Kalamazoo VALLEY™
community college

Flexible Benefits Plan

2019

KALAMAZOO VALLEY COMMUNITY COLLEGE

FLEXIBLE BENEFITS PROGRAM

Benefits At A Glance

Workbook

2019

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KALAMAZOO VALLEY COMMUNITY COLLEGE

"Benefits At A Glance 2019"

<table>
<tr><th></th><th>PLAN 1</th><th>PLAN 2</th><th>OPT OUT</th></tr>
<tr><td>Medical Insurance
ASR Health Benefits</td><td>
Deductible: $250 individual
$500 two person/family
Co-pay: 90% plan pays / 10% you pay
Office Visit: $25 copay Emergency Room: $250 copay
Prescription Copay: $10.00 Generic / $60 Brand
Special Note About the Benefit Year Deductible: An individual within a two-person or family plan option has to meet only the single deductible specified above before the Plan will begin paying benefits.
Co-premium required
<table>
<tr><th></th><th>Annual</th><th>Per month</th><th>Per pay</th></tr>
<tr><td>Single</td><td>$ 1,824</td><td>$ 152</td><td>$ 76</td></tr>
<tr><td>Two Person</td><td>$ 3,624</td><td>$ 302</td><td>$ 151</td></tr>
<tr><td>Family</td><td>$ 4,944</td><td>$ 412</td><td>$ 206</td></tr>
</table>
</td><td>
Deductible: $2,000 individual
$4,000 two person/family
Co-pay: 100% plan pays after deductible
Prescription Copay, after deductible: $10.00 Generic / $40 Brand
Special Note About the Benefit Year Deductible: The two-person or family deductible must be met in full, either by one covered family member or by any combination of covered family members, before the Plan will begin paying benefits for any individual.
Employer to fund $500 Single / $1,000 Family to H.S.A.
Co-premium required
<table>
<tr><th></th><th>Annual</th><th>Per month</th><th>Per Pay</th></tr>
<tr><td>Single</td><td>$ 1,824</td><td>$ 152</td><td>$ 76</td></tr>
<tr><td>Two Person</td><td>$ 3,624</td><td>$ 302</td><td>$ 151</td></tr>
<tr><td>Family</td><td>$ 4,872</td><td>$ 406</td><td>$ 203</td></tr>
</table>
</td><td>
OPT OUT

$3,500 cash rebate
Must provide proof of insurance coverage elsewhere.

Your other medical coverage <u>cannot be:</u>
Medicaid, Medicare, COBRA, a parent's insurance, a plan purchased as an individual or plans purchased on the Exchange Marketplace.
</td></tr>
<tr><td>Dental Insurance
Delta Dental</td><td colspan="2">EMPLOYER PROVIDED
Deductible $50 Single / $100 family
100% Preventative (no deductible required)
90% Minor Restorative
70% Major Restorative
60% Orthodontia
Yearly max: $1500 (preventative does not apply to maximum)
Lifetime orthodontia max:$1000</td><td>OPT OUT
OPT OUT
$150 cash rebate</td></tr>
<tr><td>Vision Insurance
EYEMED</td><td colspan="2">EMPLOYER PROVIDED
Exam $0 Copay
Frame $0 Copay $130 Allowance
Lenses $5 (multi-level for tiered lenses) or Contact Lenses $0 copay $130 allowance
<u>Frequency:</u>
Exam - once every calendar yr
Lenses – once every calendar yr
Frames – once every calendar yr</td><td>OPT OUT
No Cash</td></tr>
<tr><td>Long Term Disability Insurance</td><td></td><td></td><td></td></tr>
<tr><td></td><td>Max: 66 2/3% of earnings not to exceed $3,000/mo.
Min: the greater of $100 or 10%</td><td>Employee can purchase Max: 70% of earnings not to exceed $5,000/mo. Min: the greater of $100 or 10%</td><td></td></tr>
<tr><td>Term Life Accidental Death Insurance and Dismemberment</td><td>EMPLOYER PROVIDED</td><td>BUY UP X1</td><td>BUY UP X2</td></tr>
<tr><td></td><td>1 x Earnings</td><td>Employee can purchase an additional 1 X Earnings</td><td>Employee can purchase an additional 2 X Earnings</td></tr>
</table>

ADDITIONAL BENEFITS	
Voluntary Spouse and Child Life	May elect if Voluntary Life elected for the Employee. Spouse: Increments of $1,000 to a max of 50% of the Employee, but no more than $150,000 Guaranteed Issue for 2019 only as follows: if under 65 $25,000 / if 65-69 $10,000. Coverage ends at age 70. Child: $10,000, not to exceed 100% of the Employee amount. Guaranteed Issue for 2019 only.
H.S.A. Pre – Tax Contributions with HDHP Plan 2	Available
Dependent Care Reimbursement	Available
Uninsured Health Care Reimbursement	Available (for use with Plan 1 or opting out of medical coverage) *(a Limited Use Uninsured Health Care account is available with the HDHP Plan 2 H.S.A. also)*

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Table of Contents

Introduction

It is inconceivable to think that a single person, a family with children and a couple approaching retirement would all want the same benefits. As a result, the Administration and Employee representatives of K.V.C.C. gathered together to create the **Kalamazoo Valley Community College Flexible Benefits Plan**.

The Flexible Benefits Plan is based on the concept that you are the best judge of your benefit needs. Therefore, the program provides you with multiple coverage options, including electing additional coverage, less coverage, or opting out of coverage altogether. Should you decide to take less comprehensive coverage or no coverage at all, you will receive a designated amount of cash. **That cash can either be reinvested elsewhere in the menu or added to your earnings and received over your normal pay schedule.**

Flexible Benefits also provides you with an array of benefit alternatives and gives you the opportunity to pay for those benefits before the government takes out any taxes. By shifting current out-of-pocket expenses and paying for them through the Flexible Benefits Plan pretax, you not only take care of your necessary responsibilities, but you give yourself a **pay raise** at the same time. In turn, your pay raise can be used to enhance Core benefits or purchase other benefits.

The opportunity to choose is accompanied by the responsibility of understanding your choices. This booklet provides general information about your Flexible Benefits Plan and the options that are available to you.
In addition, you will find worksheets to help determine your benefit needs. It is essential that you complete the worksheets prior to your enrollment since these are intended to assist you in making the proper benefit selections. Re-enrollment can only be held **once** each year so make sure that you are prepared.

For a detailed description of your benefits, ***please refer to the carrier's summary plan descriptions.***

Please note, the annual re-enrollment period is the only time you may change your selections unless you have a change in "family status". Qualifying "status change" for benefits provided under this plan are subject to approval by your employer and include:

- Change in your legal marital status, on account of marriage, divorce, death of your spouse, legal separation or annulment;
- Change in the number of your dependents, due to birth, adoption, placement for adoption, or death of a dependent;
- Change in employment status for you, your spouse, or a dependent;
- Change because your dependent satisfies (or ceases to satisfy) the eligibility requirements;
- Significant cost increases in a qualifying benefit (other than Uninsured Health Care accounts);
- A change in coverage in a spouse's or dependent's Section 125 Plan;
- A leave under the Family Medical Leave Act.

It is very important for you to understand that you must notify Human Resources within 30 days of a "status change" in order to be allowed to select different benefit options. This includes adding dependent coverage. **It will always be to your best advantage to notify Human Resources as soon as possible. Human Resources must also be notified of dependent eligibility changes (i.e., marriage, graduation, insurance elsewhere, employment) within 30 days of the event.**

PLAN OVERVIEW

Kalamazoo Valley Community College's Flexible Benefits Plan is made up of various components.

The Core Program - includes all the **current levels of coverage** offered by the college:

- Dental Coverage for you and your eligible dependents
- Vision Coverage for you and your eligible dependents
- Long-Term Disability Income
- Term Life/Accidental Death and Dismemberment Insurance

Employee Options - allow you to modify the Core Program, as you wish.
Included among your Employee Options are a number of different alternatives:

- A choice of 2 Health plans that include Medical/Rx coverage plans for you and your eligible dependents
- No Medical Coverage in exchange for cash (you must provide proof of insurance coverage elsewhere to elect this option)
- No Dental Coverage in exchange for cash
- Additional Term Life and Accidental Death and Dismemberment Insurance
- Enhanced Long Term Disability
- H.S.A. program to coincide with the HDHP offering
- An Employee Reimbursement Account for Uninsured Health Care and/or Dependent Care Expenses

In addition to what is being offered through the Flexible Benefits menu, you will also have the opportunity to participate in other benefit programs through payroll deduction. Those programs include:

- Tax-Deferred Annuities
- Mutual Funds
- Permanent Life Insurance
- Michigan Education Savings Program
- Long Term Care Insurance

It is up to you to decide which of these employee options would best meet your needs.

ADMINISTRATOR

HUB International specializes in the design, implementation and administration of employee benefit programs. HUB International will administer the entire Flexible Benefits Plan. Representatives are available to answer any questions that you may have either prior to or during enrollment. They will also be responsible for handling the plan on an ongoing basis. For assistance call: 1-248-579-0260 or 1-248-579-0270

GLOSSARY OF TERMS

The following are a few terms which may help you understand your Flexible Benefits Program and the options available to you.

Annual Deductible — The amount you pay before being reimbursed for services.

Co-payment — The percentage or portion of expenses you pay when the plan makes a payment.

Co-Premiums (Tax-Free Contributions) — When enrollees participate in a payroll deduction program through their employer, deductions may be taken from payroll before calculating the member's taxable Federal income, social security and (for most states) taxable state income.

F.S.A. — Flexible Spending Account (Employee Reimbursement Account) enables you to pay a portion of your Uninsured Health Care and Dependent Care expenses with pretax dollars. The account is Employee funded. The Employee Reimbursement Account has two parts:
Uninsured Health Care (UHCFSA): A tax-favored savings account you can use to pay for Uninsured Health Care expenses.
Dependent Care(DCFSA): A tax-favored account which can be used to pay for Dependent Care expenses that enable you and your spouse to work or to search actively for work.

Limited Use F.S.A. — A Limited Use Uninsured Health Care FSA is allowed for H.S.A. participants, it will cover dental, vision, and over the counter items only.

H.D.H.P. — High Deductible Health Plan, An HDHP is a health benefit plan that typically offers lower premiums in exchange for higher annual deductibles when compared to traditional health plans.

H.S.A. — Health Savings Account, A tax-favored savings account you can use to pay for healthcare expenses. It is Owned by you, is 100% vested, and lets you build up savings for future needs. A requirement for opening an HSA is that it be coupled with a qualified high deductible health plan (HDHP) that covers catastrophic medical expenses after the deductible. **Employees are eligible for this account only if they have no other health plan coverage's available to them.** This is an account owned by the employee.

Important Note: If you own an HSA and later become ineligible to make deposits, you can still receive distributions from your HSA. All that is limited is your ability to put in additional contributions.

Maximum Annual Contribution — The total amount the government allows an HSA holder to add to their account in a given calendar year.

Member — The person(s) enrolled on the employee's contract.

Out-of Pocket Maximum — The total amount of the calendar year deductible plus the amount of any coinsurance and/or copays a covered person must pay each calendar year for covered services before benefits will be paid at 100%.

Qualified Medical Expense — If the money from the HSA is used for qualified medical expenses, then the money spent is tax-free, even if the expense is not covered by your HDHP. For example, most health insurance does not cover the cost of over-the-counter medicines, but HSAs can. You are responsible for and should familiarize yourself with what qualified medical expenses are (as partially defined in IRS Publication 502) and also keep your receipts in case you should need them for tax purposes.

How do I know what is included as "qualified medical expenses"? Unfortunately, we cannot provide a definitive list of "qualified medical expenses". A partial list is provided in IRS Pub 502 www.irs.gov. There have been thousands of cases involving the many nuances of what constitutes "medical care" for purposes of section 213(d) of the Internal Revenue Code. A determination of whether an expense is for "medical care" is based on all the relevant facts and circumstances. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.

Liability Worksheet

Before you can decide which benefits to choose, it is necessary to evaluate your own personal financial responsibilities. Fill in the blanks below as accurately as possible. Once you have completed this section, you will be able to determine your benefit needs.

MONTHLY EXPENSES	MONTHLY OUTSTANDING PAYMENT	TOTAL LIABILITY
Mortgages/Rent	$	$
Second Mortgage	$	$
Car Payment	$	$
Car Expense (gas/repairs)	$	$
Utilities: Electric $____+ Gas $___+ Phone $____+ Water/Sewage $____+Cable $____+ Internet $_____ + Other $_____	$	$
Cell Phone	$	$
Food/Sundries	$	$
Installment Loans	$	$
Credit Cards	$	$
Entertainment (theater, movie, sporting event, dining)	$	$
Miscellaneous (special occasions, money for children, etc.)	$	$
Monthly Total:	$	$
X 12	$	$
Annual Subtotal (1): **** NOTE: Carry this number to the bottom marked Annual Subtotal***	$	$

ANNUAL EXPENSES	ANNUAL PAYMENT	TOTAL OUTSTANDING LIABILITIES
Taxes (primary residence, secondary residence, other property) if not accounted for above.	$	
Vacation(s)	$	
Insurance(s) Life $_____ +Auto $____+Homeowners $____+ Health $____+ Cancer $____+ Disability $____+ Other $_____	$	
Miscellaneous (tuition, political and/or religious donations)	$	
Annual Subtotal (2)	+ $	$
Annual Subtotal (1) * **(from above)**	+ $	
TOTAL YEARLY EXPENSES	**$**	**$**

Medical Plan 1 – PPO PLAN Plan requires an employee co-premium.

ASR health benefits

Plan Deductible	**In Network**: **$250 Single - $500 Two Person - $500 Family** *(Deductible does apply toward the Total out-of-pocket maximum)* **Out of Network**: **$2,000 Single - $4.000 Two Person - $4,000 Family** *(Deductible does apply toward the Total out-of-pocket maximum)*
Basic Coinsurance *:	**In Network:** **Plan pays 90%, you pay 10%** up to the out-of-pocket co-insurance maximum of $1,000 single / $2,000 two person / $2,000 family. The Plan pays 100% of reasonable and customary thereafter. **Out of Network:** **Plan pays 70%, you pay 30%** up to the out-of-pocket co-insurance maximum of $5,000 single / $10,000 two person / $10,000 family. The Plan pays 100% of reasonable and customary thereafter.

*Includes coinsurance only. Does not include deductibles, in-network copayments, prescription drug co-payments, or expenses that constitute a penalty for non-compliance, exceed the usual and customary charge, exceed the limits of the Plan, or are otherwise excluded. Co-payments specified below continue to apply even after the Basic Out-of-Pocket Maximum is satisfied in a Benefit Year. An individual within a two-person or family plan has to meet only the single Basic Out-Of-Pocket Maximum before the Plan's benefits will increase to 100%.

Copays:	**In Network Only** Office Visit & Telemedicine $25.00 (not subject to deductible) Emergency Room Copay $250.00
Total Medical Out of Pocket Maximums:	**In Network: $2,250** single coverage** / **$4,500** two-person coverage or family** **Out of Network:** Unlimited

**Includes deductibles, coinsurance, and most co-payments. Does not include prescription drug co-payments or expenses that constitute a penalty for non-compliance, exceed the usual and customary charge, exceed the limits of the Plan, or are otherwise excluded. Prescription drug co-payments specified below continue to apply even after the Overall Out-of-Pocket Maximum is satisfied in a Benefit Year. Embedded Maximum: An individual within a two-person or family plan has to meet only the single Overall Out-Of-Pocket Maximum before the medical plan co-payments will no longer be charged in the Benefit Year.

Please refer to the carrier summary plan description at the end of the workbook for a detailed explanation of the covered benefits under Plan 1.

Other Features

- Physicians Care/HAP Provider Network http://www.providerlookuponline.com/HAP/po7/Search.aspx
- Medical services can be obtained from any licensed practitioner, but use of Physician Care Providers is encouraged.
- Maternity expenses are covered the same as illness expenses.
- Coverage for dependent child to age 26
- **All benefits are based on medical necessity** (diagnosis related)

Prescription Drug Plan – Medical Plan 1

BENEFIT PAYABLE

If an individual incurs expenses for covered drugs prescribed by a physician in connection with an injury or sickness, payment will be made to the participating pharmacy after the copayment is paid by the member.

- $**0 Over the Counter Drugs with a physician's prescription**
- **30 day supply at Pharmacy: Generic Drug:** $10 / **Brand Name Drug:** $60
- **You can receive a 90 day supply at 2x the required copay via mail order or at the pharmacy: Generic Drug:** $20 / **Brand Name Drug:** $120
- **RX Total Out of Pocket Maximums: In Network: $4,350** single coverage / **$8,700** two-person coverage or family; **Out of Network:** Unlimited

If covered drugs are obtained from a non-participating provider, you must pay the purchase price in full and then must submit the expense directly to the prescription drug card vendor for reimbursement. Prescription drug card services are payable by **EHIM.**

Please refer to the plan booklet and the summary pages at the end of the workbook. ***This is not a contract. It is intended as a brief description of benefits. An official description of benefits is contained in applicable KVCC Summary Plan Descriptions.***

Medical Plan 2 – HDHP with H.S.A

Plan requires an employee co-premium.

ASR health benefits

Plan Deductible	**In Network** **$2,000 Single - $4,000 Two Person - $4,000 Family** *(Deductible does apply toward the Total out-of-pocket maximum)* **Out of Network** **$4,000 Single - $8,000 Two Person - $8,000 Family** *(Deductible does apply toward the Total out-of-pocket maximum)*
Basic Coinsurance*	**In Network** Plan pays 100% after you have met the deductible. Rx copay applies after deductible has been met. **Out of Network** Plan pays 80% after you have met the deductible. Rx copay applies after deductible has been met.
Total Out of Pocket Maximums:	**In Network: $4,000** single coverage** / **$8,000** two-person coverage or family** **Out of Network: $8,000** single coverage** / **$16,000** two-person coverage or family*

**Includes deductible, coinsurance, and all co-payments, including RX. Does not include expenses that constitute a penalty for non-compliance, exceed the usual and customary charge, exceed the limits of the Plan, or are otherwise excluded. Co-payments specified below will no longer apply once the Overall Out-of-Pocket Maximum is satisfied in a Benefit Year. Embedded Maximum: An individual within a two-person or family plan has to meet only the single Overall Out-Of-Pocket Maximum before the medical plan co-payments will no longer be charged in the Benefit Year.

Please refer to the carrier summary plan description at the end of the workbook for a detailed explanation of the covered benefits under Plan 2.

Other Features

- Physicians Care/HAP Provider Network http://www.providerlookuponline.com/HAP/po7/Search.aspx
- Medical services can be obtained from any licensed practitioner, but use of Physician Care Providers is encouraged.
- Maternity expenses are covered the same as illness expenses.
- Coverage for dependent child to age 26
- **All benefits are based on medical necessity** (diagnosis related)

HDHP with Health Savings Account (H.S.A.)

You employer pre-funds a portion of the applicable deductible to an H.S.A. for your use towards your required deductible and medical expenses. You may also make pre-tax contributions or voluntary contributions toward the maximum contribution.

This plan is available only to employees with *no* other Health insurance plan benefits. If an employee's spouse or dependents have other coverage then the employee would be eligible only for a Single plan.

- ***Insurance allowable with H.S.A.*:** Life/Accident, Disability, Dental Care, Vision Care. Long Term Care, Specified Illness Insurance, your own Limited Use F.S.A.
- ***Insurance not allowed with an H.S.A*.:** Flexible Spending Account, or Spouses Flexible Spending Account, Medical coverage through a non HDHP, any VA benefits used in last 3 months, Part A and/or Part B of Medicare.

Prescription Drug Plan – Medical Plan 2

BENEFIT PAYABLE
If an individual incurs expenses for covered drugs prescribed by a physician in connection with an injury or sickness, payment will be made to the participating pharmacy after the copayment is paid by the member.

Over the Counter Drugs with a physician's prescription $0

Generic Drug: $10 / **Brand Name Drug:** $40

You can receive a 90 day supply at 2x the required copay via mail order or at the pharmacy:
Generic Drug: $20 / **Brand Name Drug:** $80

All copays apply to the Total Out of Pocket maximum on the Medical Plan 2 as noted in the previous page.

If covered drugs are obtained from a non-participating provider, you must pay the purchase price in full and then must submit the expense directly to the prescription drug card vendor for reimbursement. Prescription drug card services are payable by **EHIM.**

Please refer to the plan booklet and the summary pages at the end of the workbook. ***This is not a contract. It is intended as a brief description of benefits. An official description of benefits is contained in applicable KVCC Summary Plan Descriptions.***

Prescription Drug Plan, additional information

(Plan 1 & Plan 2)

COVERED DRUG MEANS:

1) a drug:
   (a) which requires a Prescription Order; and
   (b) which is required, under federal law, to bear the legend: "Caution: Federal law prohibits dispensing without prescription;"

or

2) a drug which does not bear the legend, but which requires a Prescription Order under the jurisdictional state law;

or

3) a compound medication of which at least one ingredient is a drug defined in (1) or (2) above; or
4) injectable insulin:
   (a) up to a 90 day supply of disposable needles and syringes if the supply of insulin is a 90 day supply.

Special Notes about Prescription Drug Benefits:

1. The pharmacy will dispense generic drugs unless the prescribing physician requests "Dispense as Written" (DAW) or a generic equivalent is not available. If the covered person refuses an available generic equivalent and the prescribing physician has not requested DAW, the covered person must pay the applicable co-payment **plus** the difference in price between the brand-name drug and its generic equivalent.
2. All generic contraceptives and all brand name contraceptives that do not have a generic equivalent are covered at 100% with the deductible waived and no co-payment. All brand contraceptives that do have generic equivalent are covered subject to either the copayment stated in the PPO Plan design or the HDHP/H.S.A. plan design as enrolled respectively.

Details on limitations are included in the plan booklet
NO PAYMENT WILL BE MADE FOR:

- Drugs received before this coverage starts.
- Experimental drugs or drugs limited by law to investigational use.
- Administration of any medication or for any medication administered in the place where it is dispensed.
- Any refill of a prescription over a year old.
- Any prescription costing **$10.00** or less.
- More than a 30-day supply of any medication.
- Drugs obtainable without the prescription of a physician.
- The administration of legend drugs and inject-able insulin.
- Drugs prescribed for treatment of an occupational injury or sickness (Worker's Compensation).

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PRE-EXISTING CONDITION EXCLUSION REMOVED

As of 01/01/2013: The plan will not impose pre-existing condition exclusions or limitations on children of covered employees under the age of 19.

As of 01/01/2014: due to PPACA The plan will not impose pre-existing condition exclusions or limitations on employees, spouses, or dependents of any age.

Cost Containment Features (Plan 1 & Plan 2)

The Medical Plans have several cost containment features. Each covered person is required to abide by the applicable cost containment provisions. **There is a 20% penalty for non-compliance with any of these requirements. Any payment required due to non-compliance will not count toward the out-of-pocket maximum.**

The following cost containment features are included with your plan. If you follow the provisions under each feature, your benefits will be paid pursuant to the applicable plan provisions. A 20% penalty will be applicable for *non-compliance*. Any payment required due to non-compliance will not count toward the out-of-pocket maximum.

PRE-ADMISSION REVIEW PROGRAM

Pre-admission review is required for any non-emergency hospital admission.

If non-emergency admission is scheduled 2 weeks or more in advance, a pre-admission review form must be completed by your doctor. If a non-emergency admission is scheduled in less than 2 weeks, contact **Physicians Care Health Management at 800-638-0573 or 800-421-9037**. You can also refer to the number found on your ID card.

If there is an emergency admission to the hospital, the patient, patient's family member, Hospital or attending Physician must contact **Physicians Care Health Management** within **24 hours** of the first business day after the admission.

Medical Plan (Pre-admission Review Program as it applies to the Medical Plan)
By following Pre-admission Review requirements, all covered hospital medical expenses will be paid at 100%. However, if you do not comply with Pre-admission-Review requirements, a 20% penalty will be applied to all covered hospital medical expenses incurred. **Outpatient surgical procedures do not require pre-certification**.

SURGICAL NECESSITY REVIEW

Anytime a surgery is recommended, you should call **Physicians Care Health Management at 800-638-0573 or 800-421-9037**, for the required Pre-Admission Review and to find out if a second opinion is required.

When a second opinion is required, a Nurse Reviewer will contact your doctor to determine the reason for surgery and the extent to which your doctor's information meets established medical criteria indicating the need for surgery. Very often, a Nurse Reviewer can waive the requirement for a second opinion. When a second opinion is required, a Nurse Reviewer can give you the names of up to three board certified doctors in your area from which you can choose a doctor to provide the second opinion. However, if you do not comply with the Surgical Necessity Review requirements, a 20% penalty will be applied to all covered surgical expenses incurred.

PRE-ADMISSION TESTING

Any pre-admission testing will be paid at 100% provided the testing is done on an outpatient basis. All tests must be medically related to surgery or hospital confinement and be performed no more than 7 days prior to surgery or hospital confinement. No benefits will be payable for non-compliance.

Cost Containment Features, Continued (Plan 1 & Plan 2)

MENTAL/NERVOUS & SUBSTANCE ABUSE PRE-CERTIFICATION

Please be sure to contact ASR Health Benefits for Pre-Certification. If you fail to do so, your benefits payable will be reduced by the 20% penalty.

HOME HEALTH CARE

Home Health Care is a progressive recovery procedure which enables the covered person to receive treatment for an illness at home rather than in the hospital. A plan is designed in writing, by a physician, which outlines the necessary care that you would receive.

There is a 120 visit limitation each calendar year from any licensed practitioner providing services to the covered individual. One visit is defined as up to 4 hours of home health care. Should additional days be necessary, they must be doctor approved and would be subject to your deductible and co-pay.

MEDICAL CASE MANAGEMENT PROGRAM

A qualified Health Care Consultant will assist you in finding the proper medical treatment as an alternative to costly long term hospital care.

HEALTH CARE NAVIGATOR

ASR has partnered with The American Health Data Institute for your chronic disease management partner.
The program covers 27 chronic conditions like asthma, diabetes, high blood pressure, high cholesterol, and coronary artery disease. If you or a family member have been diagnosed with a chronic illness you are automatically enrolled in the Health Care Navigator™ program. The Healthcare Navigator™ Nurses and Health Coaches will work with you to make sure you're receiving the care you need to manage your condition and live a healthier lifestyle.

STEP 1 If you have a qualifying chronic condition you will receive an introductory letter inviting you to partner with one of the Health Care Navigator™ Nurses or Health Coaches.
STEP 2 Following the introductory letter, one of the Healthcare Navigator™ Nurses or Health Coaches will reach out to you.
STEP 3 You and the Health Care Navigator™ Nurse or Health Coach will discuss your healthcare needs and co-design a personalized service plan. The Health Care Navigator™ Nurse or Health Coach is there as your partner to help you self-manage your chronic condition.

OR YOU CAN CONTACT A HEALTH COACH TODAY TO:
· Receive support in managing your chronic condition
· Access medical information about your condition
· Make sure you are following the recommended care for your illness(s)
Call 1.800.352.5071 Or email your questions to: CDM@ahdi.com

Coordination of Benefits

These Cost Containment provisions must be followed when coordinating benefits with another plan.
The coordination of benefits provision for the KVCC Employee Health Benefit Plan utilizes the **"Birthday Rule"**. This rule is applicable to persons that have dual insurance for Employee Health Benefit Plan coverage under any plan (not just KVCC's). Whichever person's birthday (month, not birth year) occurs first during the calendar year is deemed to be the primary coverage for dependent children; the person with the birthday that occurs second during a calendar year is considered the secondary coverage. The primary plan will be the first plan to pay health claims; the secondary plan will be the second claim payer. **Please note, an employee is always considered primary on their respective employer's plan.**

This is not a contract. It is intended as a brief description of benefits. An official description of benefits is contained in applicable KVCC Summary Plan Descriptions.

Opt Out of Medical Coverage

NO MEDICAL COVERAGE

In order to select this option, you must provide a Declination of Coverage Form. Should you elect the No Medical Coverage Option, you may qualify for a cash rebate of **$3,500.** Cash rebates will be returned in equal installments over the annual pay schedule, and are considered taxable income.

Declination of Coverage From is required each benefit year.

In order to receive cash rebate your other medical coverage cannot be: Medicaid, Medicare, COBRA, a KVCC Spouse plan, a parent's insurance, a plan purchased as an individual or plans purchased on the Exchange Marketplace.

Janet's Law

RIGHTS TO CERTAIN COVERAGE FOLLOWING A MASTECTOMY

The Women's Health and Cancer Rights Act of 1998 (also known as Janet's Law) requires that Plan coverage for mastectomy expenses also include charges for the reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and physical complications relating to all stages of the mastectomy, including lymphedemas. Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

This is not a contract. It is intended as a brief description of benefits. An official description of benefits is contained in applicable KVCC Summary Plan Descriptions.

Dependent: Spouse and Child(ren) Coverage

All Employees must complete the Spousal Affidavit each benefit year, or at time of Qualifying Status Change.

Due to Health Care Reform – dependency rules have changed.

- **Dependent children will be covered until age 26. The child need not be an IRS dependent and is eligible even if married.**

Dependent is any one of the following persons:

(1) A covered Employee's Spouse

a. The term "spouse" shall mean the legally recognized marital partner of a covered Employee. The Plan Administrator may require documentation proving a marital relationship.

(2) A covered Dependent child who is incapable of self-sustaining employment by reason of being Intellectually and Developmentally Disabled or physical handicap, primarily dependent upon the covered employee for support and maintenance, unmarried and covered under the Plan when reaching the limiting age.

(3) *IRC 152(f)(1) defines the term "child" to mean an individual who is: (1) a son, daughter, stepson, or stepdaughter of the taxpayer; or (2) an "eligible foster child" of the taxpayer. An "eligible foster child" means an individual who is placed with the taxpayer by an authorized placement agency or by judgment decree, or other order of any court of competent jurisdiction. Any adopted children of the taxpayer are treated the same as natural born children. Plans and issuers that offer dependent coverage must offer coverage to enrollees' adult children until age 26, even if the young adult no longer lives with his or her parents, is not a dependent on a parent's tax return, or is no longer a student. The new policy providing access for young adults applies to both married and unmarried children, although their own spouses and children do not qualify.*

These persons are excluded as Dependents: other individuals living in the covered employee's home, but who are not eligible as defined; the legally separated or divorced former spouse of the employee; any person who is on active duty in any military service of any country.

Eligibility Requirement for Spouse/Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage pursuant to the dependent eligibility as outlined in KVCC's Flexible Compensation Plan Summary Plan Description.

Should you choose to cover your spouse, and your spouse has coverage through his/her employer, then <u>KVCC's Health Benefit Plan will be secondary</u>.

At any time, the Plan may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent as defined by the applicable KVCC Flexible Compensation Plan Summary Plan Description.

Vision Care Program (to coincide with Medical Plan 1 or Plan 2)

NEW Vision provider for 2019 - **Welcome to EYEMED, using the Insight Network .**
Your new benefits include low copays, extra services and many cost saving alternatives.
If you elected Medical you will automatically be enrolled in the Vision Plan.

The vision plan will provide payment for the following benefits:

Vision Care Services	Member Cost In-Network	Out of Network Member Reimbursement up to:
Exam *With Dilation as Necessary*	$0 Copay	$40
Frames *Any available frame at provider location*	$0 Copay; $130 allowance, 20% off balance over $130	$91
Contact Lenses *(Contact Lens allowance includes materials only)*		
Conventional	$0 Copay, $130 allowance, 15% off balance over $130	$104
Disposable	$0 Copay, $130 allowance, plus balance over $130	$104
Medically Necessary	$0 Copay, Paid-In-Full	$210
Standard Plastic Lenses		
Single Vision	$5 Copay	$30
Bifocal	$5 Copay	$50
Trifocal	$5 Copay	$70
Lenticular	$5 Copay	$70
Standard Progressive	$60 Copay	$50
Premium Progressive Tier 1	$90 Copay	$50
Premium Progressive Tier 2	$100 Copay	$50
Premium Progressive Tier 3	$115 Copay	$50
Premium Progressive Tier 4	$180 Copay	$50
Covered Lens Options		
Standard Anti-Reflective	$45 Copay	$5
Premium Anti-Reflective Tier 1	$57 Copay	$5
Premium Anti-Reflective Tier 2	$68 Copay	$5
Premium Anti-Reflective Tier 3	$85 Copay	$5

Examination
Once every calendar year

Lenses (in lieu of contact lenses)
Once every calendar year

Contacts (in lieu of lenses)
Once every calendar year

Frame
Once every calendar year

Sample of some in network prioviders: SVS, Pearle Vision, Meijer Optical, Amercias Best, RX Optical.

Additional Discounts

Vision Care Services	Member Cost In-Network
Discounted Exam Services	
Retinal Imaging Benefit	Up to $39
Contact Lens Fit and Follow-up *(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)*	
Standard Contact Lens Fit & Follow-Up:	$40
Premium Contact Lens Fit & Follow-Up:	10% off retail price
Discounted Lens Options	
Photochromic (Plastic)	$75
Tint (Solid & Gradient)	$15
UV Treatment	$15
Standard Plastic Scratch Coating	$15
Standard Polycarbonate - age 19 and over	$40
Standard Polycarbonate - under age 19	$40

40% off
additional pairs of glasses and a 15% discount on conventional lenses once funded benefit is used – an industry exclusive

20% off
any item not covered by the plan, including non-prescription sunglasses

Lasik
Lasik or PRK from US Laser Network
15% off retail price or 5% off promotional price

Hearing Care
Amplifon Hearing Health Care Network
40% off hearing exams and a low price guarantee on discounted hearing aids

This is not a contract. It is intended as a brief description of benefits. An official description of benefits is contained in applicable KVCC Summary Plan Descriptions.

Dental Insurance

DELTA DENTAL NEW Dental provider for 2019 - **Welcome to Delta Dental!**

Your new benefits include the ability to seek a Delta PPO provider, a Delta Dental Premier Provider, or a Non Participating Dentist. The difference between the 3 options is the savings from out of pocket costs.

The vision plan will provide payment for the following benefits:

You have the option to also Waive the Dental Plan. If you waive the dental a $150 rebate will be returned in equal installments over the annual pay schedule. You may also spend your rebated dollars on other coverage elsewhere in the menu. Dependent coverage is available.

Deductible: $50 Single / $100 Family

Per calendar year on all services except diagnostic and preventive services, emergency palliative treatment, sealants, brush biopsy, X-rays, and orthodontic services.

Annual Maximum per member, per calendar year : $1,500

Ortho Life Time Maximum per child: $1,000

Delta Dental PPO (Point-of-Service) DENTAL BENEFIT HIGHLIGHTS *Coverage effective January 1, 2019*	Plan Pays		
	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-participating Dentist*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Sealants - to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services - fillings and crown repair	90%	90%	90%
Endodontic Services - root canals	90%	90%	90%
Periodontic Services - to treat gum disease	90%	90%	90%
Oral Surgery Services - extractions and dental surgery	90%	90%	90%
Other Basic Services - misc. services	90%	90%	90%
Relines and Repairs - to bridges, implants, and dentures	90%	90%	90%
Major Services			
Major Restorative Services - crowns, inlays, and onlays	70%	70%	70%
Prosthodontic Services - bridges, implants, and dentures	70%	70%	70%
Orthodontic Services			
Orthodontic Services - braces	60%	60%	60%
Orthodontic Age Limit	Up to age 26		

** 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. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.*

Your members can receive expert dental care when they are outside of the United States through our Passport Dental program. Passport Dental gives Delta Dental's enrollees access to a worldwide network of dentists and dental clinics. English speakingoperators are available around the clock to answer questions and help them schedule care. Delta Dental coverage outside of the United States is the same as Delta Dental coverage within the United States.

This is not a contract. It is intended as a brief description of benefits. An official description of benefits is contained in applicable KVCC Summary Plan Descriptions.

Long-Term Disability

GUARDIAN

Long-Term Disability (LTD) benefits provide income if you are unable to work for a prolonged period due to illness or injury.

CORE

Upon approval of a claim the payments will ***begin 180 days after the onset of your disability.***
The LTD plan replace **66 2/3%** of your base monthly salary.
The minimum benefit is **$100** or **10%** of your gross income.
The maximum benefit is **$3,000** per month.
Coverage is effective the date of hire as long as the employee is actively at work.

Disability benefits will continue if you are disabled from your own occupation for 2 years and from any occupation (taking into consideration education and experience) until retirement.

LTD benefits are coordinated with other benefits such as Social Security, Workers Compensation, and the MPSERS Pension/ORP.

EMPLOYEE OPTIONS

If you wish to protect more of your income, you may elect to purchase additional Long-Term Disability coverage. This increases the percentage of your monthly income that would be replaced in the event of a disability.

	Core Plan	**Option I**
Percent of Monthly Salary	66 2/3%	70%
Maximum Monthly Benefit	$3,000	$5,000

The cost to elect this coverage is shown on the "*Optional Long Term Disability Rate Sheet"* page. Rates were correct at time of printing, however, they are subject to change.

LONG-TERM DISABILITY WORKSHEET

In order to determine your disability income needs, follow steps 1-3.

Step 1 $_____ (Monthly base salary) X 66 2/3% (Core benefit) = $_____ (Gross monthly disability payment)

Step 2 $_____ (Gross monthly disability payment) -- $_____ (66 2/3 Monthly tax liability) (Fed. + state + local taxes) (Listed on paystub) = $_____ (Net monthly disability payment

Step 3 $_____ (Net monthly disability payment) -- $_____ (Total Monthly expense) (Listed on the Liability worksheet) = $ X_____

If _X__ is a positive number, then you already have enough disability coverage.

If _X__ is a negative number, then you should probably purchase additional coverage unless you have additional income from other sources to cover the deficit.

Optional Long-Term Disability

Rate Sheet

To calculate the cost of additional Long Term Disability:

(1) $_____ x .0017 = $_____
Annual Salary Annual Cost

(2) $_____ / _____ = $_____
Annual Cost # of Pays Cost Per Pay

EXAMPLE:

- Annual Salary $25,000
- Would like to purchase additional long term disability benefits
- 24 pays per year

(1) $ $25,000 x .0017 = $ $42.50
Annual Salary Annual Cost

(2) $ $42.50 / 24 = $ $1.77
Annual Cost # of Pays Cost Per Pay

Term Life w/ AD&D Insurance

GUARDIAN

Term Life insurance provides a source of funds to assist you in meeting financial responsibilities in the event of your death. It may be used to ensure the repayment of a loan or mortgage for yourself or your family. It can cover your children's college tuition or provide a source of income for your dependents.

Accidental Death and Dismemberment (AD&D) insurance pays an additional death benefit above any Core or Optional Term Life insurance coverage in the event of your death or dismemberment which results from an accident.

CORE

The following is your Core Term Life insurance benefit:

1 x Annual Salary

Should you be employed on or after the first day of the calendar month in which you reach age 65, both your Term Life Insurance benefit and Accidental Death and Dismemberment benefit will be reduced (see life book for actual schedule). Term Life coverage will cease at retirement. Coverage is effective the date of full time hire as long as the employee is actively at work.

EMPLOYEE OPTIONS

OPTION I	OPTION II
Additional 1 x Annual Salary	**Additional 2 x Annual Salary**

If you wish, you may add to your Core coverage by purchasing additional Term Life Insurance.
Both alternatives are in addition to your Core Life Insurance Benefit.
The maximum allowable amount of coverage Core plus Optional Insurance is $300,000.
The first $50,000 of coverage can be paid for with pre-tax dollars.
With amounts in excess of $50,000, the Internal Revenue Service requires taxation on a portion of your premium.
The cost to provide this coverage is shown on the *"Optional Life Insurance Rate Sheet"* page.
Rates are subject to change.
New employees have 31 days from date of hire to purchase Optional Life Insurance without proof of medical insurability.
Current employees will have to submit an Evidence of Insurability form if they wish to purchase more than their current level of coverage.

To determine the amount of life insurance that you need, take the numbers from the *"Liability Worksheet"* and fill in the blanks below. The amount shown on the third line will tell you how much life insurance that you should have.

a. Annual expenses $_____
b.Outstanding liabilities + $_____
= Amount of life insurance needed $_____

SPOUSE & CHILD (ren) OPTIONS

If you wish to add to your Voluntary elections you can add Spouse & Child(ren) insurance

Spouse: Increments of $1,000 to a max of 50% of the Employees amount, but no more than $150,000.
Guaranteed Issue for 2019 only as follows: if under 65 $25,000 / if 65-69 $10,000.
Coverage ends: at age 70.

Child(ren): $10,000, not to exceed 100% of the Employee amount. Infant to 13 days $500 maximum.
Coverage to age 23, to age 25 of Full Time Student.
Guaranteed Issue for 2019 only.

Optional Term Life/Accidental Death & Dismemberment

Rate Sheet *(these rates are Term Life and ADD combined)*

Employee Voluntary Life

Age	Rate per 1,000
0 - 24	$ .0878
25 - 29	$ .0740
30 - 34	$ .0740
35 - 39	$ .0909
40 - 44	$ .1235
45 - 49	$ .1779
50 - 54	$ .2629
55 - 59	$ .4008
60 - 64	$ .5719
65 - 69	$ .8620
70 - 74	$1.7673
75 - 80	$4.1030

Spouse Voluntary Life
(rates are based on the Employee age)

Age	Rate per 1,000
0 - 24	$ .0878
25 - 29	$ .0740
30 - 34	$ .0740
35 - 39	$ .0909
40 - 44	$ .1235
45 - 49	$ .1779
50 - 54	$ .2629
55 - 59	$ .4008
60 - 64	$ .5719
65 - 69	$ .8620
70 - 74	$1.7673
75 - 80	$4.1030

Child Life

Age	Rate per 10,000
14 days – 23	$1.90 p/mo
Infant max $500	$0.95 p/mo
To age 25 if Full time Student	

To calculate the cost of additional Term Life Insurance/Accidental Death & Dismemberment (do this calculation separately for Employee or Spouse or Child:

1)Find your age and corresponding monthly cost per thousand

2)_____ (Cost per thousand) X _____ (Life ins. amount (omit 000)) = _____ (Monthly Cost)

3)_____ (Monthly Cost) X 12 (months) = _____ (Annual Cost)

4)_____ (Annual Cost) / (divide) _____ (No. of pays) = _____ (Cost per pay)

EXAMPLE:

- 42 years old (.1235 per thousand)
- Annual salary $25,000
- would like to purchase additional one (1) x salary
- 24 pays per year

2) .1235 (Cost per thousand) X 25 (Life ins. amount (omit 000)) = $3.0875 (Monthly Cost)

3) $3.0875 (Monthly Cost) X 12 (months) = $37.05 (Annual Cost)

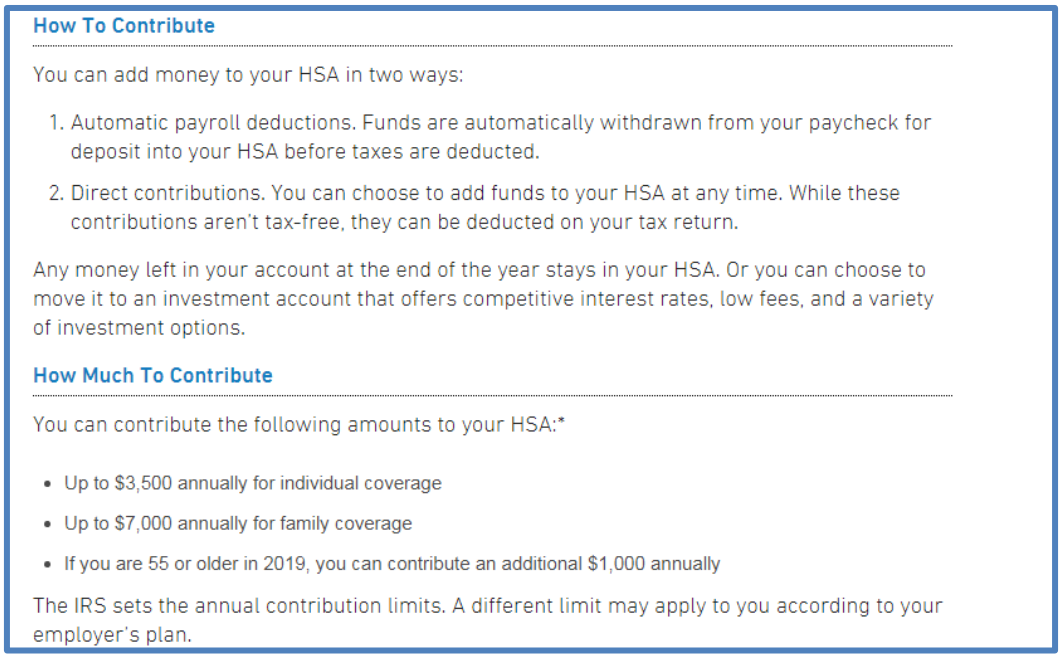
4) $37.05 (Annual Cost) / 24 (No. of pays) = $1.54 (Cost per pay)

Health Savings Account (HSA)

The following is a brief explanation of the H.S.A. that is combined with your HDHP plan if you enrolled in this medical plan. More information is provided online and via the WageWorks®website.

By law, HSAs are available to members who enroll in an HDHP, are under age 65, are not Medicare enrolled, are not covered by another health plan, or are not claimed as a dependent on someone else's Federal tax return. The health plan credits a portion of the health plan premium to the HSA. The credited amount is different for a Self Only enrollment than for a Family enrollment. You have the option to make additional tax-free contributions to your account, so long as total contributions do not exceed the limits established by law. The funds in your HSA can be used to pay for your plan deductible and/or qualified medical expenses that do not count towards your deductible.

You will use the WageWorks®Card for services. Please see the next page for information on Wage Works.



How To Contribute

You can add money to your HSA in two ways:

1. Automatic payroll deductions. Funds are automatically withdrawn from your paycheck for deposit into your HSA before taxes are deducted.
2. Direct contributions. You can choose to add funds to your HSA at any time. While these contributions aren't tax-free, they can be deducted on your tax return.

Any money left in your account at the end of the year stays in your HSA. Or you can choose to move it to an investment account that offers competitive interest rates, low fees, and a variety of investment options.

How Much To Contribute

You can contribute the following amounts to your HSA:*

- Up to $3,500 annually for individual coverage
- Up to $7,000 annually for family coverage
- If you are 55 or older in 2019, you can contribute an additional $1,000 annually

The IRS sets the annual contribution limits. A different limit may apply to you according to your employer's plan.

Features of an HSA include:

- Your own HSA contributions are tax-deductible. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). See IRS Publication 969.
- Contributions to your HSA can be made through an employer sponsored plan such as a Section 125 Cafeteria Plan. In a Cafeteria Plan, the employer takes your HSA contributions out of each paycheck on a pre-tax basis.
- Interest earned on your account is tax-free
- Withdrawals for qualified medical expenses are tax-free
- Unused funds and interest are carried over, without limit, from year to year
- You own the HSA and it is yours to keep — even when you change plans, leave employment, or retire
- Your HSA is administered through Choice Strategies, your account is with Mellon Bank
- Eligible medical expenses are defined as those expenses paid for care as described in Section 213(d) of the Internal Revenue Code. Additionally, the IRS allowed some over-the-counter drugs to qualify as eligible medical expenses. You are encouraged to view the IRS's website (Publication 502) for a complete list of eligible medical expenses. For a list of qualified medical expenses that can be reimbursed through an HSA: www.irs.gov/pub/irs-pdf/p502.pdf

A Limited Use Uninsured Health Care FSA (LU-UHCFSA) is allowed for H.S.A. participants, it will cover dental, vision, and over the counter items only. It will not cover any deductibles or medical co-pays, but can be used for the prescription drug co-pays after your deductible has been met.

Health Savings Account (HSA) continued

ADMINISTRATOR

WageWorks® is the administrator of your H.S.A account. Representatives are available to answer any questions that you may have with regards to your accounts. WageWorks® makes it easy for you to get the help you need now. Browse our Frequently Asked Questions for answers to common questions. If you can't find what you're looking for, please call 1-877-924-3967 (Monday - Friday 8 a.m. to 8 p.m. ET).

WageWorks® makes it easy to manage your HSA. Log into the WageWorks® secure web portal at www.wageworks.com to manage all aspects of your WageWorks® account. You can also log into www.wageworks.com/myhsa

Be sure to download the EZ Receipts app, which allows you to check account balances, submit claims, view transactions, snap photos of receipts and get account alerts—all on the go.

A special "stored valued" card that draws your annual HSA funds. It gives you an easy, automatic way to pay for qualified healthcare expenses not covered by your health insurance. Each time you incur a qualified healthcare expense at a health-related business (like a pharmacy or doctor's office) , simply use your Wage Works Card. The amount of your qualified purchases will be deducted automatically and the pre-tax dollars are electronically transferred to the provider for immediate payment.

- **Works like a debit card, just swipe and go**
- **Funds come directly from your HSA**
- **No PIN required**

Web Portal and Mobile App Make Your HSA Easy to Manage

WageWorks makes it easy to manage your HSA. Log into the WageWorks secure web portal to manage all aspects of your WageWorks account:

- Check account balances
- Withdraw funds from your account and view account activity
- Look up eligible expenses
- Upload and store receipts for your tax records
- Select your reimbursement methods (by check or direct deposit)
- Choose to receive account alerts by email or text

The WageWorks EZ Receipts® mobile app puts the power of the WageWorks web portal in the palm of your hand. Download this handy app to your mobile device, log into your account, and check balances, submit claims, view transactions, snap photos of receipts, get account alerts by text or email—all on the go!

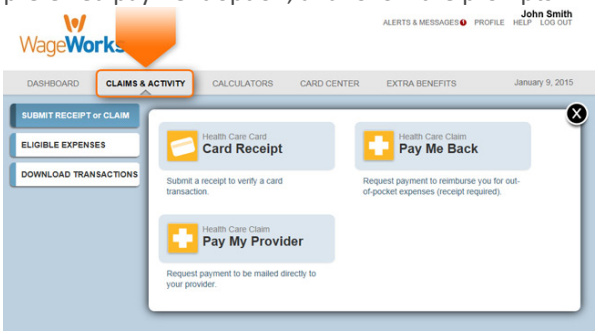
Check Your Receipts - Before you leave the doctor's office or pharmacy, look at your receipt. All receipts must show three things: **• Date of service or purchase date • Brief description of the item or service • Dollar amount**

This is especially important when you purchase a prescription, as pharmacies sometimes provide only the debit card receipt, which doesn't include an item description. If your receipt is incomplete, ask the provider or pharmacist to print out a receipt for you showing all three pieces of information.

H.S.A. Payment Options

WageWorks makes it easy for you to use the money in your healthcare benefit accounts to pay for hundreds of eligible healthcare expenses

These payment options are fully automated. Log into your WageWorks account on either the web portal or the mobile app, select your preferred payment option, and follow the prompts.



Your WageWorks account gives you a variety of payment options to choose from.

The Pay Me Option

You can withdraw funds directly from your HSA to pay for eligible expenses. This option works just like an ATM, but without the ATM fees. You may also have HSA funds directly deposited into your bank account or a check mailed to you.

The Pay Me Back Option

If you've already paid for an eligible expense out of your own pocket, you can arrange to pay yourself back from your WageWorks account in two ways:

1. Have a check mailed to you; or
2. Have your reimbursements deposited directly into your bank account

The quickest, easiest way to get reimbursed for eligible expenses you've paid out of pocket is to sign up for direct deposit.
Here's how to submit a Pay Me Back claim.

Via the Web Portal

1. Log into your WageWorks account.
2. If this your first time logging into your WageWorks account, be sure to first register for your WageWorks account.
3. Once you have logged into your account, Click Submit Receipt Or Claim and select Pay Me Back.
4. Enter payment information and select Submit Claim.
5. Upload digital copies of your receipts.

Via the Mobile App

1. Log into your WageWorks account on the WageWorks EZ Receipts® mobile app.
2. Click on Submit New Receipt and then Health Care Claim.
3. Follow the prompts to take and send photos of your receipts and other documentation.

Via Fax or Mail

1. Download a Healthcare Pay Me Back Claim Form.
2. Fill in all the information requested on the form and sign it.
3. Fax or mail the form, along with copies of your receipts, to:
   - Claims Administrator
     P.O. Box 14053
     Lexington, KY, 40512
     Fax: 877-353-9236

Most Pay Me Back claims are processed within one to two business days after they are received and verified. Payments are sent shortly thereafter.

Questions about Pay Me Back claims? Check out the FAQs in the Employee Support Center.

Employee Reimbursement Account

An attractive feature of the Flexible Benefits Plan is your Employee Reimbursement Account. It enables you to pay a portion of your Uninsured Health Care and Dependent Care expenses with pretax dollars. This can save you a considerable amount in taxes.

The Employee Reimbursement Account has two parts: one for Uninsured Health Care expenses (medical type expenses) and one for Dependent Care expenses (day care type expenses). Just before the beginning of each plan year, you will have the opportunity to elect to fund your Reimbursement Account for the coming year. The amount that you select will be deducted from your gross salary through automatic payroll deductions. Then, during the plan year, you may submit claims to the Administrator to reimburse yourself for Dependent Care expenses and/or Health Care expenses incurred during the plan year but not reimbursed by your insurance plans.

NOTES ABOUT YOUR ACCOUNT

WageWorks® is the administrator of your Flexible Spending Accounts. Representatives are available to answer any questions that you may have with regards to your accounts. WageWorks® makes it easy for you to get the help you need now. Browse our Frequently Asked Questions for answers to common questions. If you can't find what you're looking for, please call 1-877-924-3967 (Monday - Friday 8 a.m. to 8 p.m. ET).

During the year, you should keep receipts for all qualified expenses. *The final check run is 75 days after the plan year ends, otherwise any remaining balance in the account will be forfeited.*

With a variety of convenient payment options, your WageWorks Healthcare FSA makes it easy for you to get reimbursed for hundreds of eligible healthcare expenses, like copayments for doctor visits, prescription drugs, and new eyeglasses or contact lenses.
Payment options include:

- **Pay My Provider**. Arrange for convenient direct payments to your healthcare provider. Simply log into your WageWorks account and fill out a form to have eligible expenses paid directly from your account. This works for Dependent Care plans too.
- **Pay Me Back**. Arrange for account funds to be directly deposited into your bank account or a check to be mailed to reimburse you for eligible expenses you've already paid. This works for Dependent Care plans too.
- **Pay by a Prepaid Card**. You may use the convenient WageWorks Healthcare Card associated with your account to pay for hundreds of eligible healthcare products and services. If you have more than one WageWorks account, this smart prepaid card knows which account to draw money from first. Just don't forget to save your receipts as some expenses charged to your prepaid card may need to be verified.

Keep Your Receipts

The IRS has specific rules for Healthcare FSAs and you always have to verify expenses with receipts. Save receipts for each eligible expense you submit for reimbursement under your Healthcare FSA. Make sure receipts include the following five pieces of information:

1. **Patient's Name**. The name of the person who received the service or for whom the item was purchased. For retail store purchases, this information may be excluded.
2. **Provider's Name**. The provider that delivered the service or the merchant where the item was purchased.
3. **Date of Service**. The date when services were provided or the item was purchased.
4. **Type of Service**. A detailed description of the service provided or item purchased. A bag tag is sufficient for prescriptions.
5. **Cost**. The amount paid for the service or product and/or the portion that is not reimbursed through your insurance carrier.

WageWorks is required to verify that all purchases made with your WageWorks Healthcare Card are for eligible expenses, so we may ask you to send copies of your receipts to verify card transactions.
WageWorks makes it easy to manage your receipts. Take a photo of each receipt and store them in the WageWorks® EZ Receipts® mobile app.

Tax Savings Example

The following example (assuming Single taxpayer) illustrates how the payment of after-tax expenses on a pretax basis creates a pay raise for the employee.

	WITH ACCOUNT(S)	WITH OUT ACCOUNT(S)
ANNUAL GROSS SALARY	24,000	24,000
DEPENDENT CARE (PRE TAX)	1,800	0
HEALTH CARE EXPENSES (PRE TAX)	700	0
TAXABLE INCOME	21,500	24,00
FEDERAL TAX (18.5% BLENDED)	3,978	4,440
FICA (7.65%)	1,645	1,836
STATE TAX (4.25%)	914	1,020
AFTER TAX INCOME	14,963	16,704
AFTER TAX DEPENDENT CARE	0	1,800
AFTER TAX HEALTH CARE	0	700
SPENDABLE INCOME	14,963	14,204
NET PAY RAISE	**759.00**	

NOTE: ***A portion of your pay raise should be used to address the possible disadvantage of pretax funding. (See the section entitled "How to Avoid Potential Disadvantages.")***

Please keep these important considerations in mind:

1. **The Internal Revenue Service (IRS) requires that any money left in your account at the end of the Plan Year must be forfeited.** This means you should allocate only as much to the Account as you feel certain you will incur in reimbursable expenses during the year. The plan has a two and one-half month grace period (medical and dependent care), so claimants can incur claims until March 15 after the plan year ends, and they can submit claims until March 31 after the plan year ends. All expenses incurred during a plan year must be submitted for reimbursement by ***March 31st*** of the following year. Otherwise, any money left in the Account will be forfeited. In the unlikely event of forfeiture, there may still be substantial tax savings to the employee. For example, assume an employee contributes $2,400 to the plan, but only incurs $2,000 of expenses. The $2,000 of expenses are reimbursed tax free and the unused $400, in this case, would be forfeited. An employee in the 30% tax bracket (combined Federal, State, FICA) saves $720 in taxes on the $2,400 set aside ($2,400 x 30% = $720). If you subtract the $400 loss attributable to the forfeiture from the $720 tax savings, the employee still comes out $320 ahead.

2. If you elect to participate, the amount you designate will be withheld automatically from your paycheck in equal installments. **The minimum contribution to the Account is $130 per calendar year.**

3. The annual re-enrollment period is the only time you may change your selections unless you have a change in "family status". Qualifying "status changes" for benefits provided under this plan are subject to approval of your employer, must be on account of a particular event, and satisfy any specific consistency rules that may apply to the particular benefit. Please reference your summary plan description for a detailed list of qualified “status changes”. Examples include:
   - Change in your legal marital status, on account of marriage, divorce, death of your spouse, legal separation or annulment;
   - Change in the number of your dependents, due to birth, adoption, placement for adoption, or death of a dependent;
   - Change in employment status for you, your spouse, or a dependent;
   - Change because your dependent satisfies (or ceases to satisfy) the eligibility requirements;
   - Significant cost increases in a qualifying benefit (other than Uninsured Health Care accounts);
   - A change in coverage in a spouse's or dependent's Section 125 Plan;
   - A leave under the Family Medical Leave Act;

   It is very important for you to understand that you must notify Human Resources within 30 days of a "status change" in order to be allowed to select different benefit options. This includes adding dependent coverage. If you have a status change, the new coverage becomes effective as of the date you notify Human Resources of the change or, if administratively possible, the date of the status change. It will always be to your best advantage to notify Human Resources as soon as possible.

4. Although you have only one Reimbursement Account, the Uninsured Health Care portion and Dependent Care portion are entirely separate. Only Health Care expenses may be reimbursed from the Health Care portion; only Dependent Care expenses may be reimbursed from the Dependent Care portion. Once a given portion is used up for the year, no more expenses may be reimbursed for that year. You cannot transfer funds from one portion of the Account to the other.

5. The Dependent Care portion of the Account cannot reimburse you for more money than has been deposited into it by the date you make a claim. Remember, your contributions are deducted each pay, so funds build up gradually in your Dependent Care Reimbursement Account. If you do submit a claim for more than the amount in your Account at that time, any excess will be held for reimbursement until sufficient funds have accumulated.

6. If you should terminate employment during the plan year, you will have 75 days from your date of termination to file for reimbursable expenses incurred during the period in which you were an eligible participant of the plan. In addition, you may continue in the Uninsured Health Care Reimbursement Account for the remainder of the plan year with proper contributions.

7. Keep in mind that the funds you contribute to your Reimbursement Account are deducted before taxes are withheld, so you have not paid any taxes on them. Therefore, any items submitted through your Employee Reimbursement Account cannot be used as either a tax credit or deduction.

NOTE: There is a worksheet following the Dependent Care section which is designed to help those employees with Dependent Care decide whether it is more beneficial to pay those expenses from their Reimbursement Account or take the income tax credit.

Uninsured Health Care Expenses

You may contribute up to $2,650 of your earned income per calendar year to the Health Care portion of the Account to reimburse yourself for expenses incurred by you or an eligible dependent. Common examples include:

- Plan deductibles
- Medical, Dental and Vision expenses not reimbursed by your plan.

**Please note, an eligible expense must be a medically necessary expense incurred for diagnosis, cure, treatment, mitigation, or prevention of disease, or for the purpose of affecting any bodily function or structure.*

The following is a *representative* list of Health Care expenses allowable under the Internal Revenue Code:

Acupuncture.....	Performed by a licensed practitioner
Alcoholism or drug dependency.....	Payment to a treatment center
Ambulance	
Birth control pills....	If medically necessary
Car controls.....	Special controls for the handicapped
Chiropractors.....	Services within the scope of license
Contact lenses.....	Balances not paid by other vision insurance
Copayments.....	Balances not paid by other health insurance
Cosmetic surgery.....	For medically necessary procedures
Crutches.....	Purchase or rental
Deductibles and coinsurance.....	Balances not paid by other health insurance
Dental fees.....	X-rays, fillings, braces, extractions, false teeth, orthodontia services, treatments (non cosmetic procedures only), etc. *Cosmetic teeth whitening is **not** reimbursable*.
Doctor's fees	
Excess charges.....	Charges not paid by other health insurance
Eyeglasses.....	Lenses, frames, examinations
Eye Care.....	RK Surgery
Founder's fee.....	Monthly or lump sum fee to a retirement home (covers portion specifically for medical care)
Guide dog.....	Purchase, for blind or deaf
Halfway house.....	Care to help individual adjust from life in a mental hospital to community living
Health care equipment..... .	Not of general use as articles of furniture, household items or appliances
Hearing aids	
Hospitalization.....	Including private room coverage
Hypnosis.....	For treatment of illness
Laboratory fees	
Learning disability....	Tutoring by licensed school or therapist for a child with severe learning disabilities
Lifetime care.....	Advance payment to private institution for lifetime care, treatment or training of mentally or physically handicapped patient
Medicines.....	Prescribed and legally obtained drugs and medicines
Nursing home.....	Confinement for treatment of illness or injury
Nursing service.....	By registered nurse or licensed practical nurse for medical care
Optometrist.....	Services within scope of license
Over The Counter Medicines(O.T.C.)	*Must be prescribed by Medical Doctor*
Oxygen.....	If medically necessary
Psychologist.....	Services within scope of license
Psychotherapy.....	If by a licensed practitioner
Schools.....	Special schooling to relieve handicap
Smoke ender programs.....	If prescribed by a doctor
Surgery.....	Including experimental and medically necessary cosmetic procedures
Syringes, needles, and injections	
Telephone.....	Special for the deaf
Television.....	Audio display equipment for the deaf
Therapy.....	Physical or occupational therapy by a licensed therapist
Transplants	
Tuition fee.....	Charges for medical care included in the tuition fee of a college or university (if billed separately)
Wheelchairs.....	If medically necessary

Note: ***Currently, in order to receive a tax deduction for medical expenses on your tax return; expenses must exceed 7.5% of your adjusted gross income. Therefore, your Uninsured Health Care expense account provides you with the only opportunity to receive full credit for ALL medical expenses incurred regardless of income.***

Estimating Health Care Expenses For You and Your Family

(You should refer to the sections entitled "Medical/Dental Options" to help you accurately estimate your expenses.)

	Previous Year (Actual)	**This Year** (Expected)
Medical plan deductibles	$	$
Medical plan coinsurance (the percentage that your plan does not pay)	$	$
Dental or orthodontic expenses that are not covered by your plan	$	$
Vision care expenses that are not covered by insurance elsewhere	$	$
Hearing aids	$	$
Medicine or drugs prescribed by a doctor but not covered by your plan	$	$
Other qualified expenses not paid by your plan	$	$
YOUR TOTAL HEALTH CARE EXPENSES:	$	$

Dependent Care Expenses

The Employee Reimbursement Account can be used to pay for Dependent Care expenses that enable you and your spouse to work or to search actively for work.

REIMBURSEMENT LIMITATIONS:

A married employee may only be reimbursed for Dependent Care expenses up to the lesser of:

a. $5,000 ($2,500 if married filing a separate return); or
b. 50% of the employee's compensation; or
c. the earned income of the employee's spouse.

Therefore, a married employee whose spouse does not work is generally not entitled to Dependent Care assistance reimbursement. However, if the employee's spouse is a full-time student or incapable of caring for himself or herself then the employee will be allowed a limited benefit under the plan. The allowable limit of reimbursement for each month the spouse is a full-time student is $200 if the employee has one dependent or $400 if the employee has two or more. If the employee's spouse is incapacitated, the allowable limit is $200 per month if the employee has one or more additional dependents.

An unmarried employee may be reimbursed for all Dependent Care expenses up to the lesser of:

a. $5,000; or
b. 50% of the employee's compensation

For the purpose of Dependent Care expenses, a dependent includes anyone you claim as a dependent on your income tax return and who is:
Age 12 or younger, or Physically or mentally incapable of caring for himself or herself (for example, a disabled spouse or an elderly parent).
A person other than your spouse must rely on you for more than one-half of his or her support to qualify as a dependent.

ELIGIBLE DEPENDENT CARE EXPENSES INCLUDE:

Payments made for services provided in your home (babysitters, for example). These services cannot be provided by someone you claim as a dependent or someone who is a relative, living in your home.

Payment made for dependent child care services outside your home. If you use the services of a dependent care center that provides care for at least six people (other than residents), the center must be in compliance with the state and local laws.

Payments made for care outside your home for a dependent (other than a child), if the dependent spends at least eight hours a day in your home. (For example, 24-hour nursing home care for a dependent parent would not qualify).

If you utilize a Dependent Care Reimbursement Account, you must furnish the name, address and tax identification (social security number or corporate tax ID) number for the provider of dependent care services to the administrator of the plan.

Estimating Your Dependent Care Expenses

Previous Year(Actual)

$	x	= $
weekly expense	number of weeks	annual total

This Year(Expected)

$	x	= $
weekly expense	number of weeks	annual total* **(B)**

Total contributions to your Dependent Care Reimbursement Account **(B)**	$
Divide by # pay periods for total deduction per paycheck	$

How To Avoid Potential Disadvantages Should You Fund Your Employee Reimbursement Account…

Since contributions to your Employee Reimbursement Accounts are treated as a reduction in income, there will be a slight reduction in Workers Compensation and Social Security disability and survivorship benefits. This potential disadvantage is easily overcome if the employee invests part of his/her tax savings into a tax deferred annuity.

Typically, for every $100 reduction in income for Social Security purposes, at age 40 an employee only has to invest $5.00 out of $22.00 in tax savings to have more benefits at retirement than the Social Security system would provide.

The amount of tax savings that have to be reinvested to make up for the lost Social Security benefit goes up the longer the employee is in the plan.

Other Benefits

In addition to what is being offered through the Flexible Benefits menu, other benefits will be made available on a payroll deduction basis for your convenience. You may use your tax savings or money received from the menu, as well as, money from your paycheck to purchase these benefits.

TAX-DEFERRED ANNUITIES
A popular savings vehicle available to employees of non-profit organizations is the tax-deferred annuity. A tax-deferred annuity (TDA) is a type of interest earning account. It is often referred to as a tax sheltered annuity (TSA). This account allows your contributions and any interest earned to accumulate on a tax- deferred basis until you withdraw the funds. Since you pay no taxes on contributions or earned interest prior to withdrawal, your TDA can grow much faster than a traditional savings account. Information regarding TDA's is available through the Director of Employee Benefits.

MICHIGAN EDUCATION SAVINGS PROGRAM
A Section 529 College Savings Plan administered by the Michigan Department of Treasury and managed by TIAA-CREF Tuition Financing Inc. Please contact the Director of Employee Benefits for details.

LONG TERM CARE INSURANCE
This is a voluntary program. Please see the Director of Employee Benefits for details.

SUPPLEMENTAL ACCIDENT INSURANCE
This is provided by the employer. Please see the Director of Employee Benefits for details.

Participation in optional benefits is strictly voluntary. Any advice received does not necessarily reflect that of your employer.

Making Your Selections

Once you have reviewed the Flexible Benefits Workbook, you can start planning your selections for coverage's and your Employee Reimbursement Account.

Each year, you will have an opportunity to either reconfirm or change your selections during the annual enrollment process. Should any costs or levels of coverage be changed, the re-enrollment period allows you to assess those changes as they pertain to your own personal situation. ***You are required to participate in the annual re-enrollments to make certain that your benefit choices remain consistent with your objectives.***

Take the time to plan a customized package that will be best for you and your family. Please do not forget that **HUB International** is available to help. Representatives will be happy to answer any questions that you may have about the various plans that make up the Kalamazoo Valley Community College Flexible Benefits Plan. They will also be available to assist you during the enrollment process. The number to call is: (248) 579-0270 or (248) 579-0260.

NOTE: Payment of any benefits is subject to the terms and conditions of the plan document rather than any information given here. This description does not change in any way the provisions set forth in the plan document.

Notes

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