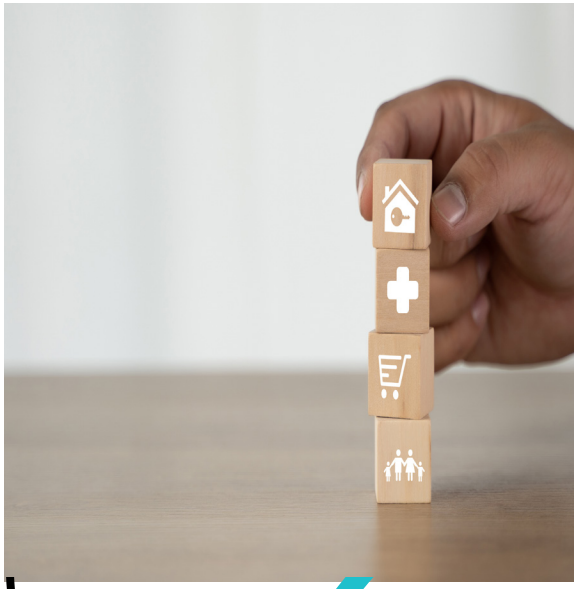
2026 BENEFITS GUIDE

MICHIGAN MEMBERSHIP

WHAT'S INSIDE



WELCOME TO YOUR 2026 BENEFITS!

Use this Benefits Guide to see what's new and to learn about your benefit plan options.

Reformed Benefits Association (RBA) 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 document was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide 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.

WELCOME

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	Examples	Documentation Needed
Change in Marital Status	• Marriage • Divorce/Legal Separation • Death	• Copy of marriage certificate • Copy of divorce decree • Copy of death certificate
Change in Number of Dependents	• Birth or adoption • Step-child • Death	• 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	• Change in your eligibility status (i.e., full-time to part-time) • Change in spouse's benefits or employment status	• 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

TO ENROLL OR MAKE CHANGES FOR 2026:

Go online to https://reformedbenefits.bswift.com.

Call toll-free at 844-643-1131

Changing Benefits After Enrollment

During the year, you cannot make changes to any benefits 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).

PROTECTION YOU NEED
Our medical coverage provides you and your family the protection you need for everyday health issues or when the unexpected happens.

MEDICAL PLANS

You have five plan options available to you through HMA, accessing the Priority Health PPO network for all plans. Note that the HMA plans do have out-of-network benefits, but it is always more cost effective for you to see in-network providers.

How This Health Plan Works

RBA partners with HMA, our plan administrator, to provide Michigan membership with access to the Priority Health network. You will be receiving a standard medical ID card if you enroll in an HMA plan, but you'll also receive a Priority Health Provider Support Card to help reinforce your provider and facility access with Priority Health providers. You will show both your Provider Support Card and your HMA member ID card when receiving care at a Priority Health provider or facility. Your Provider Support Card does not replace your HMA member ID card.

To get started with HMA, register on the member portal, where you can access benefit and claims information, check out your benefits, and more! Visit accesshma.com for more details. You can also contact HMA's Customer Care Team Mon-Fri 8am-9pm EST by calling the number of the back of your HMA member ID card.

You can also download the HMA mobile app, where you can:

- View your digital member ID cards
- Find an in-network provider or hospital
- Securely access your claims and benefits at home or on the go
- Get connected to HMA's Customer Care team at the touch of a button

You can also find in-network providers where you will be able to search for providers, facilities and more.

Please note that HMA utilizes the Cigna Open Access Plus (OAP) network for any care received outside the state of Michigan. Members can see any provider within the OAP network when traveling outside of the state. The Cigna OAP logo on your member ID card indicates to providers that you have access to this network when traveling, etc.

MEDICAL PLAN COMPARISON

	HMA Premium Plan (HRA Compatible)		HMA Consumer Plan (HSA Compatible)		HMA $4,000 HDHP Plan (HSA Compatible)		HMA $8,000 HDHP Plan (HSA Compatible)		HMA Copay Plan (FSA Compatible)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Annual Deductible										
Individual	$2,000*	$4,000*	$2,000*	$6,000*	$4,000*	$8,000*	$8,000*	$12,000*	$500*	$15,000*
Family	$4,000*	$6,000*	$4,000**	$12,000**	$8,000*	$16,000*	$16,000*	$20,000*	$1,000*	$30,000*
Out-of-Pocket Maximum										
Individual	$5,000*	$15,000*	$5,000*	$15,000*	$8,000*	$15,000*	$8,000*	$15,000*	$5,000*	$19,650*
Family	$10,000*	$30,000*	$10,000*	$30,000*	$16,000*	$30,000*	$16,000*	$30,000*	$10,000*	$39,300*
Benefit Coverage Details (Percentage amounts listed below are applicable after deductible)										
Preventive Care	$0	Not covered	$0	Not covered	$0	Not covered	$0	Not covered	$0	50%
Primary Care Physician	$20 copay	50%	20%	50%	30%	50%	0%	50%	$75 copay	50%
Specialist	$120 copay	50%	20%	50%	30%	50%	0%	50%	$100 copay	50%
Urgent Care	$50 copay	50%	20%	50%	30%	50%	0%	50%	$100 copay	50%
Emergency Room	20%	20%	20%	20%	30%	30%	0%	0%	$500 copay[1]	$500 copay[1]
X-ray and Lab (Diagnostic)	20%	50%	20%	50%	30%	50%	0%	50%	$200 copay[1]	50%
Major Imaging (MRI, CT, PET)	20%	50%	20%	50%	30%	50%	0%	50%	$500 copay[1]	50%
Hospital Inpatient	20%	50%	20%	50%	30%	50%	0%	50%	$2,500 copay[1]	50%
Outpatient Surgical Facility	20%	50%	20%	50%	30%	50%	0%	50%	$1,000 copay[1]	50%

* Embedded Deductible/OOPM **Non-Embedded Deductible /OOPM
1 Copay applies, then subject to deductible

Terms to know:

- **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 (OOPM)**- 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 the 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.
- **Embedded Deductible/OOPM -** An embedded deductible or out-of-pocket maximum is a feature where individual members of a family plan each have their own deductible or out-of-pocket limit, and once any member meets their individual limit, the plan begins to cover expenses for that member even if the overall family limit hasn't been reached.
- **Non-embedded deductible/OOPM -** A non-embedded deductible or out-of-pocket maximum is a feature where the entire family must collectively meet the full family deductible or out-of-pocket limit before the plan starts to cover expenses for any family member.

PHARMACY BENEFITS

If you enroll in one of the RBA medical plans, you will automatically receive prescription drug coverage through Optum. 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.

PHARMACY BENEFITS

	HMA Premium Plan (HRA Compatible)		HMA Consumer Plan (HSA Compatible)		HMA $4,000 HDHP Plan (HSA Compatible)		HMA $8,000 HDHP Plan (HSA Compatible)		HMA Copay Plan (FSA Compatible)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Prescription	Mail Order 2.5x		Mail Order 2.5x		Mail Order 2.5x		Mail Order 2.5x		Mail Order 2.5x	
Retail Tier 1	$10 copay	50%	$10 after ded	50%	$10 after ded	50%	$0 after ded	50%	$10 copay	50%
Retail Tier 2	$40 copay	50%	$40 after ded	50%	$40 after ded	50%	$0 after ded	50%	$90 copay	50%
Retail Tier 3	$80 copay	50%	$80 after ded	50%	$80 after ded	50%	$0 after ded	50%	$160 copay	50%
Retail Tier 4	$100 copay	50%	$100 after ded	50%	$100 after ded	50%	$0 after ded	50%	$440/$480/ $530 copay	50%

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, visit the Optum website at www.optumrx.com or call 855-524-0381.

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 Optum website at www.optumrx.com or call 855-524-0381.

RazorMetrics

We're excited to partner with RazorMetrics, a program that can help lower your prescription costs. RazorMetrics operates behind the scenes and identifies savings on your prescriptions. If a lower-cost option is available, your doctor will be notified — and only medications they approve will be recommended. There's nothing you need to do. No forms, no sign-up, no changes to your pharmacy routine.

MEDICAL PLAN RESOURCES & TOOLS

You have many valuable resources available to you if you choose to enroll in one of our medical plans.

Concierge Support

Health care can be confusing…you have a Care Navigator available to help!

Care Navigator Plus through HMA provides a one-stop-shop to help answer questions and help you make better informed healthcare decisions. Your Care Navigator team can assist with items such as, but not limited to:

- Finding the best provider in your area
- Understanding complex bills
- Education on benefits and resources available in your plan
- Preparing for surgical procedures
- Identify ways to lower your health care spend
- And more!

Contact your Care Navigator at 1-833-865-0143 or at mycarenav@accesstpa.com for support.

Price Comparison Tool

HMA members have access to a price comparison tool through Healthcare Bluebook to find savings for all shoppable procedures. The tool makes it easy to search for the Fair Price and compare estimated procedure costs between facilities including what your personal deductible and out-of-pocket share will look like.

To access Healthcare Bluebook, log in to your HMA member portal at https://mi.accesshma.com/, click on "Explore Your Benefits" and "Shop and Compare Procedure Costs".

Virtual Telemedicine

Virtual telemedicine is available to all HMA members through MDLIVE. Visit mdlive.com or the MDLive app and activate your account by signing up through the Member Portal or by texting HMA to 635483.

Copay and PPO plan members are $20 per visit
HDHP members are 80% after deductible/coinsurance per visit.

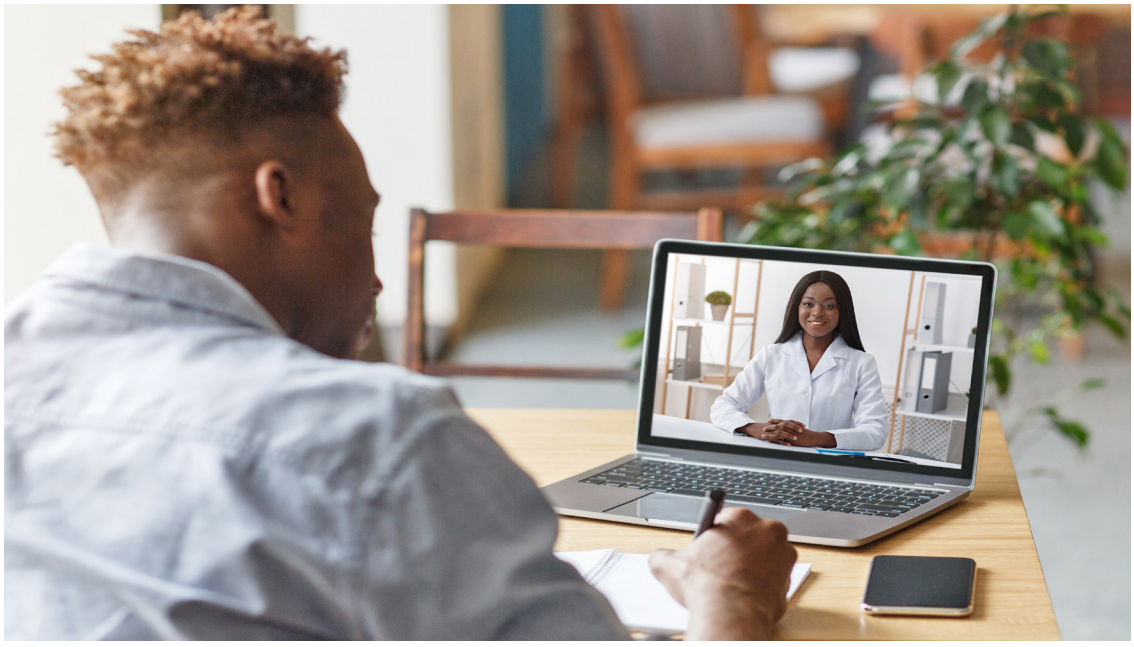
Diabetes Support

Teladoc Diabetes program can provide FREE, customized diabetic support to members living with a diabetes diagnosis.

Visit myrbabenefits.com for more information.

Virtual Exercise Therapy

Hinge Health provides customized virtual exercise therapy for UMR members experiencing back pain, joint pain, those in need of pelvic floor therapy, etc. To get started, call 855-902-2777 or go to hingehealth.com/rba.



SUPPLEMENTAL MEDICAL

Just as it sounds, Supplemental Medical Plans – Accident, Critical Illness and Hospital Indemnity 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 pay 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

Sample of Covered Benefis:

- Emergency room visits
- Hospital stays
- Medical exams (including major diagnostics)
- Physical therapy
- Fractures and dislocations
- Transportation and lodging if the accident occurs away from home
- And more!

How the plan works:

John was in a car accident on his way to work and received treatment, including ambulance transport to the emergency room. He had a dislocated hip, had a 5-day hospital stay, and received physical therapy, and more. His total benefit payout was **$5,450**. He used this to cover copays, his deductible, and supplemental income for his missed work days.

Sample Reimbursements

Service	Benefit Amount
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 INSURANCE

Provides a **lump sum payment** if you are diagnosed with a covered serious illness after your coverage begins. You can use the money however you choose, whether for lost income, medical costs, travel, or everyday expenses.

Sample of Covered Conditions:

- Heart attack
- Stroke
- Major organ failure
- Alzheimer's disease
- Parkinson's disease
- Multiple sclerosis
- And more

How the plan works:

Tom suffered a small stroke, was hospitalized for five days, then entered rehab. He submitted his claim and received a **$10,000** lump-sum payment to support his recovery and related expenses.

Sample of Covered Conditions:

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

HOSPITAL INDEMNITY INSURANCE

Hospital indemnity insurance provides a range of fixed, lump-sum daily benefits to help cover costs associated with a hospital admission and confinement. Benefits are paid directly to the insured following a hospitalization that meets the criteria.

SAMPLE BENEFIT AMOUNT

Hospital Admission Benefits	
Hospital Admission (1 daily benefit per coverage year)	$1,000
Hospital Admission: ICU (1 daily benefit per coverage year)	$1,000
Hospital Admission: Nursery Care (1 daily benefit per coverage year)	$250
Hospital Confinement Benefits	
Hospital Confinement (30 daily benefits per coverage year)	$200
Hospital Confinement: ICU (30 daily benefits per coverage year)	$200
Hospital Confinement: Nursery Care (30 daily benefits per coverage year)	$50

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 a 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 $4,400 if you enroll only yourself, or $8,750 if you enroll in family coverage. You can make an additional catch-up contribution of $1,000 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 your company or retire, your HSA goes with you and you can continue to pay and save for future eligible healthcare 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 healthcare 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.

Only your employer can contribute to the HRA.

Son Tyler has strep throat; John injures his foot and needs an X-ray.	
HRA Fund	$350
Expenses • 2 office visits x$20 • Urgent Care visit for injured foot • Foot X-ray • Annual physicals for entire family • Annual OB/GYN exam	 $40 $50 $120 $0 $0
Amount paid from HRA (applied to deductible)	$210
Amount paid by John	$0

USING THE HRA

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

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."

DENTAL PLAN

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 our 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	Non-participating*
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, X-rays, 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		
Children (up to 19th birthday)	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.

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 $160	Up to $88
Standard Plastic Lenses		
Single Vision	$25 copay	Up to $25
Bifocals	$25 copay	Up to $40
Trifocals	$25 copay	Up to $60
Standard Progressive	$90 copay	Up to $40
Premium Progressive Tier 1 Tier 2 Tier 3 Tier 4	 $110 $120 $135 $90 copay, 80% less $120 allowance	 Up to $40 Up to $40 Up to $40 Up to $40
Lenticular	$25 copay	
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 12 months	Once every 12 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 INSURANCE

Life insurance pays a lump-sum benefit to your beneficiary(ies) to help meet expenses in the event of your death. Accidental Death and Dismemberment (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. This coverage is administered by Reliance Standard.

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. Class 3 includes full and part-time Ordained employees formerly of ARC. 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 Class 3 Only: $275,000	None

VOLUNTARY /LIFE AND AD&D INSURANCE

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

Coverage Level	Coverage Amount	Evidence of Insurability/Proof of Good Health
Employee	Increments of $10,000 not to exceed $500,000	Required if electing coverage greater than $200,000
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.

LONG-TERM 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	**Class 1**: Non-ordained domestic Agency employees of the CRCNA and active full-time or part-time nonordained 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 **Class 2:** Non-ordained employees of the CRCNA or RCA congregation, institution, agency or eligible affiliated organization **Class 3:** Each active, Full-time and Part-time ordained employee of ARC, except any person employed on a temporary or seasonal basis
Coverage	**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 **Class 2**: 60% of your pre-disability earnings, up to a maximum of $5,000 per month until you recover, your Social Security Normal Retirement Age (SSNRA), whichever is sooner **Class 3**: 66.67% of your pre-disability earnings, up to a maximum of $5,000 per month until you recover, your Social Security Normal Retirement Age (SSNRA), whichever is sooner
When Benefits	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	Website	Phone
Medical	HMA	accesshma.com	833-865-0141
	HMA Care Navigator Plus	mycarenav@accestpa.com	833-865-0143
	Hinge Health	hingehealth.com/rba	855-902-2777
	MDLive	mdlive.com	N/A
Pharmacy	OptumRx	www.optumrx.com	855-524-0381
Dental	Delta Dental	www.deltadental.com	800-524-0149
Vision	EyeMed	www.eyemed.com	866-723-0513
Life and AD&D Insurance	Reliance Standard	www.reliancestandard.com	800-351-7500
Long-Term Disability	Reliance Standard	www.reliancestandard.com	800-351-7500
Supplemental Medical (Accident, Critical Illness & Hospital Indemnity)	Reliance Standard	www.reliancestandard.com	800-435-7775

REQUIRED NOTICES

IMPORTANT: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug programs give you more choices about your prescription drug coverage.

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 (9.96% for plans that start in 2026) 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. Reformed Benefits Association	**4. EIN:**	
5. 4500 60th St. SE	**6. 800-701-8992**	
7. Grand Rapids	**8. MI**	**9. 49512**
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	**12. 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 full-time employees

  Eligible dependents are:

  - Employee that are full-time and work regularly scheduled 30+ hour per week
- With respect to dependents, we do offer coverage.

  Eligible Dependents are:

  - Spouses

- Children up to the age of 26
- Grandchildren (which legal guardianship and/or financial support is provided)

✓ 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 Williamson County (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 January 1, 2026.

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. Williamson County 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

Your 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
4500 60th St. SE
Grand Rapids, MI 49512
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 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 Williamson 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. 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. RBA has determined that the prescription drug coverage offered by the RBA 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:

- V**isit www.medicare.gov.**

- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date: 1/1/2026
Name of Entity/Sender: Reformed Benefits Association
Contact/Office: Benefits Department
Address: 4500 60th St. SE
Grand Rapids, MI 49512
Phone Number: 800-701-8992

You can learn more about many of these options at **www.healthcare.gov.**

OTHER NOTICES

P60-Day Special Enrollment Period

In addition to the qualifying events listed in the enrollment guide, 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 31 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 31 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.

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 RBA may use aggregate information it collects to design a program based on identified health risks in the workplace. The RBA Wellness Program will never disclose any of your personal information either publicly or to the employer. Also, medical information that personally identifies you that is provided relating to 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.

In addition, all medical information obtained through the wellness program will be maintained by the various providers of the Wellness Program mentioned above and not your employer. Your information is stored electronically and will be encrypted. No medical 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.

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.