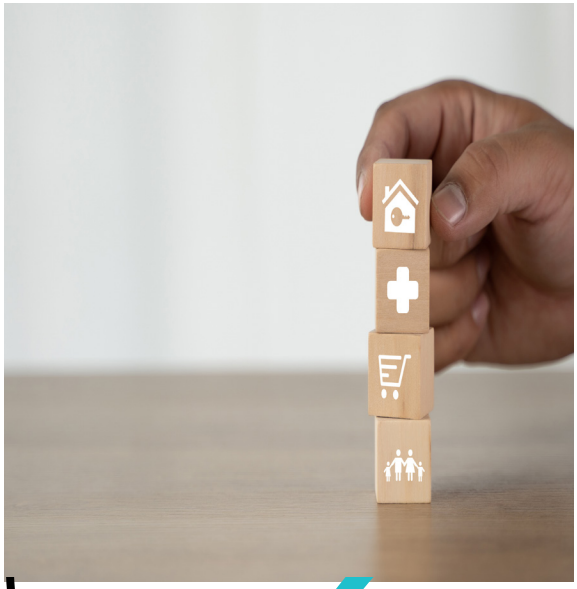
2026 BENEFITS GUIDE

NON-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 UMR and Surest, all offered through the UHC Choice Plus network. Note that the UMR plans do have out-of-network benefits, but the Surest plan does not have out-of-network benefits. It is always more cost effective for you to see in-network providers.

How a Health Plan Works

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

The plans have different:

- **Annual deductible amount** - The amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay.
- **Out-of-pocket maximums (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.

For Your Protection

The out-of-pocket maximum provides financial protection in the event of a serious illness or injury. The out-of-pocket maximum, however, does not include penalties (such as a late cancellation fee for a doctor's appointment), and out-of-network out-of-pocket maximums are significantly higher vs in-network (or not covered on the Surest plan).

MEDICAL PLAN COMPARISON

	UMR Premium Plan (HRA Compatible)		UMR Consumer Plan (HSA Compatible)		UMR $4,000 HDHP Plan (HSA Compatible)		UMR $8,000 HDHP Plan (HSA Compatible)		Surest 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
Annual Deductible									
Individual	$2,000*	$4,000*	$2,000**	$6,000**	$4,000*	$8,000*	$8,000*	$12,000*	$0
Family	$4,000*	$6,000*	$4,000*	$12,000*	$8,000*	$16,000*	$16,000*	$20,000*	$0
Out-of-Pocket Maximum									
Individual	$5,000*	$15,000*	$5,000*	$15,000*	$8,000*	$15,000*	$8,000*	$15,000*	$6,000*
Family	$10,000*	$30,000*	$10,000**	$30,000**	$16,000*	$30,000*	$16,000*	$30,000*	$12,000*
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
Primary Care Physician	$20 copay	50%	20%	50%	30%	50%	0%	50%	$35-$140 copay
Specialist	$120 copay	50%	20%	50%	30%	50%	0%	50%	$35-$140 copay
Urgent Care	$50 copay	50%	20%	50%	30%	50%	0%	50%	$90 copay
Emergency Room	20%	20%	20%	20%	30%	30%	0%	0%	$850 copay
X-ray and Lab (Diagnostic)	$0	Not covered	20%	50%	30%	50%	0%	50%	$0
***Major Imaging (MRI, CT, PET)**	20%	50%	20%	50%	30%	50%	0%	50%	$200-$1,050 copay
Hospital Inpatient	20%	50%	20%	50%	30%	50%	0%	50%	$3,500 copay
Outpatient Surgical Facility	20%	50%	20%	50%	30%	50%	0%	50%	$300-$1,150 copay

For the UMR plans, the UnitedHealth Premium program provides physician designations based on quality and cost-efficiency criteria to help members make more informed choices about their medical care.

Physicians may also use these designations when referring patients to other physicians. In markets where tiered benefit plans are available, employers may choose to offer their employees a tiered benefit plan with a lower member cost share for using Premium Care Physicians.

The Surest plan offers set copays for **ALL** services with no deductible, but all copays accumulate towards your out-of-pocket maximum. Surest uses the same network as the UMR plans but provides copay ranges based on provider selection. You still have full access to the same providers as with UMR, but have the opportunity to pay lower copays for certain providers, as well as have a copay amount confirmed for **ALL** services (surgeries, etc.) before your date of service (no more balance bills!). You will not see the above mentioned "heart" ranking if you enroll in the Surest plan but will receive lower copays if you see higher quality providers.

* Embedded Deductible/OOPM

** Non-Embedded Deductible/OOPM

♥♥	**Premium Care Physican** The physican meets the UnitedHealth Premium program quality and cost-effective care criteria.
♥♥	**Quality Care Physician** The physician meets the UnitedHealth Premium program quality care criteria but does not meet the program's cost-effective care criteria or is not evaluated for cost-effective care.
♥♥	**Does Not Meet Premium Quality Criteria** The physician does not meet the UnitedHealth Premium program quality criteria, so the physician is not eligible for a Premium designation.
♡♡	**Not evaluated for Premium Care** The physician's speciality is not evaluated in the UnitedHealth Premium program or the physician's program's evaluation is in process. Or the physician does not have enough claims data to be evaluated for UnitedHealth Premium program quality, so the physician is not eligible for the Premium Care Physician designation.

Physicians can review their Premium designation details by signing into UnitedHealthPremium.uhc.com after they receive their evaluation notifications.

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

	UMR Premium Plan (HRA Compatible)		UMR Consumer Plan (HSA Compatible)		UMR $4,000 HDHP Plan (HSA Compatible)		UMR $8,000 HDHP Plan (HSA Compatible)		Surest 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**
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
Retail Tier 2	$40 copay	50%	$40 after ded	50%	$40 after ded	50%	$0 after ded	50%	$90 copay
Retail Tier 3	$80 copay	50%	$80 after ded	50%	$80 after ded	50%	$0 after ded	50%	$160 copay
Retail Tier 4	$100 copay	50%	$100 after ded	50%	$100 after ded	50%	$0 after ded	50%	$440/$480/$530 copay

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.

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.

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.

MEDICAL PLAN RESOURCES & TOOLS

You may have different programs and resources available to you depending on if you have enrolled in the Surest plan or a UMR plan, but both plans offer robust resources. See below for a comparison and further information on all resources embedded into both plans.

	SUREST PLAN (For all resources below, visit your Surest app)	UMR PLAN
App/Website	Visit benefits.surest.com or visit your Surest app to find in-network doctors, copay tiers, and more! If you choose to see higher quality doctors in the UHC Choice Plus network you will have a decreased copay for your healthcare needs. You can also locate claim details and ID cards, check your medical benefits and out of pocket maximum accumulation, and more! If you are new hire or looking for more info on Surest before enrolling, visit join.surest.com/RBA and enter code "RBA2026."	Members enrolled in either UMR plan have access to the UMR website or UMR mobile app where you can search for ID cards, search for in-network providers, check your medical benefits and out-of-pocket maximum accumulation, review claims, and more.
Concierge Support	Visit the Surest app to receive assistance with any medical & prescription benefits.	UMR plan members have access to GenerationYou, a health care provider navigation service.
Virtual Telemedicine Telemedicine works best for non-emergency medical issues and questions, if you traveling and in need of medical care, or if you need care after normal business hours or on weekends. Common conditions treated include colds, flu, ear infections, sinus infections, skin inflammation, and more.	FREE virtual telemedicine is available to all Surest members through multiple virtual platforms. Visit the Surest app or website, search "Telemedicine Visit" and select "Find Providers" for more information on a virtual telemedicine visit. **Note:** Certain visit platforms may not be able to accommodate all ages of dependents.	Virtual telemedicine is available to all UMR members through Teladoc. Visit the Teladoc app or text "Get Started" to 469-844-5637 for more information. » $20 per visit for Premuim plan members/80% after deductible per visit for HSA members.
Virtual Behavioral Health Members can see a behavioral health professional 24/7 from your mobile device, tablet or computer. These types of virtual visits are beneficial if you are experiencing depression, anxiety, ADD/ADHD, addiction and mental health disorders, and more.	Virtual behavioral health visits are available to Surest members through multiple virtual platforms at a $35 copay per visit. Visit the Surest app or website, search "Behavioral Health Therapy" and select "Find Providers" for more information on a virtual behavioral health visit. **Note:** Certain visit platforms may not be able to accommodate all ages of dependents.	Virtual behavioral health visits are available to UMR members through Teladoc at the following costs. Visit the Teladoc app for more information. » Licensed Therapist Visit: $20 Premium/$95 HSA » Initial Visit w/ Psychiatrist: $20 Premium/$235 HSA » Follow Up Visit w/ Psychiatrist: $20 Premium/$105 HSA
Diabetes Support	Virta Health is a virtual clinic that may help you lower blood sugar, lose weight, and rely less on pricey drugs. Members eat their way to better health thanks to a plan made just for them and support from medical providers, coaches, and digital health tools. Check eligibility: www.virtahealth.com/join/surest	Teladoc can provide FREE, customized diabetic support to members living with a diabetes diagnosis. Visit myrbabenefits.com for more information.
Virtual Exercise Therapy	Kaia Health provides FREE customized virtual physical and exercise therapy for Surest members experiencing back pain, joint pain, etc. Visit the Surest app or website, search "Physical Therapy" and select "Find Providers" for more information.	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.
Real Appeal	Real Appeal is a weight loss program that incorporates small goals each day to guide you toward a healthier life. Through your coach's guidance and support, group sessions, educational material and activities. Real Appeal will track your daily progress. You can enroll in Real Appeal by visiting enroll.realappeal.com.	
Gym Discounts	Visit OnePassSelect.com for information on how to sign up for gym discounts and more through your UMR or Surest medical plans.	

OTHER UMR PLAN RESOURCES

GenerationYou
GenerationYou is a personalized health benefits experience through UMR.

Once you complete your "Story Of You" questionnaire, GenerationYou will be able to support you and your enrolled family members with all items related to the UMR medical plan, including but not limited to:

- General customer support (questions about coverage, etc)
- Finding high-quality, in-network care
- Ensure medical claims are being paid correctly if you have billing questions
- Engage the UMR Clinical teams to meet your unique needs

OTHER SUREST PLAN RESOURCES

Virtual Primary Care
Virtual primary care is a convenient alternative to an in-person visit with a Primary Care Physician (PCP). Virtual primary care is offered through multiple provider platforms & is FREE to all Surest members! Visit the Surest app or website, search "Virtual Primary Care" and select "Find Providers" for more information on a virtual primary care visit.

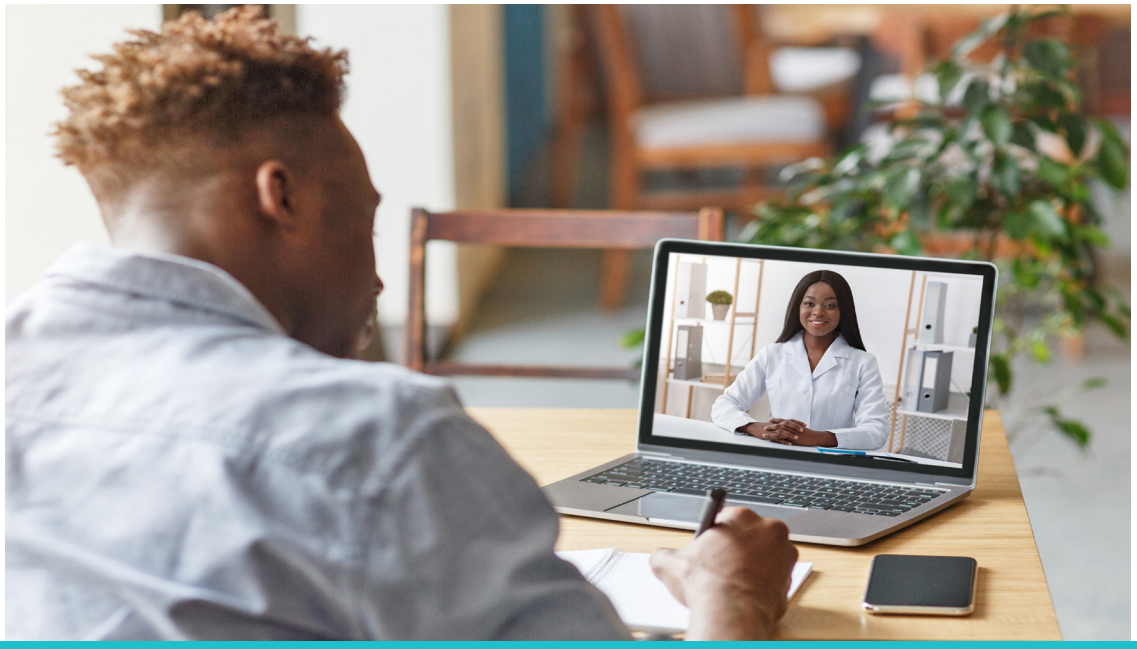
Note: Certain visit platforms may not be able to accommodate all ages of dependents.

Virtual Migraine Clinic*
Cove provides customized support for Surest members ages 18+ from physicians who specialize in migraine care. Cove has a member cost of $35 per 90 days of care. Visit the Surest app or website, search "Migraine Treatment" and select "Find Providers" for more information.

*Not available in DE, ID, or WV

Second Opinion Service
If you have received a diagnosis and would like a second opinion, 2nd MD is FREE and included for all Surest members! Visit www.2nd.md/activate/step1/surest or call 1-866-841-2575 for more information.

Surest App
Search for doctors, treatments, and procedures with the Surest health plan, then see prices before making an appointment. Below is an example of how you can navigate the Surest app to see cost and provider options. You can search for your specific healthcare need, select "Find Providers", then you will be directed to a map of provider options. You will select the copay or the "Options" in the map to see more about costs, options, provider details, etc. Remember, you can receive the lowest copays possible if you opt to see the highest quality providers in the UHC Choice Plus network!



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 (UMR Plan)	UMR	umr.com	844-600-0919
	Teladoc	member.teladoc.com	469-844-56371
	Talkspace	talkspace.com/connect	N/A
	Livongo	www.myrbabenefits.com	800-945-4355
	Real Appeal	enroll.realappeal.com	N/A
	One Pass Select	OnePassSelect.com	N/A
	GenerationYou	umr.com	844-600-0919
Medical (Surest Plan)	Surest	866-683-6440 benefits.surest.com or visit your Surest app	
	Dr. On Demand		
	Talkspace		
	Virta		
	Kaia Health		
	Cove		
	2nd MD		
	Real Appeal	enroll.realappeal.com	N/A
	Oshi	oshihealth.com/surest	N/A
	One Pass Select	OnePassSelect.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

REQUIRED NOTICES

Health Insurance Marketplace Coverage Options and Your Health Coverage

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 9.12%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 9.12% of the employee's household income.[12]

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 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 throgh 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. 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 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 or contact Reformed Benefits Association. 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.

1. Indexed annually; see irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

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% 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.

Special Enrollment Notice

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

If you are declining coverage 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).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact: Reformed Benefits Association.

Your Information. Your Rights. Our Responsibilities.

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.

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication

- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated your specific authorization.

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claim records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, you have both the right and choice to tell us to:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

OTHER INSTRUCTIONS FOR NOTICE

- Effective Date of this Notice: 1/1/2026
- Privacy Contact: benefits@reformedbenefits.org or 800-701-8992

Important Notice from Reformed Benefits Association About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with RBA 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. **RBA has determined that the prescription drug coverage offered by the RBA 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 15 to December 7. 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 coverage will not be affected. If you decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

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

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

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through RBA changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of 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--Position/Office: Benefits Department
Address: 4500 60th Ste SE, Grand Rapids, MI 49512
Phone Number: 800-701-8992

Women's Health and Cancer Rights Act

ENROLLMENT NOTICE

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 consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 800-701-8992.

ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 800-701-8992 for more information.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

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The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the Frequently Asked Questions (FAQs) About the Newborns' and Mothers' Health Protection Act.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact 877-999-6442. Visit for more information about your rights under federal law, please visit www.dol.gov.

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 Williamson County, 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, 2025. Contact your State for more information on eligibility -

State	Website/Email	Phone
Alabama (Medicaid)	Website: http://myalhipp.com/	1-855-692-5447
Alaska (Medicaid)	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	1-866-251-4861
Arkansas (Medicaid)	Website: http://myarhipp.com/	1-855-692-7447
California (Medicaid)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado (Medicaid and CHIP)	Medicaid: https://www.healthfirstcolorado.com/ CHIP: https://hcpf.colorado.gov/child-health-plan-plus HIBI: https://www.mycohibi.com/	1-800-221-3943 1-800-359-1991 1-855-692-6442 State relay 711

State	Website/Email	Phone
Florida (Medicaid)	https://www.flmedicadtplrecovery.com/flmedica	1-877-357-3268
Georgia (Medicaid)	HIPP:https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp CHIPRA:https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, press 1 678-564-1162, press 2
Indiana (Medicaid)	Healthy Indiana Plan for low-income adults 19-64: http://www.in.gov/fssa/hip/ All other Medicaid: https://www.in.gov/medicaid	1-877-438-4479 1-800-457-4584
Iowa (Medicaid and CHIP)	Medicaid: https://dhs.iowa.gov/ime/members CHIP: http://dhs.iowa.gov/Hawki HIPP:https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas (Medicaid)	https://www.kancare.ks.gov/	1-800-967-4660 HIPP: 1-800-967-4660
Kentucky (Medicaid and CHIP)	Medicaid: https://chfs.ky.gov/agencies/dms KI-HIPP:https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.apsx KI-HIPP E-mail:KIHIPP.PROGRAM@ky.gov KCHIP:https://kynect.ly.gov	1-855-459-6328 1-877-524-4718
Louisiana (Medicaid)	www.medicaid.la.gov www.ldh.la.gov/lahipp	1-888-342-6207 1-855-618-5488
Maine (Medicaid)	https://www.maine.gov/dhhs/ofi/applications-forms https://www.mymaineconnection.gov/benefits/s/?language=en_US	Enroll: 1-800-442-6003 Private HIP: 1-800-977-6740 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	https://www.mass.gov/masshealth/pa Email: masspremassistance@accenture.com	1-800-862-4840 TTY: 711
Minnesota (Medicaid)	CHIP:https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Medicaid:http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp	1-800-657-3739
Missouri (Medicaid)	https://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana (Medicaid)	https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HHSHIPPProgram@mt.gov	1-800-694-3084
Nebraska (Medicaid)	https://www.ACCESSNebraska.ne.gov	1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada (Medicaid)	https://dhcfp.nv.gov/	1-800-992-0900
New Hampshire (Medicaid)	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium- program	603-271-5218 or 1-800-852-3345, ext. 5218
New Jersey (Medicaid and CHIP)	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	Medicaid: 609-631-2392 CHIP: 1-800-701-0710

State	Website/Email	Phone
New York (Medicaid)	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina (Medicaid)	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota (Medicaid)	https://www.hhs.nd.gov/healthcare	1-844-854-4825
Oklahoma (Medicaid and CHIP)	http://www.insureoklahoma.org	1-888-365-3742
Oregon (Medicaid)	http://healthcare.oregon.gov/Pages/index.aspx	1-800-699-9075
Pennsylvania (Medicaid and CHIP)	Medicaid: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx CHIP: https://www.dhs.pa.gov/chip/pages/chip.aspx	Medicaid: 1-800-692-7462 CHIP: 1-800-986-KIDS (5437)
Rhode Island (Medicaid and CHIP)	http://www.eohhs.ri.gov/	1-855-697-4347 or 401-462-0311 (Direct Rlte)
South Carolina (Medicaid)	https://www.scdhhs.gov	1-888-549-0820
South Dakota (Medicaid)	http://dss.sd.gov	1-888-828-0059
Texas (Medicaid)	https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	1-800-440-0493
Utah (Medicaid and CHIP)	Medicaid: https://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip	1-877-543-7669
Vermont (Medicaid)	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
Virginia (Medicaid and CHIP)	https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs	1-800-432-5924
Washington (Medicaid)	https://www.hca.wa.gov/	1-800-562-3022
West Virginia (Medicaid)	https://dhhr.wv.gov/bms/ http://mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 1-855-699-8447
Wisconsin (Medicaid and CHIP)	https://dhs.wisconsin.gov/badgercareplus/p-10095.htm	800-362-3002
Wyoming (Medicaid)	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

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.