Employee Benefits Enrollment Guide

Plan Year: January 01, 2025 – December 31, 2025

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This Benefit Guide contains only a brief summary of your benefits. We have tried to ensure the accuracy of these materials, but if there is any discrepancy between the benefits discussed in these materials and the official plan documents, the official plan documents will rule. Actual benefits will be paid in accordance with the carrier contracts and any amendments to those contracts in place at the time of the claim. Please refer to the carrier booklets for details regarding your coverage, including benefit limitations and exclusions. Calhoun County reserves the right to amend, modify or terminate any plan at any time and in any manner. In addition, please be aware that the information contained in these materials is based on our current understanding of the federal health care reform legislation, signed into law in March 2010. Our interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. government. Therefore, we defer to the actual carrier contracts, processes, and the law itself as the governing documents.

Your 2025 Benefit Enrollment Guide

Welcome to Calhoun County! We are thrilled to have you join our team and become part of our community. You bring unique skills, experiences, and perspectives, and we can't wait to see the impact you'll make. This guide is designed to help you navigate the benefits and resources available to you as a new employee. We believe that a supportive and inclusive workplace is essential for your success, and we're here to ensure you have everything you need to thrive.

Our Commitment To You

At Calhoun County, we are committed to fostering a diverse, equitable, and inclusive environment. We want you to feel valued, respected, and empowered as you start your journey with us. Whether it's providing a comprehensive benefits package, supporting your professional growth, or creating a safe and welcoming workplace, we're dedicated to your well-being.

What's Inside

In this guide, you'll find information about the benefits available to you, including:

- **Health and Wellness:** Medical, dental, and vision plans, as well as resources to support your mental health and well-being.
- **Financial Security:** Retirement plans, life insurance, and other financial benefits to help you plan for the future.
- **Work-Life Balance:** Flexible work arrangements, paid time off, and employee assistance programs designed to support you and your family.

We're Here to Help

Starting a new job can be both exciting and overwhelming, but you don't have to navigate it alone. Our Human Resources team is here to answer any questions you have about your benefits, company policies, or anything else you need to know. Don't hesitate to reach out—we're here to support you every step of the way.

Thank you for choosing Calhoun County as your new workplace. We're excited to work with you and look forward to achieving great things together. Welcome aboard!

Human Resources | (269) 781-0980 | hr-department@calhouncountymi.gov

Benefits are an important part of your total compensation, and they provide valuable protection for you and your family. Please take the time to review the enrollment materials provided to you. Should you have any questions, contact Human Resources at (269) 781-0980 or hr-department@calhouncountymi.gov.

Online Resources

Find resources, guides, and more from our benefit provides on **EARL Intranet**

Contact Information for Human Resources and Benefit Vendors

Human Resources staff will be available to help you at the HR sessions, Lunch & Learn and by appointment. **Human Resources** Marshall County Building #3-100 (269) 781-0980 hr-department@calhouncountymi.gov EARL Intranet	**BCBSM** (800) 972-9797 bcbsm.com **BCBSM** – Non-Michigan (800) 810-2583 bcbsm.com **Delta Dental** (800) 482-8915 deltadentalmi.com **Express Scripts** (800) 282-2881 express-scripts.com	**Wex FSA and HSA** (866) 451-3399 wexinc.com **Premise Health & Wellness Center** (269) 743-3315 (Direct) mypresmisehealth.com **VSP/BCBSM** (800) 877-7195 bcbsm.com **New York Life** (800) 362-4462 – Disability Claims (800) 754-3207- Elective Benefits newyorklife.com

Steps to Complete Enrollment

Not sure where to start? The following steps will help you complete benefits enrollment by the deadline: **30 days after your date of hire.**

1

Review Benefit Enrollment Materials
Review this Benefit Guide completely, starting with the New and Notable section for the 2025 plan year

2

Ask Questions or Learn More
You can find contact information for HR and our benefit vendors on Page #4. Your session with the Benefits Session offers opportunities to ask questions or learn more about your options.

3

Make Decisions
Decide what benefits, plans, and dependents will remain the same or change for next plan year.

4

Take Action by DEADLINE
Follow the instructions to make your elections for 2025. All employees must make their elections annually.

5

Other Items to Consider
The following may be updated at any time of year:

- **Retirement Savings:** You may want to review your retirement saving options to make changes to enrollment or contributions. See EARL for information on plan offerings and how to change your contributions: EARL - Retirement
- **Beneficiary(ies):** We encourage you to evaluate your life and retirement beneficiaries annually to ensure we have current beneficiaries on file. Retirement plan beneficiaries can be changed on the Alerus portal: Alerus
- **Emergency Contacts:** Log in to ESS, Select "Personal Information," Click the "Contacts" tab, then update your Emergency Contacts section by selecting the Add New/Edit/Delete buttons.

New and Notable Information

Read the following important changes, updates, and/or reminders regarding this year's benefits and the 2025 plan year. Visit EARL for the most updated information.

- **New Enrollment Platform:** The same Employee Self Service (ESS) platform you use to enter your time and PTO requests will be your go-to for benefit enrollment.
- **IRS Maximum Contribution Amounts for 2025**

	Annual Contribution Limit	Catch-Up Contribution
Flexible Spending Account Health Care Account	$3,300	N/A
Flexible Spending Account Dependent Care Account	$5,000 per household $2,500 for married individuals filing separately	N/A
Health Savings Account (Employer + Employee)	Self Only: $4,300 Family: $8,550	Age 55+ $1,000
401(k) and 457 Retirement Plans	$23,500 Employee Contribution $70,000 Employer + Employee Contribution	Age 60-63 $7,500

- **The Community Blue (CB3) Flexible Blue (FB3) and the Simply Blue (SB3) plans** will all continue to be available in 2025, as well as the same plans for dental and vision. Refer to the Medical Plan section for plan design features for health insurance, and the Dental and Vision sections for more information.
- **County Health Savings Account (HSA) Contributions:**
  - Flexible Blue (FB3) plan: employer HSA contribution will be $750 for an individual and $1,500 family.
  - Simply Blue (SB3) plan: employer HSA contribution will be $1,500 for an individual and $3,000 family.
- **The Calhoun County Health & Wellness Center:** The Health & Wellness Center benefit operated by Premise Health continues to be available to employees on the medical plans. All preventative care office visits and preventative prescriptions continue to be free of charge through the center. For those with an HSA Plan, the IRS requires that the County charge fair market value for non-preventative services, which will remain the same for 2025 ($50 for office visits and prescriptions) preventative services are all still at no charge. Mail order services will also continue to be provided. Employees opting out of the medical plans can still access the wellness components of the center, such as flu shots, HRA's, and on-line portal.
- **Ancillary Benefits:** Voluntary life and disability will remain with New York Life (NYL), as well as voluntary accident/critical illness that was formerly with Cigna. There will also be a new hospital indemnity plan available through NYL. New York Life is allowing employees to enroll in 2025 without providing Evidence of Insurability or answering medical questions during your enrollment for certain levels of coverage.

- **HelpNet and the Employee Assistance Program** will continue to be available for mental health and other counseling needs for you and your family, which includes five free visits for each issue, per person, per year (for most individuals this will allow for more than 5 sessions per calendar year).
- **Opt-Out Incentive:** The incentive for opting-out of the medical plans is $100 per pay period for full-time employees.

Learn More or Ask Questions

We encourage you to use the following resources to receive assistance during your enrollment.

HR Support

Human Resources is ready to assist you throughout your enrollment process. Appointments recommended.

(269) 781-0980
hr-department@calhouncountymi.gov
Marshall County Building #3-100

E-Benefits Online Enrollment Instructions

We are using a new e-benefits portal within Employee Self-Service (ESS). This easy-to-use platform allows you to manage and enroll in your employee benefits with just a few clicks. Follow the step-by-step instructions below to complete your benefits enrollment.

Miscellaneous Reminders

- Part-Time employees are eligible for the medical benefit plans and are required to select or "Decline."
- To Opt-Out, please select the "Decline" button on the applicable benefit screens.

Accessing the System

- Open your web browser (Chrome works best) and go to the ESS Portal link: https://calhouncountymi.munisselfservice.com/ess/default.aspx
- Enter your login credentials (same as when you access ESS for your timesheet)
- Once logged in, navigate to the **Benefits** section in the left navigation menu.
- Click on the blue **Enrollment** hyperlink at the top of the screen.
- You'll see a list of the benefits available to you, including health, dental, vision, life insurance, and more.

How to Enroll in Coverage

1) **Review/Compare your options:** Review the available plans/coverage levels and the Benefits Guide to determine the best plans for you and your family. If applicable, you will see your existing benefit listed for each benefit section
2) **Complete Each Benefit Section** by selecting Select / No Changes / Decline. Scroll to the bottom right of the page and select Continue to advance to the next benefit option.
3) **Add Dependents:** If enrolling in dual or family coverage, the system will prompt you to assign dependents for each plan (e.g. health, dental, vision).
4) **Review Your Selections:** After selecting your benefits, click the blue Continue button at the bottom of the screen to review your choices.
5) **Submit Your Enrollment:** Once you are satisfied with your selections, click the blue Submit button on the bottom of the screen
6) **Add Life Insurance Beneficiaries:** You'll update your beneficiaries outside of the benefit portal, but still within the ESS system.
    a. On the left navigation menu, select Personal Information, then on the menu going horizontal across the page, select Beneficiaries
    b. Use the buttons Add Person or Add Entity to update your beneficiaries for life insurance only. This will not impact your beneficiaries for retirement (MERS, 401k, or 457).

For more detailed enrollment instructions (including screenshots) visit the ESS Benefits Enrollment Guide on EARL.

Medical Plan Options

Medical coverage is one of the most important benefits employees choose. Calhoun County understands that each employee and family is unique and as a result, different plan options are provided through Blue Cross Blue Shield of Michigan (BCBSM) to help meet varying needs.

1. Community Blue (CB3)

Community Blue is a traditional PPO insurance plan that operates with deductibles, copays, and co-insurance for services.

- PPO stands for "Preferred Provider Organization". Quite simply, a PPO is a network of doctors and hospitals that work under one umbrella to provide medical services at a discount to its membership. BCBSM's PPO is one of the largest in the country. To see what providers are in the BCBSM PPO network, refer to the BCBSM Website at www.bcbsm.com.

- Prescription drugs are covered through Express Scripts with copays of $10 generic/$20 brand/$40 non-formulary.

2. Flexible Blue (FB3) with Health Savings Account (HSA)

Flexible Blue is also part of the BCBS PPO network. It is a Consumer Driven Heath Plan that has a higher deductible than a traditional plan, but is paired with a Health Savings Account (HSA) that you get to manage based on your individual or family needs:

- The HSA is an interest bearing, tax-favored account that is owned by you and is portable from employer to employer. It allows you to save money through pre-tax payroll deductions to help you pay for your out-of-pocket medical expenses, such as the deductible and coinsurance. The deductible for this plan is $2,000 for an individual and $4,000 for 2-person or family.

- **Calhoun County will also contribute $750 per single and $1,500 per 2-person or family annually into your HSA for this plan.** This, in turn, will also reduce your annual deductible. The money will roll over each year, and you may have investment options depending on the size of your account. The HSA offers a way to begin saving for current and future medical expenses on a tax-free basis.
- Prescription drugs are covered by Express Scripts and are subject to the deductible and coinsurance under this plan.

3. Simply Blue (SB3) with Health Savings Account (HSA)

Simply Blue plan is also part of the BCBS PPO network. It is a Consumer Driven Heath Plan that has a higher deductible than a traditional plan, but is paired with a Health Savings Account (HSA) that you get to manage based on your individual or family needs:

- The HSA is an interest bearing, tax-favored account that is owned by you and is portable from employer to employer. It allows you to save money through pre-tax payroll deductions to help you pay for your out-of-pocket medical expenses, such as the deductible and coinsurance. The deductible for this plan is $3,500 for an individual and $7,000 for 2-person or family.

- **Calhoun County will also continue to contribute $1,500 per single and $3,000 per 2-person or family annually into your HSA for this plan.** This, in turn, will also reduce your annual deductible. The money will roll over each year, and you may have investment options depending on the size of your account. The HSA offers a way to begin saving for current and future medical expenses on a tax-free basis.

- This plan has been enhanced by reducing the out-of-pocket maximum to equal the deductible (resulting in lower costs to employees). The County will still continue to fund the corresponding Health Savings Accounts (HSA) at the same level of $1,500 single/$3,000 dual-family. This means that after the deductible has been met the plan pays at 100%.

- Prescription drugs are covered by Express Scripts and are subject to the deductible and coinsurance under this plan.

Blue Cross Blue Shield of Michigan

Medical Plan Comparison

	Community Blue (CB3)	Flexible Blue (FB3)	Simply Blue (SB3)
Medical Coverage - BCBS	In-Network	In-Network	In-Network
Employer HSA Contribution	N/A	$750 Single $1,500 Family	$1,500 Single $3,000 Family
Deductible	$250 Single $500 Family*	$2,000 Single $4,000 Family	$3,500 Single $7,000Family
True Out-of-Pocket Max (*includes ded, coins, copays, and RX*)	$3,000 Single $6,000 Family**	$3,000 Single $6,000 Family	$3,500 Single $7,000 Family
Coinsurance	80% after deductible	80% after deductible	100% after deductible
Coinsurance Maximum	$1,000 Single $2,000 Family	Not Applicable	Not Applicable
Preventive Care	100%	100%	100%
Office Visit Copay	$25	80% after deductible	100% after deductible
Emergency Room Copay	$150	80% after deductible	100% after deductible
Prescription Drug Coverage – Express Scripts			
Generic	$10 Copay	80% after deductible	100% after deductible
Brand Formulary	$20 Copay	80% after deductible	100% after deductible
Brand Non-Formulary	$40 Copay	80% after deductible	100% after deductible

** If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

* If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

How Do the Medical Plans Compare?

The following charts illustrate the differences between the three medical plans depending on your level of utilization. Note: all charts assume: single coverage, full-time employee using in-networks, $120 per office visit, $500 per ER visit, $55 per brand prescription.

Low Utilizer

	Community Blue (CB3)	Flexible Blue (FB3 w/HSA)	Simply Blue (SB3 w/HSA)
Employer Contribution	N/A	$750	$1,500
Deductible *(your portion)*	Not Utilized	$470	$470
Coinsurance Maximum *(your portion)*	$1,000	N/A	N/A
Copays Office Visits - 3 ER Visit - 0 Brand Rx* - 2	 $25 x 3 = $75 $100 x 0 = $0 $40 x 2 = $80	 $120 x 3 = $360 $500 x 0 = $0 $55 x 2 = $110	 $120 x 3 = $360 $100 x 0 = $0 $55 x 2 = $110
Annual EE Premium Contribution	$86.64 x 26 = $2,252.64	$37.30 x 26 = $969.80	$27.13 x 26 = $705.38
Total Out-Of-Pocket Cost	**$2,407.64**	**$689.80**	**$0**

High Utilizer

	Community Blue (CB3)	Flexible Blue (FB3 w/HSA)	Simply Blue (SB3 w/HSA)
Employer Contribution	N/A	$750	$1,500
Deductible *(your portion)*	Not Utilized	$2,000	$3,500
Coinsurance Maximum *(your portion)*	$1,000	N/A	N/A
Copays/Deductible Cost Office Visits - 12 ER Visit - 1 Brand Rx* - 24	 $25 x 12 = $300 $150 x 1 = $150 $20 x 24 = $480	 $120 x 12 = $1,440 $500 x 1 = $500 $55 x 24 = $1,320 (deductible met)	 $120 x 12 = $1,440 $500 x 1 = $500 $55 x 24 = $1,320
Annual EE Premium Contribution	$86.64 x 26 = $2,252.64	$37.30 x 26 = $969.80	$27.13 x 26 = $705.38
Total Out-Of-Pocket Cost	**$3,182.64**	**$2,219.80**	**$2,465.38**

2025 Medical Costs and Cost Sharing

2025 Cost Sharing					
Plan	**Option**	**2025 Total Monthly Costs**	**Employer Monthly Cost**	**Employee Monthly Cost**	**Employee Cost Per Pay Period**
Community Blue (CB3): The Employee pays 20% of the Standard Plan costs					
PPO without HSA funding	**Single**	$1,125	$902	$223	$102.92
	Dual	$2,251	$1,805	$446	$205.85
	Family	$3,073	$2,465	$608	$280.62
Flexible Blue (FB3): The Employee pays 20% of the plan costs					
Figures do not include HSA funding of $750 Single or $1,500 Family	**Single**	$579	$463	$116	$53.54
	Dual	$1,159	$927	$232	$107.08
	Family	$1,580	$1,264	$316	$145.85
Simply Blue (SB3): The Employee pays 20% of the plans costs					
Figures do not include HSA funding of $1,500 Single or $3,000 Family	**Single**	$420	$336	$84	$38.77
	Dual	$838	$670	$168	$77.54
	Family	$1,145	$916	$229	$105.69

**Elected Officials must pay 20% on all plans.*

How To Choose the Right Plan

Selecting the best medical plan for you and your family is an important decision. Here are some key factors to consider to ensure you're making an informed choice:

1. **Assess Your Healthcare Needs**
   Current Health Status: Consider your overall health and that of your dependents. If you or a family member has a chronic condition or requires frequent medical care, a plan with higher premiums but lower out-of-pocket costs might be more economical in the long run.
   Expected Healthcare Usage: Think about the medical services you anticipate using in the coming year. This includes doctor visits, prescription medications, specialist care, and any planned procedures.
2. **Understand the Costs**
   Premiums vs. Deductibles: Higher premiums often mean lower deductibles and out-of-pocket costs. If you expect frequent medical care, a plan with higher premiums may save you money overall.
   Copayments and Coinsurance: Consider the fixed costs (copays) and the percentage you'll pay (coinsurance) for services. Choose a plan with costs that fit your budget.
   Out-of-Pocket Maximum: This is the most you'll pay in a year. Once reached, the plan covers 100% of your medical expenses. A lower maximum can protect you from unexpected costs.
3. **Check the Provider Network**
   Preferred Doctors and Hospitals: Ensure your preferred healthcare providers and hospitals are in the plan's network. Out-of-network care can be significantly more expensive or may not be covered at all. If you or a family member sees specialists regularly, check if they're in-network and whether a referral is needed from your primary care doctor.
4. **Consider Prescription Drug Coverage**
   Make sure your medications are covered and note the costs, including any deductibles or copayments specific to prescriptions.
5. **Consider Your Financial Situation**
   Align your choice with your overall financial situation. Consider how much you can afford in monthly premiums versus out-of-pocket costs when healthcare services are needed.
6. **Review and Reflect**
   Review your healthcare expenses from the previous year to identify trends and needs that could influence your decision. Consider any anticipated life changes, such as having a baby, that might affect your healthcare needs.

Choosing the right plan can seem daunting, but by carefully evaluating your options and considering your specific needs, you can select a plan that provides the right balance of coverage and cost for you and your family. If you need assistance, our HR team is here to help guide you through the process.

Calhoun County Health & Wellness Center

What is the Health and Wellness Center?

The Health and Wellness Center is a dedicated clinic near our workplace that provides a wide range of medical services with reduced or no cost to employees and their dependents. This clinic is staffed by experienced healthcare professionals who are committed to supporting your wellbeing.

Services Offered

The Health and Wellness Center provides comprehensive care, including but not limited to:

- **Primary Care Visits:** Routine check-ups, management of chronic conditions, sports physicals, and preventive care.
- **Acute Care:** Treatment for minor illnesses and injuries.
- **Laboratory Services:** Blood tests, screenings, and other diagnostic services.
- **Immunizations:** Flu shots, vaccinations, and more.
- **Health Screenings:** Health risk assessments and biometric screenings.
- **Wellness Programs:** Personalized health coaching, weight management, and chronic condition programming.
- **Prescriptions:** The on-site pharmacy has over 150 different generic medications. Ask about mail order for long-term medications.

Benefits of Using the Health and Wellness Center

- **Convenience:** Located close to your workplace, making it easy to schedule appointments during work hours or on your way home.
- **Time Saving:** Enjoy easy scheduling online or by phone and minimal wait times (average under 5 minutes). Extended hours on nights and weekends.
- **Cost Savings:** Enjoy reduced or free pricing on most services, helping you save on out-of-pocket expenses.
- **Quality Care:** Access to high-quality care from trusted healthcare providers who understand your needs.
- **Confidential:** All appointments and medical records are kept confidential

How to Use the Health and Wellness Center

- **Scheduling an Appointment:** Call (269)743-3315 or visit the website to schedule an appointment. Same-day appointments are often available for urgent needs.
- **Hours of Operation:** The clinic is open Monday - Saturday, offering flexible hours to accommodate your schedule.

Who Can Use the Health and Wellness Center

All employees and their dependents enrolled in the County medical plans are eligible to use the Health and Wellness Center. This includes spouses and children (2+ years old). The Calhoun County Health & Wellness Center provides medical plan participants with a primary health care option that is high-quality, convenient, inexpensive, and confidential. Non-medical plan participants are also eligible to access the My Premise Health online portal and participate in the annual Health Risk Assessment free of charge.

Note: Employees on the Flexible Blue or Simply Blue plans that have an HSA, receive FREE preventative services and medications through the Calhoun County Health & Wellness Center. However, the IRS requires that a nominal contribution or "fair market value" be charged for non-preventative items. For 2025, the fees are $50 for non-preventative services and medications.

For employees that already have a primary care physician, please remember you can still use the center for lab work, preventative meds, free coaching (registered dietitian, smoking cessation, behavioral health, diabetes, etc.…), as well as all the My Premise Health online tools.

Your health is important to us, and the Health and Wellness Center is here to make sure you have easy access to the care you need. Whether you need a routine check-up, help managing a chronic condition, or just want to stay on top of your wellness goals, the clinic is a valuable resource for you and your family.

Contact Information

Location: 34 Green St, Battle Creek, MI 49014
Phone Number: (269) 743-3315
Website: mypremisehealth.com
Hours:

- Monday – Thurs 7 AM – 7 PM
- Friday 7 AM – 5 PM
- Saturday 9 AM – 3 PM

Dental Coverage

Delta Dental of Michigan continues to be the provider for 2025.

Dental coverage is an important benefit employees choose. Calhoun County understands that each employee and family is unique and therefore different plan options are provided through Delta Dental of Michigan:

1. **Core Plan ($0 premium)**
2. **Buy-Up Plan**

The **Core Plan** is provided by the County with no premium charge for you and your family. Calhoun County also offers a **Buy-Up** option, which provides coverage at a higher percentage and higher lifetime maximum for orthodontia. You are responsible for the cost difference between the Core and Buy-Up plan if you chose to elect this benefit.

How To Select a Dentist

Under these plans, you are free to select any dentist; however, it would be most cost-effective to choose a dentist who participates in one of Delta Dental's two networks:

- **Delta Premier:** If you choose a Delta Premier dentist, the dentist has agreed to accept Delta Dental's fee schedule and file claims on your behalf.
- **Delta PPO:** If you choose a Delta PPO dentist, the dentist has agreed to discounted services. This is the lowest cost option.
- **Out-Of-Network:** If you choose an out-of-network dentist, Delta will cover up to the usual and customary amount for the services provided. Your dentist may balance bill.

To find a network dentist, go to www.deltadentalmi.com.

No matter which dentist you choose, the plan covers:

Dental Plan Coverage		
	Delta Dental Core	**Delta Dental Buy-Up**
Annual Deductible	None	None
Annual Maximum per person	$1,500 per person Classes II and III services combined	$2,000 per person Classes II and III services combined
Class I *Diagnostic and Preventive Services, Cleanings, Exams & Fluoride treatments*	Covered at 100%	Covered at 100%
Class II *Basic and Restorative Services, Oral Surgery, Fillings, Root Canals, Bridge and Denture Repair*	Covered at 80%	Covered at 80%
Class III *Prosthodontic Services, Bridges and Dentures*	Covered at 50%	Covered at 80%
Class IV *Orthodontia Services (up to age 19)*	Covered at 50%, ($1,500 Lifetime Maximum per dependent)	Covered at 50%, ($2,000 Lifetime Maximum per dependent)

Delta Dental Plan Limits	
Covered Services	**Benefit Frequency** (Core and Buy-Up)
Oral Exams	Twice per calendar year
Prophylaxes (cleanings)	Twice per calendar year
Fluoride Treatments	Once per calendar year (up to age 19)
Bitewing X-rays	Once per calendar year (under age 15); Once per two-year period (ages 15+)
Full Mouth X-rays	Once in any five-year period

Dental Premium Rates		
Coverage	**Core Plan**	**Buy-Up Plan**
Single	$0	$1.40
Dual	$0	$2.94
Family	$0	$5.63

Vision Coverage

Vision coverage is provided by BCBSM through Vision Service Plan (VSP) using the VSP provider network. Your vision plan is designed to provide you with the highest level of benefit and the least amount of out-of-pocket costs when you choose a participating provider. Participating providers have signed agreements to accept the approved amount, less your copay, as payment in full for covered services.

Blue Vision-VSP		
	VSP Provider	**Non-Participating Provider**
Vision Examination (once per calendar year)	Covered 100% after $5 copay	Up to $35, less a $5 copay (member responsible for any difference)
Lenses and Standard Frames (once per calendar year)	Covered 100% after $10 copay for lenses and standard frames	Up to a predetermined amount for lenses and up to $45 for frames, less a $10 copay (member responsible for any difference)
Elective Contact Lenses (once per calendar year)	$150 Allowance for lenses and exam	$105 Allowance for lenses and exam
Please Note: Benefits are payable for either eyeglass lenses or contact lenses, but not both.		

Premium

Calhoun County provides vision coverage to employees and their spouse/dependents with no premium charge (100% employer paid)

Flexible Spending Accounts

A Flexible Spending Account (FSA) allows you to set aside a set amount of money from your paycheck before taxes to pay for specific health care or dependent care expenses, which lowers your taxable income. The County partners with Wex for administration of this benefit.

The main advantage of an FSA is the tax savings it offers. An FSA enables you to pay for eligible out-of-pocket expenses with money you set aside from your pay before any taxes are taken out. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after taxes are withheld.

Calhoun County offers two types flexible spending accounts:

1. **Health Care FSA**
2. **Dependent Care FSA**

What is an FSA?

An FSA is a special account where you can set aside money from your paycheck before taxes are taken out. This means you lower your taxable income, and you can use the funds to pay for eligible out-of-pocket expenses, giving you a tax break on those costs. You'll receive a debit card attached to this account to easily cover eligible expenses.

Eligible Expenses – Health FSA

Use this account for medical, dental, and vision expenses not covered by your insurance, such as copayments, coinsurance, deductibles, prescription medications, eyeglasses, contact lenses, and over-the-counter medications.

Eligible Expenses – Dependent Care FSA

This account helps cover costs for dependent care services, such as daycare, preschool, after-school programs, and child care for a dependent who is unable to care for themselves while you work.

A complete list of qualified medical expenses can be found on the IRS website: www.irs.gov.

Flexible Spending Account	Annual Contribution	
	Minimum	**Maximum**
Health Care Spending *(medical, dental, vision)*	$150	$3,300
Dependent Care	$150	$5,000*

**$2,550 if married and filing separately*

How Do You Save Money with a Flexible Spending Account?

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

It is important to plan carefully when choosing which plans and contribution amounts are right for you as any remaining amounts at the end of the calendar year are forfeited. You must enroll in this benefit each year you wish to participate.

Note: you are not eligible to participate in a health care flexible spending account if you are enrolled in a HSA medical plan (the Flexible Blue or Simply Blue plans). You can still enroll in the dependent FSA on any plan.

The FSA is a powerful tool to help manage healthcare and dependent care costs while saving on taxes. By carefully planning your contributions and understanding how to use your FSA, you can maximize your savings and ensure you're prepared for any unexpected expenses throughout the year.

Additional Benefits

Short Term Disability (STD), Basic Life and AD&D Plans

Calhoun County provides Short Term Disability and Basic Life and AD&D benefits at no cost to you. Eligibility and coverage levels for these benefits vary. Please refer to the County policy or your union contract for details. Life benefits reduce for employees age 65 and older.

New York Life

New York Life administers the County's voluntary benefits. For more information, forms, and calculators, visit: https://www.newyorklife.com/group-benefit-solutions/calhoun-county or use this QR Code

Voluntary Benefits Available

- Optional Life and AD&D
- Optional Long-Term Disability
- Critical Illness Insurance
- Accident Injury Insurance
- Hospital Indemnity

Optional Life and AD&D Plans

Choosing the right amount of Life and Accidental Death & Dismemberment Insurance is something only you and your family can decide based on your needs. The Optional Life and AD&D plan allows you to purchase additional coverage for you, your spouse and/or your dependent child(ren). To purchase coverage for your spouse or child(ren), you must first elect optional coverage for yourself. Coverage effective dates and increases in coverage may be delayed if you or your dependents are disabled on the date coverage is scheduled to take effect. You may be required to provide Evidence of Insurability if you or your spouse does not elect optional life and AD&D insurance when initially eligible but later elect it or if you elect an amount of coverage in excess of $150,000 for yourself or $25,000 for your spouse. Life benefits reduce for employees age 65 and older. The full cost of the optional coverage is deducted from your paycheck on an after-tax basis.

- **Employee Optional Life and AD&D**
  Employees may purchase optional life and AD&D insurance in increments of $10,000. The minimum amount is $10,000 and the maximum is the lesser of 8 times your annual earnings or $500,000. Rates charts available on EARL
- **Spouse Optional Life**
  You may purchase coverage for your spouse in increments of $5,000 to the lesser of 50% of your optional life insurance or $50,000. Rates charts available on EARL
- **Child Optional Life**
  You may purchase Optional Life insurance for your children. Coverage for children live birth to 6 months is $500; coverage for children aged 6 months to 23 years (25 years if full time student) is $10,000. Rates charts available on EARL

Optional Long-Term Disability Plan

The Optional Long-Term Disability Plan (LTD) provides a stable source of income should you become disabled and are unable to work for an extended period of time or indefinitely. The LTD benefit is equal to 60% of your monthly income to a maximum benefit of $3,000. Monthly income is defined as total income before taxes and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. LTD benefits are payable after 180 days of disability for employees with 26 weeks of STD and after 360 days of disability for employees with 52 weeks of STD. LTD benefits may continue until you reach age 65, or longer in some instances.

If you do not elect optional Long-Term Disability when initially eligible and you wish to elect this coverage during a subsequent annual enrollment period, you will be required to provide proof of insurability. Your coverage effective date may be delayed if you are not actively at work on the date coverage is scheduled to take effect. No benefits are payable for disability due to a pre-existing condition unless the disability starts after you complete one day of active work after the date you are insured under this plan for 24 months in a row. The full cost of this optional coverage is deducted from your paycheck on a post-tax basis and benefits would be paid on a pre-tax basis. *Premiums are based on employee age and salary. Rates charts available on EARL

Group Critical Illness Insurance

New York Life's group critical illness insurance can help protect your finances from the expense of a serious health problem, such as a stroke or heart attack. Cancer coverage is also available. This plan pays a lump-sum benefit directly to you – not to a doctor or health care provider – at the first diagnosis of a covered condition. Employees can choose $10,000, $20,000, or $30,000 in coverage and reduced amounts are available for spouses and dependent children. Rates charts available on EARL

**This year, you can elect Critical Illness without answering any medical questions – even if you declined this coverage in previous years.

The following specified critical illnesses are covered under the base plan and pre-existing condition limitations apply. Please refer to the policy for complete details about these covered conditions.

- Heart Attack
- Blindness
- Stroke
- Cancer
- Major Organ Transplant
- End-Stage Renal (Kidney) Failure
- Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- Coronary Artery Disease (pays 25% of lump sum benefit)
- Carcinoma In Situ (pays 25% of lump sum benefit)
- Permanent Paralysis as a result of a covered accident
- Wellness Benefit Included

Critical Illness Plan Options	
Relationship	**Benefit Options**
Employee	$10,000, $20,000, or $30,000
Spouse	50% of employee benefit
Child	25% of employee benefit

Group Accident Insurance

New York Life's group accident insurance can pay lump-sum benefits based on the injury you receive and the treatment you need, including emergency room care and related surgery. The benefit can help offset the out-of-pocket expenses that medical insurance does not pay, including deductibles and co-pays. A wellness benefit will provide an annual pay-out for preventive care. Group accident insurance can be purchased for you, your spouse, and your child(ren).

What is covered?

Covered Injury	Benefit Amount
Fractures (open or closed)	Up to $2,000
Dislocations (open or closed)	Up to $2,000
Burns	Up to $300
Concussion	$100
Coma due to a covered injury	$5,000
Laceration	Up to $100
Eye injury	$200
Paralysis	Up to $2,000
Covered Expense	**Benefit Amount**
Emergency room treatment	$100
Physician follow up visit	$50 (up to 10 per accident)
Hospitalization	$500 for admission $100 per day for hospital stay (up to 365 days) $200 per day for ICU stay (up to 365 days)
Follow up physical therapy	$25 (up to 10 per accident)
Ambulance	$100 ground, air

See the schedule of benefits for a full list of covered injuries and expenses.

Accident Injury Premium Rates	
Employee Only	$3.77
Employee + Spouse	$6.42
Employee + Child(ren)	$6.31
Employee + Family	$8.96

*All Accident benefits are paid when a covered injury results, directly and independently of all other causes, from a covered accident. New York Life does not consider pregnancy an accident.

**This year, you can elect Accident without answering any medical questions – even if you declined this coverage in previous years.

Hospital Indemnity

New York Life's hospital indemnity insurance pays a daily benefit for a covered stay in a hospital, intensive care unit, or rehabilitation facility. Hospital Indemnity Insurance pays a covered person benefits upon experiencing a confinement due to illness or injury in a covered facility as defined.

Hospital Admission Benefits	Benefit Amount
Hospital Admission Payable on day 1 of confinement, payable once per confinement Calendar Year Limit (times payable)	$1,000 2
Intensive Care Unit Admission Payable on day 1 of confinement, payable once per confinement Calendar Year Limit (times payable)	$2,000 2
Confinement Benefits	**Benefit Amount**
Daily Inpatient Hospital Confinement Payable on day 2 of confinement when the admission benefit is applicable Period of Confinement Limit (days)	$200 30
Intensive Care Unit Confinement Payable on day 2 of confinement when the admission benefit is applicable Period of Confinement Limit (days)	$400 15
Rehabilitation Facility Confinement Payable on day 2 of confinement when the admission benefit is applicable Period of Confinement Limit (days)	$50 30
Short Stay/Observation Unit Payable for a stay that is 4 consecutive hours or more, other than as an inpatient stay Benefit is not payable if admitted, as the admission/confinement would be payable instead Calendar Year Limit (days)	$150 5
Newborn Confinement Benefits	**Benefit Amount**
Newborn/Health Baby Confinement **Confinement payable day 2 when the admission benefit is applicable, payable due to birth** Period of Confinement Limit (days)	$100 3
Health Screening Benefit	**Benefit Amount**
Health Screening Benefit Payable once per calendar year by covered person	$50

Hospital Indemnity Premium Rates	
Employee Only	$13.41
Employee + Spouse	$29.17
Employee + Child(ren)	$25.59
Employee + Family	$44.32

Making Mid-Year Changes

If you 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 Legal Notices more details.

The benefit elections you make during the annual enrollment period are effective throughout the next plan year (January 1 through December 31) – so choose wisely! Each fall, you make new selections for the next plan year. You have the flexibility to reevaluate your benefit needs each year, allowing you to change your coverage as you wish. Between annual enrollments, you can change your benefit coverage decisions only if you have a qualified change in status.

Qualified change in status events include:

- Birth, placement for adoption or adoption of a child, or being subject to a Qualified Medical Child Support Order, which orders you to provide medical coverage for a child
- Marriage, legal separation, annulment, or divorce
- Death of a spouse or covered dependent
- Change in the job status of employee or spouse
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan
- Spouse's loss or gain of equivalent coverage through their employer

Under IRS regulations, the change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. Or if your spouse's employment terminates and they lose coverage through their employer, you may add your spouse to your coverage. However, the change must be requested within 31 days of the event. If you do not notify Human Resources within 31 days, you must wait until the next annual benefit enrollment period to make a change.

Children's Health Insurance Program Reauthorization Act of 2009 adds the following two special enrollment opportunities.

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

It is your responsibility to notify Human Resources within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined.

Eligible Dependents

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

Eligible SPOUSE:

- Your legally married spouse.

Eligible CHILDREN:

- Medical, Prescription, Vision: You 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. Covered through the end of the year in which they turn 26.
- Dental: Dependent children to the end of the calendar year in which they turn 25.

Eligible DISABLED DEPENDENTS:

- A dependent 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 reaches the limiting age.

Where to Go for Help

Human Resources

(269) 781-0980 hr-department@calhouncountymi.gov MCB #3-100

Vendor	Coverage	Contact Number	Website
Blue Cross Blue Shield of Michigan	Medical	(800) 972-9797	www.bcbsm.com
		To find providers out of Michigan: (800) 810-2583	www.bcbs.com
Express Scripts	Prescription Drugs	(800) 282-2881	www.express-scripts.com
Delta Dental	Dental	(800) 482-8915	www.deltadentalmi.com
Blue Cross Blue Shield of Michigan/VSP	Vision	(800) 877-7195	www.bcbsm.com
WEX Health	Flexible Spending Accounts Health Savings Account	(866) 451-3399	https://www.wexinc.com
New York Life	Short Term Disability Life/AD&D Voluntary Life Voluntary Long-Term Disability Critical Illness & Group Accident	Disability Claims Intake: (800) 362-4462 Elective Benefits Claims Intake: (800) 754-3207	http://www.newyorklife.com/group-benefit-solutions/forms

Legal Notices

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).

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (WHCRA) of 1998 is a federal law that helps protect health plan members who choose to have breast reconstruction after a mastectomy. If you are receiving benefits in connection with a mastectomy, and you decide to have breast reconstruction, coverage must be provided for:

- *All stages of reconstruction of the breast on which the mastectomy has been performed;*
- *Surgery and reconstruction of the other breast for a balanced appearance;*
- *Prostheses, such as bra inserts, that are needed before or during reconstruction surgery; and*
- *Treatment of physical complications during all stages of the mastectomy. This includes lymphedema, swelling caused by a buildup of fluid in the arm and hand or other areas near the surgery site.*

These benefits will be provided subject to deductibles and coinsurance to the same extent as for any other illness under your coverage.

All other features and benefits of your policy remain the same and are not impacted by this annual notification.

Call your HR Department for more information.

Your HIPAA Privacy Rights

Keeping your personal health information private is your right. That's why the U.S. government passed the "Privacy Rule" – part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rule, passed in 2003, protects your health information and makes it illegal for health care providers to reveal information about your health without your permission unless needed to treat your condition. It also prevents the improper use of health information by health care benefit insurers and administrators. Doctors' offices and health care facilities are required by law to obtain your written permission to appropriately reveal information about your health.
A copy of our Notice of Privacy Practices is available upon your request by contacting Human Resources.

Special Enrollment Rights

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

In addition, if you have a new dependent 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.

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

To request special enrollment or obtain more information about it, please contact Human Resources.

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 July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 1-916-445-8322 Fax: 1-916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecover y.com/hipp/index.html Phone: 1-877-357-3268

Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp Phone: 1-678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorizationact-2009-chipra Phone: 1-678-564-1162, Press 2	Health Insurance Premium Payment Program All Other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Medicaid Phone: 1-800-338-8366 Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hippHIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 1-603-271-5218

	Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 1-919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 1-304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-andeligibility/ Phone: 1-800-251-1269

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

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

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

1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

Patient Protection Model Disclosure

Priority Health generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Priority Health.
For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Priority Health 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 Priority Health.

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 Calhoun County may use aggregate information it collects to design a program based on identified health risks in the workplace, Calhoun County 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. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are health professionals in order to provide you with services under the wellness program.

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.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage for the 24-month period that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

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.

Important Notice 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 **Calhoun County** 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. Calhoun County has determined that the prescription drug coverage offered by its group health 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 and drop your Calhoun County prescription drug coverage, be aware that your current prescription drug coverage is part of your medical coverage from Calhoun County. You cannot drop your Calhoun County prescription drug coverage unless you also drop your Calhoun County medical coverage. If you enroll in a Medicare Part D plan and drop your creditable coverage with Calhoun County, you may not be able to return to the same plan through Calhoun County until the next enrollment period or if you experience a qualifying life event.

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 Calhoun County 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 19 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 as long as you are covered by the Calhoun County group health plan. If in the plan, you will also get it before the next period you can join a Medicare drug plan, and if this coverage through Calhoun County changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.ssa.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,

Date:	November 5, 2024
Name of Entity/Sender:	Calhoun County Kim Archambault 315 W. Green St Marshall, MI 49068
Contact Person:	Kim Archambault
Phone:	(269) 781-0992

Calhoun County Group Health Plan Procedures for Handling Medical Child Support Orders

1. The plan administrator will designate a responsible individual, by name, title or both, to receive all medical child support orders (MCSOs) delivered to Calhoun County request.

2. Employees who could receive the MCSOs will be instructed to deliver any medical child support order, and any domestic relations order which purports to be a medical child support order, to the individual designated for this purpose. The immediate delivery of any such order to the designated individual is absolutely necessary in order to minimize potential fiduciary liabilities for failing to act prudently as required by ERISA, including liabilities for uncovered medical expenses.

3. Upon receipt of a MCSO, the designated individual will:

   (a) Forward a copy of the MCSO and related correspondence to the plan administrator or its designated representative to determine if the MCSO is a qualified MCSO ("QMCSO"); and

   (b) Promptly notify the effected employee and each alternate recipient of (1) the receipt of the MCSO, (2) the plan's procedures for determining whether the MCSO is a QMCSO, and (3) the alternate recipient's right to designate a representative for the receipt of copies of notices to be sent to the alternate recipient with respect to the MCSO. If the alternate recipient is a minor, the notice will be sent in care of the custodial parent or legal guardian identified in the order.

4. If the MCSO is a National Medical Support Notice (as defined in ERISA Section 609(a)(5)(c)), the designated individual will notify the issuing agency, within 20 business days of the date of the notice, if the employee is not eligible for coverage under the plan or if state or federal withholding limitations prevent the withholding from the employee's income of the amount required to obtain coverage under the terms of the plan. (In which case, no coverage will be provided to the proposed alternate recipient).

5. Within a reasonable time after receipt of the MCSO, the designated individual, or legal counsel on his or her behalf, will review the MCSO and make a determination as to whether the MCSO meets all of the requirements for a QMCSO under ERISA. (See the Plan Administrator's QMCSO Determination Checklist for the factors to be used to determine the MCSO's status).

6. If the MCSO is a National Medical Support Notice, the notice will be deemed to be a QMCSO if it contains the name of the issuing agency, the name and mailing address of an employee who is participating under the plan, the name and mailing address of the alternate recipient(s) (or name and address of the official or agency which has been substituted for the mailing address of the alternate recipients) and identifies an underlying child support order. The designated individual, or legal counsel on his or her behalf, will determine whether the notice complies with the requirements of this paragraph.

7. The responsible individual, or legal counsel on his or her behalf, will notify the employee and each alternate recipient (or his/her designated representative or the issuing agency), in writing, of the determination as to the qualification of the MCSO as a QMCSO within a reasonable period of time after receipt of the order but not later than 40 business days after the date of the notice with respect to a National Medical Support Notice.

8. If the MCSO fails to meet the requirement for a QMCSO, the notice described in 7 above will include an explanation of the deficiency. If the MCSO is a National Medical Support Notice, the designated individual will complete item 5 of the plan administrator response, sign the response and send it to the issuing agency.

9. If the MCSO is, or ultimately becomes, a QMCSO, the designated individual will (1) determine the coverage and benefit options available, if any, to the alternate recipient in accordance with these procedures, and (2) deliver applicable enrollment forms, plus filing instructions, a copy of the plan's current summary plan description, including any applicable summary of material modifications and benefit booklets or other benefit descriptions not included in the summary plan description or summary of material modifications, to each alternate recipient identified in the QMCSO or to his/her designated representative or the issuing agency.

10. If the QMCSO is a National Medical Support Notice, the plan administrator will notify the issuing agency, within 40 business days of the date of the notice, of the alternate recipient's eligibility for coverage, the effective date of coverage and, if necessary, the steps to be taken by the custodial parent or agency to obtain coverage for the alternate recipient. If the custodial parent must take any steps to obtain coverage, the plan administrator will provide a copy of the plan's current summary plan description, applicable enrollment forms and filing instructions to the custodial parent.

11. Coverage will be offered to the alternate recipient in accordance with the plan's terms as follows:

    (a) If the employee is covered under the plan with family coverage, the alternate recipient will only be offered coverage in that same coverage option. However, the plan administrator should have the alternate recipient complete the plan's enrollment form. The enrollment form should be sent to the alternate recipient with the coverage option box selected and a cover letter should also be sent explaining that the alternate recipient may only receive coverage under the employee's existing coverage option, but that the other portions of the enrollment form need to be completed before the alternate recipient is covered under the plan.

    (b) If the employee is receiving coverage under the plan, but the alternate recipient lives outside the network or HMO coverage area of the employee's coverage option, the plan administrator will allow the employee to elect a different option that will cover the alternate recipient. If the employee does not make a timely election, the custodial parent (or authorized issuing agency) may elect the coverage option and the employee's coverage will be changed to the option so elected.

    (c) If the employee is not receiving coverage under the plan, the plan administrator will allow the employee to elect the coverage option that will apply to both the employee and the alternate recipient. If the employee does not elect a coverage option in a timely fashion, the alternate recipient's custodial parent (or issuing agency, in the

case of a national medical support notice) may elect the coverage option. The employee will be required to be covered under the plan when the alternate recipient's coverage begins. **If the plan administrator does not hear from the alternate recipient's custodial parent or authorized issuing agency within 20 business days of the date the notice is sent to the alternate recipient's custodial parent or the issuing agency, the alternate recipient (and employee) will be enrolled in the Priority Health Plan.**

12. Upon receipt of fully completed enrollment forms, the plan administrator will enroll each alternate recipient as an eligible dependent of the employee in the plan in the coverage option available to the alternate recipient as determined in paragraph 11. The alternate recipient's coverage will be effective on the first day of the calendar month coincident with or following the receipt by the plan administrator of such fully completed enrollment forms. The alternate recipient is not entitled to coverage or any type or form of benefit, or any option, not otherwise offered by the plan. However, the alternate recipient is entitled to options such as dental and vision, if offered by the plan, even though the employee only has major medical coverage, if the employee is eligible for such coverage, and if the QMCSO states the alternate recipient is to have such coverage.

13. Effective as of the date the alternate recipient's coverage commences under the plan, the plan administrator may take any necessary steps to collect any applicable premium for the alternate recipient's coverage which the employee is required to pay pursuant either to the terms and conditions of the QMCSO or the terms and conditions of the plan. The means of collection may include, but is not limited to, pre-tax or post-tax payroll deductions.

14. Any claims submitted to the plan administrator for medical expenses incurred prior to the effective date of the alternate recipient's coverage under the plan will not be considered as eligible expenses and no payment or other reimbursements will be made for such expenses by the plan.

15. Any payment of plan benefits in reimbursement of eligible expenses paid by an alternate recipient, or by an alternate recipient's custodial parent or legal guardian on his/her behalf, will be made to the alternate recipient or to the applicable custodial parent or legal guardian.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.02%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.02% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-24-35.pdf for 2025.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and November 30, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can

request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description.

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 Calhoun County	4. Employer Identification Number (EIN) 38-6004358		5. Phone Number 269-781-0992
6. Employer Address 315 W. Green St	7. City Marshall	8. State MI	9. Zip Code 49068
10. Who can we contact about employee health coverage at this job? Kim Archambault			
11. Phone Number (if different from above) 269-781-0992		12. Email Address karchambault@calhouncountymi.gov	

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

- As your employer, we offer a health plan to:

  ☒ All employees. Eligible employees are:

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

Spouse, you or your spouse's child who is under the age of 26, including natural child, stepchild, a legally adopted child, child placed for adoption or child whom you or your spouse are the legal

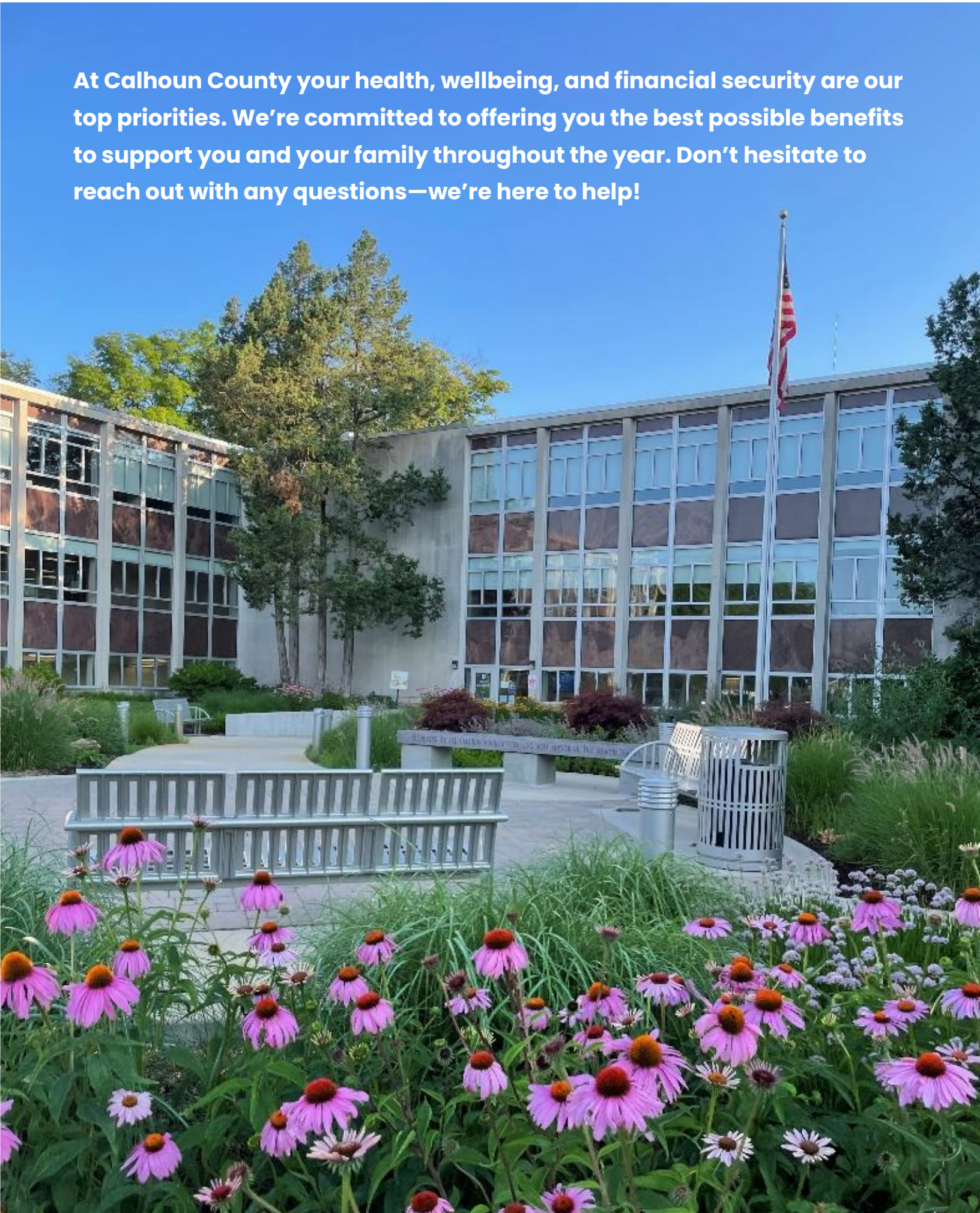
☐ We do not offer coverage.

☒ I 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, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986.



At Calhoun County your health, wellbeing, and financial security are our top priorities. We're committed to offering you the best possible benefits to support you and your family throughout the year. Don't hesitate to reach out with any questions—we're here to help!