632-7478
Nicole Joyce  Human Resources Specialist I  (616) 632-7464
Shanna Scott  Human Resources Specialist I  (616) 632-7462
Holly Hartley  Benefits/Compensation Manager  (616) 632-7459

Retirement Services

Q. Where can I find information about the pension plan and deferred compensation plan?
A. The pension plan is a defined benefit plan with mandatory participation and is administered by Kent County. Employee contributions are made on a pre-tax basis via payroll deduction.

The deferred compensation plan (457) is a voluntary pre-tax retirement plan sponsored by Kent County with investment options and recordkeeping provided by Nationwide. You can find the information regarding the deferred compensation plan on the Kent County Intranet site (http://kcintranet/).

You may find contact information on page 38 of this benefit book.

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

Q. How do I change my beneficiary election for my pension plan and/or deferred compensation plan?
A. You may download forms from the Kent County internet site by going to (www.accesskent.com) under Forms-Human Resources, or you may contact Human Resources to obtain these forms. You may elect to change beneficiaries and submit the forms directly to Human Resources to process your change.
IMPORTANT NOTICE FROM KENT COUNTY ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with County of Kent and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide 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.
IMPORTANT NOTICE FROM KENT COUNTY ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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.

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) as long as 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.
IMPORTANT NOTICE FROM KENT COUNTY ABOUT YOUR
PRESCRIPTION DRUG COVERAGE AND MEDICARE

For more information about Medicare prescription drug coverage:

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

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

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

Date: September 22, 2017
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 of 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 of the ways we are permitted to use and disclose information will fall within one of the categories.

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

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

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

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

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.
Disclosure to Health Plan Sponsor. Information may be disclosed to another health plan maintained by Plan Sponsor for purposes of facilitating claims payments under that plan. In addition, your protected health information may be disclosed to Plan Sponsor and its personnel for purposes of administering benefits under the Plan or as otherwise permitted by law and Plan Sponsor’s HIPAA privacy policies and procedures.

Special Situations

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

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

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

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

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

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

- in response to a court order, subpoena, warrant, or summons;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person’s agreement; or
- about criminal conduct.
Coroners and Medical Examiners. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Your Rights Regarding Your Protected Health Information

You have the following rights regarding your protected health information which we maintain:

Right to Access. You have the right to request access to the portion of your protected health information containing your enrollment, payment and other records used to make decisions about your Plan benefits. This includes the right to inspect the information as well as the right to a copy of the information. You may request that the information be sent to a third party. You must submit a request for access in writing to the Privacy Officer. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request (such as a thumb drive in the case of a request for electronic information – see next paragraph). We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

If the Plan maintains your protected health information electronically in a designated record set, the Plan will provide you with access to the information in the electronic form and format you request if readily producible or, if not, in a readable electronic form and format as agreed to by the Plan and you.

Right to Amend. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.
NOTICE OF PRIVACY PRACTICES

**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.
NOTICE OF PRIVACY PRACTICES

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.

Call your HR Department for more information.

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

**GINA Notice**
The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual’s family medical history, the results of an individual's or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.
County of Kent is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA or to participate in the blood test or other medical examinations.

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

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

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

**Protections from Disclosure of Medical Information**

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

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

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at 616-632-7440.
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 August 10, 2017. Contact your State for more information on eligibility –

<table>
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<tr>
<th>State</th>
<th>Medicaid Website</th>
<th>Medicaid Phone</th>
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<tbody>
<tr>
<td>ALABAMA</td>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447</td>
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<tr>
<td>ALASKA</td>
<td>The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
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<tr>
<td>ARKANSAS</td>
<td>Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)</td>
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<td>COLORADO</td>
<td>Medicaid Website: <a href="http://www.colorado.gov/hcpf">http://www.colorado.gov/hcpf</a> Medicaid Customer Contact Center: 1-800-221-3943</td>
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<td>FLORIDA</td>
<td>Website: <a href="http://ffmedicalidptprecovery.com/hipp/">http://ffmedicalidptprecovery.com/hipp/</a> Phone: 1-877-357-3268</td>
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<td>GEORGIA</td>
<td>Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a> - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507</td>
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<td>IOWA</td>
<td>Website: <a href="http://www.dhs.state.ia.us/hipp/">http://www.dhs.state.ia.us/hipp/</a> Phone: 1-888-346-9562</td>
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<td>INDIANA</td>
<td>Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.hip.in.gov">http://www.hip.in.gov</a> Phone: 1-877-438-4479 All other Medicaid Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a> Phone 1-800-403-0864</td>
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<td>COLORADO</td>
<td>Medicaid Website: <a href="http://www.colorado.gov/hcpf">http://www.colorado.gov/hcpf</a> Medicaid Customer Contact Center: 1-800-221-3943</td>
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<tr>
<td>State</td>
<td>Program</td>
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<td>Kansas</td>
<td>Medicaid</td>
<td><a href="http://www.kdheks.gov/hcf">Website</a></td>
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<td>Nevada</td>
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<td><a href="http://dwss.nv.gov/">Website</a></td>
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<td><a href="http://www.dhss.nv.gov/oii/documents/hippapp.pdf">Website</a></td>
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<td>Louisiana</td>
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<td><a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">Website</a></td>
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<td>New Hampshire</td>
<td>Medicaid and CHIP</td>
<td><a href="http://www.njfamilycare.org/index.html">Website</a></td>
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<td>Kentucky</td>
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<td><a href="http://www.mass.gov/MassHealth">Website</a></td>
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<td>New York</td>
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<td><a href="http://www.nyhealth.gov/health_care/medicaid/">Website</a></td>
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<td>North Carolina</td>
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<td><a href="http://www.dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">Website</a></td>
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<td>Oregon</td>
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<td><a href="http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx">Website</a></td>
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<td>Virginia</td>
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<td><a href="http://www.coverva.org/programs_premium_assistance.cfm">Website</a></td>
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<td>South Carolina</td>
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<td><a href="http://www.scdhhs.gov">Website</a></td>
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<td>WISCONSIN</td>
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<td>Website: <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a></td>
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<td>Website: <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a></td>
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<td>VERMONT</td>
<td>Medicaid</td>
<td>Website: <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a></td>
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To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

**U.S. Department of Labor**
Employee Benefits Security Administration
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)
1-866-444-EBSA (3272)

**U.S. Department of Health and Human Services**
Centers for Medicare & Medicaid Services
[www.cms.hhs.gov](http://www.cms.hhs.gov)
1-877-267-2323, Menu Option 4, Ext. 61565
DISCRIMINATION IS AGAINST THE LAW

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

County of Kent:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

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

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

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


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 tulang 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
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-616-632-7468
УВАГА: Якщо ви розмовляєте на українській мові, ви маєте можливість користуватися безкоштовними послугами переводу. Зв'яжіться з номером 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
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