

2022 Guide to Employee Benefits





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Welcome

Reformed Benefits Association is a non-profit organization providing insurance benefits to churches, denominational staff and similar ministries. RBA is committed to delivering the highest level of benefits care with attentiveness, warmth and integrity. We understand your ministry, and we're qualified and prepared to work through the uniqueness that can be presented when working with churches and non-profits. We'll walk with you step-by-step to ensure you have comprehensive coverage for a price that meets your budget. This brochure was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this brochure to make sure you understand the benefits that are available to you and your family—then be sure to take action.

This document is distributed at open enrollment each year to serve as the summary of material modifications for the Reformed Benefits Association's health and welfare plan. Please see the benefit descriptions and charts for detailed information on the benefit plans. When referencing the guide and the Summary Plan Description (SPD), the SPD should be considered the governing document.

Eligibility

If you work at least 30 hours per week, you are eligible for benefits. Most of your benefits are effective on the first day of the month following your date of hire. You may also enroll your eligible dependents for coverage. This includes the following:

- Your legal spouse
- Children under the age of 26, regardless of student, dependency or marital status
- Children who are past the age of 26 and are fully dependent on you for support due to a mental or physical disability, and who are indicated as such on your federal tax return

Part-time employees (at least 20 hours per week) are eligible for benefits at employer’s discretion.

Qualified Life Events

Generally, you may only change your benefit elections during the Open Enrollment period. However, since life happens, you also may change your benefit elections during the year if you experience a Qualified Life Event.

Qualified Life Event		Documentation Needed
Change in marital status	<ul style="list-style-type: none"> » Marriage » Divorce/Legal Separation » Death 	<ul style="list-style-type: none"> » Copy of marriage certificate » Copy of divorce decree » Copy of death certificate
Change in number of dependents	<ul style="list-style-type: none"> » Birth or adoption » Step-child » Death 	<ul style="list-style-type: none"> » Copy of birth certificate or copy of legal adoption papers » Copy of birth certificate plus a copy of the marriage certificate between employee and spouse » Copy of death certificate
Change in employment	<ul style="list-style-type: none"> » Change in your eligibility status (i.e., full-time to part-time) » Change in spouse’s benefits or employment status 	<ul style="list-style-type: none"> » Notification of increase or reduction of hours that changes coverage status » Notification of spouse’s employment status that results in a loss or gain of coverage

Changing Benefits After Enrollment

During the year, you cannot make changes to your medical, dental, or vision unless you have a Qualified Life Event. If you do not contact RBA within 30 days of the Qualified Life Event, you will have to wait until the next annual Open Enrollment period to make changes (unless you experience another Qualified Life Event).



Medical Plans

Medical insurance is essential to your well-being and our medical coverage provides you and your family the protection you need for everyday health issues or when the unexpected happens.

How a Health Plan Works

Preventive Care – like physical exams, flu shots and screenings – is always covered 100% when you use in-network providers. The key difference between the plans is the amount of money you'll pay each pay period and when you need care. The plans have different:

- **Annual deductible amount** – The amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay.
- **Out-of-pocket maximums** – The most you will pay each year for eligible network services including prescriptions. After you reach your out-of-pocket maximum, the plan picks up the full cost of covered medical care for the remainder of the year.
- **Copays** – A copay is a fixed amount you pay for a health care service. Copays do not count toward your deductible but do count toward your annual out-of-pocket maximum.
- **Coinsurance** – Once you've met your deductible, you and the plan share the cost of care, called coinsurance. For example, you pay 20% for services and the plan will pay 80% of the cost until you have reached your out-of-pocket maximum.

For Your Protection

The out-of-pocket maximum provides financial protection in the event of a serious illness or injury. The out-of-pocket maximum, however, does not include penalties (such as a late cancellation fee for a doctor's appointment).



Medical Plan Comparison

	Premium Plan		Consumer Plan		Copay Plan	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible						
Individual	\$2,000	\$4,000	\$2,800	\$6,000	\$500	\$15,000
Family	\$4,000	\$6,000	\$5,600	\$12,000	\$1,000	\$30,000
Calendar Year Out-of-Pocket Maximum (includes Deductible and Copays)						
Individual	\$5,000	\$15,000	\$5,000	\$15,000	\$5,000	\$19,650
Family	\$10,000	\$30,000	\$10,000	\$30,000	\$10,000	\$39,300
	You Pay		You Pay		You Pay	
Coinsurance						
Preventive Care	\$0	Not covered	\$0	Not covered	\$0	Not covered
Primary Care Physician	\$20 copay	50%*	80%*	50%*	\$75 copay	50%*
Specialist	80%*	50%*	80%*	50%*	\$100 copay	50%*
Urgent Care	\$50 copay	50%*	80%*	50%*	\$100 copay	50%*
Emergency Room	80%*	80%*	80%*	80%*	\$500 copay*	\$500 copay*

* After deductible



Pharmacy Benefits

	Premium Plan		Consumer Plan		Copay Plan	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Retail Rx (up to 31-day supply)						
Tier 1	\$10 copay	50%*	\$10 copay*	50%*	\$30 copay	50%*
Tier 2	\$40 copay	50%*	\$40 copay*	50%*	\$100 copay	50%*
Tier 3	\$80 copay*	50%*	\$80 copay*	50%*	\$150 copay*	50%*
Mail Order Rx (up to 90-day supply)						
Tier 1	\$25 copay	N/A	\$25 copay*	N/A	\$75 copay	N/A
Tier 2	\$100 copay	N/A	\$100 copay*	N/A	\$250 copay	N/A
Tier 3	\$200 copay*	N/A	\$200 copay*	N/A	\$375 copay*	N/A

* After deductible

Prescription Drug Coverage

If you enroll in one of the RBA medical plans, you will automatically receive prescription drug coverage through Express Scripts. When you need prescriptions, you can purchase them through a local retail pharmacy or, for maintenance medications, through the mail order program.

We encourage you to speak to your physician about the drug that's best for you and to request less expensive prescription drugs (generic drugs). Your pharmacist will be able to recommend alternatives that create the same desired effect but may be more cost efficient than a name brand drug.

Retail Prescription Program

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. For more information about a particular pharmacy or pharmacy claim, contact your MyQHealth Coordinators.

Mail Order Program

The mail order program offers a convenient and cost-effective way to fill prescriptions for medications you take on a regular basis (maintenance medications). Your medications are mailed directly to your home. To order prescriptions through the mail order program, please visit the Express Scripts website at www.express-scripts.com or contact your MyQHealth Coordinators for assistance.

MyQHealth Care Coordination

A personalized, guided health care experience

MyQHealth will be your primary contact and assist you with all your health care-related issues and questions. MyQHealth Care Coordinators organize and simplify your medical and prescription benefits to provide you with a better experience when you need care. From medical claims to checkups and even precertifications, your Care Coordinators are with you every step of your health care journey.



Search

Search for a medical procedure and find providers in your area.



Manage

Manage chronic conditions with health routines.



Save

Save hundreds to thousands of dollars on out-of-pocket costs.

MyQHealth Care Coordinators do things like:

- Verify coverage
- Provide health education resources
- Advocate for your care
- Help manage chronic conditions
- Find in-network providers
- Contact providers to discuss treatment
- Answer claims, billing and benefits questions
- Create health-improvement plans
- Help reduce unnecessary, out-of-pocket costs

Contact your MyQHealth Care Coordinators

- Call 877-498-1382
- Visit myrbabenefits.com
- Download the MyQHealth – Care Coordinators app



Teladoc

Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. Set up your account today, so when you need care *now*, a Teladoc doctor is just a call or click away.



1

Online:
Go to [Teladoc.com](https://www.teladoc.com) and click "set up account."

Set Up Your Account

Set up your account by phone (toll-free) web, mobile app or by texting "Get Started" to 469-844-5637.

Mobile App:
Download the app and click "Activate account." Visit [teladoc.com/mobile](https://www.teladoc.com/mobile) to download the app.

Call Teladoc:
Teladoc can help you register your account over the phone.



2

Provide Medical History

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.



3

Request a Consult

Once your account is set up, request a consult anytime you need care. And talk to a doctor by phone, web or mobile app.

Livongo®

The Simpler Way to a Healthier You

An advanced blood glucose meter and blood pressure monitor, plus the support you need, 100% paid for by your health plan.



Cost-Free Programs

Diabetes Management

- Unlimited strips & lancets
- Connected blood sugar meter
- Personalized insights & more



Advanced Technology

Blood Pressure Management

- One-on-one coaching
- Connected monitor
- Real-time tips & more



Encouraging Coaching

Real Appeal

Real Appeal is a weight loss program that incorporates small goals each day to guide you toward a healthier life. Through your coach's guidance and support, group sessions, educational material and activities, Real Appeal will track your daily progress. You can enroll in Real Appeal by visiting enroll.realappeal.com.



Supplemental Medical

Just as it sounds, Supplemental Medical Plans – Accident and Critical Illness insurance – can help you pay for costs you may incur after an accidental injury, illness or hospitalization. These plans are administered by Reliance Standard and are 100% voluntary.

Supplemental Medical Plans pays a fixed, one-time benefit amount which you can use for any purpose you like. It can help pay for expenses not covered by your health care plan (such as your deductible or copays), lost income, child care, travel to and from treatment, home health care costs or any of your regular household expenses.

Accident Insurance

Eligible Expenses	
	Emergency Room Visits
	Hospital Stays
	Fractures and Dislocations
	Medical Exams – including major diagnostic exams
	Physical Therapy
	Transportation and Lodging – if you are away from home when the accident happens

How the Plan Works

- On his way to work, John was in a car accident.
- He was transported by ground ambulance to the emergency room and admitted to the hospital.
- He had a dislocated hip and spent five days in the hospital.
- He had several physical therapy sessions before returning to work.
- John submitted his accident claim and received \$5,490 from his accident insurance coverage.
- He used it toward his deductible, copay and supplemental income for his missed work days.

Sample Reimbursements	
Ground Ambulance	\$150
Emergency Treatment	\$200
Diagnostic Examination	\$200
Hospital Stay – Admission + 5 days	\$2,250
Dislocated Hip (non-surgical)	\$2,400
Medical Appliance	\$150
Physical Therapy (4 sessions)	\$140
Total Benefit Paid	\$5,490





Critical Illness

Sample of Covered Conditions



Heart Attack



Multiple Sclerosis



Stroke



Alzheimer's Disease



Parkinson's Disease



Major Organ Failure

How the Plan Works

- Tom suffered a relatively small stroke.
- He was hospitalized for five days.
- He began rehab to get back to where he was physically before the stroke.
- Tom submitted his claim and received a lump-sum payment of \$10,000.

Benefit Amount

Employee and Spouse

\$10,000 – \$30,000 in \$10,000 increments

Children

25% of the Insured Person's approved Amount of Insurance, up to \$12,500

Health Savings Account (HSA)

An HSA is a personal savings account you can use to pay for qualified out-of-pocket medical expenses with pre-tax dollars – now or in the future. RBA does not administer the HSA. As a member, you must enroll in an HSA through your employer or by opening your own account through a bank.

How a Health Savings Account (HSA) Works



Eligibility

You must be enrolled in the High Deductible Health Plan.



Your Contributions

You contribute on a pre-tax basis and can change how much you contribute from each paycheck up to the IRS maximum of \$3,600 if you enroll only yourself, or \$7,200 if you enroll in family coverage. You can make an additional catch-up contribution if you are age 55.



Eligible Expenses

Medical, dental, vision and prescription drug expenses incurred by you and your eligible family members.



Your HSA is always yours – no matter what

One of the best features of an HSA is that any money left in your HSA account at the end of the year rolls over so you can use it next year or sometime in the future. And if you leave the company or retire, your HSA goes with you and you can continue to pay and save for future eligible health care expenses.

The Triple Tax Advantage

HSAs offer you tax advantages like no other:

- 1 You can use your HSA funds to cover qualified medical expenses, plus dental and vision expenses too – tax-free.
- 2 Unused funds grow and can earn interest over time – tax-free.
- 3 You can save your HSA funds to use for your health care when you leave the Company or retire – tax-free.



Health Reimbursement Account (HRA)

An HRA is an account that you can use to pay out-of-pocket medical expenses with pre-tax dollars. If you are enrolled in the Premium Plan, you are eligible for the HRA. You can use HRA money to pay for eligible medical expenses for you and your covered dependents. HRAs are also a way for an individual or a family to pay for medical expenses without the funds being taxed by the government beforehand. The employee may not contribute to the HRA.

Using the HRA

Please note: Funds available for reimbursement are limited to the balance in your HRA.

How a Health Reimbursement Account (HRA) Works



Reformed Benefits Association contributes to your account

\$350 for individual employees.



Your expenses are paid by your HRA

Your HRA pays your eligible deductible and coinsurance amounts.



You make all applicable copayments at the doctor's office

These payments apply towards your out-of-pocket maximum.



You pay your deductible

After you use all of your HRA funds, you then pay the rest of the deductible amount out of your own pocket.



After that, you pay only coinsurance

Once you have met your deductible, you share in the cost of the expenses. This is called "coinsurance."



How the Plan Works

John enrolls his family of three in the HRA plan. This plan has an HRA fund of \$350 for the plan year.

Son Tyler has strep throat;
John injures his foot and needs an X-ray.

HRA Fund	\$350
Expenses	
» 2 office visits x \$20	\$40
» Urgent Care visit for injured foot	\$50
» Foot X-ray	\$120
» Annual physicals for entire family	\$0
» Annual OB/GYN exam	\$0
Amount paid from HRA (applied to deductible)	\$210
Amount paid by John	\$0



Dental Plans

Taking care of your oral health is not a luxury, it is a necessity to long-term optimal health. With a focus on prevention, early diagnosis and treatment, Dental insurance can greatly reduce your costs when it comes to restorative, and emergency procedures. Preventive services are covered at no cost to you and include routine exams and cleanings. You will only pay a small deductible and coinsurance for basic and major services.

Delta Dental administers your Dental insurance. When you visit an in-network dentist, you will maximize your savings. To find an in-network dentist, go to <https://www.deltadentalmi.com/Member/Using-Your-Benefits/Find-a-Dentist> and click the Delta Dental PPO and Delta Dental Premier search button. These in-network dentists have agreed to reduced fees, meaning you won't be charged more than your expected share of the bill.

	Delta Dental PPO	Delta Dental Premier	Nonparticipating*
Calendar Year Deductible			
Individual	\$50	\$50	\$50
Family	\$150	\$150	\$150
Calendar Year Maximum			
Per Individual	\$1,200	\$1,200	\$1,200
Diagnostic and Preventive			
Exams, Cleanings, Fluoride, Space Maintainers, Sealants, Brush Biopsy and Radiographs	\$0	\$0	\$0
Basic Services			
Emergency Palliative Treatment, Fillings, Crown Repair, Endodontics, Periodontics, Extractions and Oral Surgery	20%	20%	20%
Major Services			
Crowns, Dentures and Bridgework Repairs and Prosthodontics	50%	50%	50%
Orthodontia			
Braces	50%	50%	50%
Lifetime Maximum	\$2,000		
Age Limit	No Age Limit	No Age Limit	No Age Limit

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what the dentist charges, and you are responsible for that difference.

The plan with the largest discount rate is the Delta Dental PPO. By enrolling in the Delta Dental PPO, you can make your claim dollars go farther.

Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. You may enroll yourself and your eligible dependents or you may waive vision coverage. You do not have to be enrolled in medical coverage to elect vision coverage or cover the same dependents under medical and vision.

EyeMed administers the Vision insurance. The vision plan utilizes the Insight Network. To find an in-network provider, go to www.eyemed.com and select "Find an Eye Doctor."

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

	Vision Plan	
	IN-NETWORK YOU PAY	OUT-OF-NETWORK REIMBURSEMENT*
Cost		
Exam	\$0	Up to \$40
Frames	\$0 copay, \$160 allowance; 20% off balance over \$150	Up to \$88
Standard Plastic Lenses		
Single Vision	\$25 copay	Up to \$25
Bifocal	\$25 copay	Up to \$40
Trifocal	\$25 copay	Up to \$60
Standard Progressive	\$90 copay	Up to \$40
Premium Progressive		
» Tier 1	\$110	Up to \$40
» Tier 2	\$120	Up to \$40
» Tier 3	\$135	Up to \$40
» Tier 4	\$90 copay, 80% less \$120 allowance	Up to \$40
Lenticular	\$25 copay	Up to \$60
Contact Lenses**		
Conventional	\$0 copay, \$175 allowance; 15% off balance over \$175	Up to \$140
Disposable	\$0 copay, \$175 allowance; plus balance over \$175	Up to \$140
Medically Necessary	\$0 (paid in full by Benefit)	Up to \$210
Benefit Frequency		
Exams	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months
Contacts	Once every 12 months	Once every 12 months

* You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

** For prescription contact lenses for only one eye, the Benefit will pay one-half of the amount payable for contact lenses for both eyes.

Life and Accidental Death & Dismemberment (AD&D) Insurance

Life insurance pays a lump-sum benefit to your beneficiary(ies) to help meet expenses in the event of your death. AD&D Insurance pays a benefit if you die or suffer certain serious injuries as the result of a covered accident. In the case of a covered accidental injury (e.g., loss of sight, loss of a limb), the benefit you receive is a percentage of the total AD&D coverage you elected based on the severity of the accidental injury.

The Basic Life and AD&D benefit available is based on an employee's class. Class 1 includes full-time employees and Class 2 is comprised of part-time domestic employees regularly scheduled to work 20 - 29 hours per week. Your organization determines whether option 1 or option 2 is offered.

Life and AD&D Insurance – For You		
COVERAGE LEVEL	COVERAGE AMOUNT	EVIDENCE OF INSURABILITY/ PROOF OF GOOD HEALTH
Life and AD&D	Option 1: Class 1: \$175,000 / Class 2: \$100,000 Option 2: Class 1: \$75,000 / Class 2: \$50,000	None
Supplemental Life and AD&D	Increments of \$10,000 not to exceed \$500,000	Required if electing coverage greater than \$200,000

Life and AD&D Insurance – for Your Dependents

Supplemental Life insurance for your dependents can help protect your family during difficult times.

Life and AD&D Insurance – For Your Dependents		
COVERAGE LEVEL	COVERAGE AMOUNT	EVIDENCE OF INSURABILITY/ PROOF OF GOOD HEALTH
Spouse	Increments of \$10,000 up to \$250,000 – not to exceed 100% of Employee coverage	Required for amounts greater than \$30,000 or if you have previously declined this coverage
Child(ren)	\$10,000	None



Guaranteed Issue and Evidence of Insurability

Employees and spouses who elect coverage when first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective.

Imputed Income

Under current tax laws, imputed income is the value of your Basic Life insurance that exceeds \$50,000 and is subject to federal income, Social Security, and state income taxes, if applicable. This imputed income amount will be included in your paycheck and shown on your W-2 statement.



Disability Insurance

Disability insurance can keep you financially stable should you become disabled and unable to work. It can help provide a sense of security, knowing that if the unexpected should happen, you'll still receive a monthly income.

Long-Term Disability Benefits at a Glance

Classes	<p>Class 1: Non-ordained domestic Agency employees of the CRCNA and active full-time or part-time non-ordained employees of the GSC of the Reformed Church of America. All active, Full-time non-ordained employees of another eligible affiliated organization as approved by the Board of Trustees of RBA</p> <p>Class 2: Non-ordained employees of the CRCNA or RCA congregation, institution, agency or eligible affiliated organization</p>
Coverage	<p>Class 1: 66.67% of your pre-disability earnings, up to a maximum of \$5,000 per month until you recover or reach your Social Security Normal Retirement Age (SSNRA), whichever is sooner</p> <p>Class 2: 60% of your pre-disability earnings, up to a maximum of \$5,000 per month until you recover or reach your SSNRA, whichever is sooner</p>
When Benefits Begin	Benefit begins after 180 days of disability
Election Required	Yes

A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience.



Important Contacts

Coverage	Contact	Phone	Website
Medical	MyQHealth	877-498-1382	www.myrbabenefits.com
Dental	Delta Dental	800-524-0149	www.deltadental.com
Vision	EyeMed	866-723-0513	www.eyemed.com
Life and AD&D	Reliance Standard	800-351-7500	www.reliancestandard.com
Disability	Reliance Standard	800-351-7500	www.reliancestandard.com
Telemedicine	Teladoc	800-835-2362	www.teladoc.com
Diabetes and Hypertension Program	Livongo	800-945-4355	www.livongo.com
International Medical	UHC Global	877-844-0280	members.uhcglobal.com
Supplemental Medical	Reliance Standard	800-435-7775	www.reliancestandard.com

Required Notices

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

Since key parts of the health care law took effect in 2014, there is another way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace’s annual Open Enrollment period or if you experience a qualifying life event.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.83% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Benefits Department at benefits@reformedbenefits.org.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name: Reformed Benefits Association	4. Employer Identification Number (EIN):	
5. Employer Address: 1700 28th Street SE	6. Employer Phone Number: 616-224-5881	
7. City: Grand Rapids	8. State: MI	9. Zip Code: 49508
10. Who can we contact about employee health coverage at this job?: Human Resources		
11. Phone Number (if different from above):	12. E-Mail Address: shull@reformedbenefits.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to all employees / some employees.

Eligible employees are:

- Full-time employees working 30+ hours per week
- More detail on employee eligibility can be found in the plan document

- With respect to dependents, we do / do not offer coverage.

Eligible dependents are:

- Your legal spouse
- Children under the age of 26, regardless of student, dependency, or marital status
- Children who are past the age of 26 and are fully dependent on you for support due to a mental or physical disability, and who are indicated as such on your federal tax return
- More detail on the definition of dependents can be found in the plan document

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, www.healthcare.gov will guide you through the process.

RBA HEALTH AND WELFARE PLAN 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.

OUR COMPANY'S PLEDGE TO YOU

This notice is intended to inform you of the privacy practices followed by the RBA Health and Welfare Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on 1/1/2022.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. RBA requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that

information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or Required by Law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of RBA for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless

you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Benefits Department
Reformed Benefits Association
1700 28th St SE
Grand Rapids, MI 49508
800-701-8992 & benefits@reformedbenefits.org

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

IMPORTANT NOTICE FROM REFORMED BENEFITS ASSOCIATION 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 Reformed Benefits Association 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.

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

You should also know that if you drop or lose your current coverage with RBA 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. 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 RBA changes. You also may request a copy of this notice at any time.

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

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

Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of "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: 1/1/2022
Name of Entity/Sender: Reformed Benefits Association
Contact/Office: Benefits Department
Address: 1700 28th St SE,
Grand Rapids, MI 49508
Phone Number: 800-701-8992

OTHER NOTICES

60-DAY SPECIAL ENROLLMENT PERIOD

In addition to the qualifying events listed in this document, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in Reformed Benefits Association medical coverage 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 no more than 30 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in RBA medical coverage as long as you request enrollment by contacting the benefits manager no more than 30 days after the marriage, birth, adoption or placement for adoption. For more information, contact RBA, Benefits Department at benefits@reformedbenefits.org.

NEWBORN & MOTHERS HEALTH PROTECTION NOTICE

For maternity hospital stays, in accordance with federal law, the Plan does not 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 delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact RBA or your medical plan administrator.



This brochure highlights the main features of the Reformed Benefits Association Employee Benefits Program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Reformed Benefits Association reserves the right to change or discontinue its employee benefits plans at any time.

