



**GENTEX**  
CORPORATION

# 2020 BENEFITS SUMMARY



ENROLL HERE: [GENTEX.BSWIFT.COM](https://gentex.bswift.com)

LEARN MORE: [BENEFITS.GENTEX.COM](https://benefits.gentex.com)

EMAIL: [BENEFITS@GENTEX.COM](mailto:benefits@gentex.com)

# HOW TO ENROLL IN BENEFITS

## PRIOR TO ENROLLING

Gather the following information from all of your dependents and life insurance beneficiaries:

- Legal name
- Date of birth
- Social security number
- HSA bank information

You can **LOG IN** to Bswift two different ways via Single Sign On or directly on the website.

### DIRECTLY:

Log into [gentex.bswift.com](http://gentex.bswift.com) using your default username and password.

### SINGLE SIGN ON:

Go to [myworkplace.gentex.com](http://myworkplace.gentex.com)

Enter your Gentex email address and password

Click on the All Apps icon

Click on the BSwift icon to be automatically signed in to the BSwift dashboard.



\* **SKIP STEP 2.**

## STEP 1

**USERNAME:** First initial of first name, entire last name and last four digits of social security number.

**PASSWORD:** Birthdate without dashes (mmddyyyy). Passwords have been reset to date of birth for open enrollment.

**EXAMPLE:** John Smith born July 23, 1980, SSN 987-65-4321

**Username:** jsmith4321 **Password:** 07231980

## STEP 2

Change your password.

**RULES:** Password must be at least eight characters long and contain at least one letter and number. Please note that passwords are case sensitive.

## STEP 3

Click **START YOUR ENROLLMENT.**

Welcome to your enrollment!

Enrollment Deadline **9/20/2016**

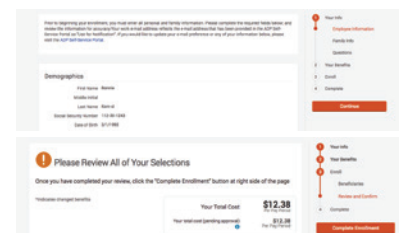
Your Status **Not Started**

[Start Your Enrollment](#)

## STEP 4

Continue through, clicking **CONTINUE** to advance to the next page.

Once you have selected and reviewed your benefits choices, click **COMPLETE ENROLLMENT.**



## STEP 5

Print or email yourself the confirmation notice for your records.



HAVE A QUESTION?

bswift  
Customer Service  
866-524-5063

Traci Streeter  
Gentex Benefits Team  
616-772-1590 X4070

Brittany Denton  
Gentex Benefits Team  
616-772-1590 X5906

Laura Hulet  
Gentex Benefits Team  
616-772-1590 X4173

# ENROLLING IN 2020 BENEFITS

**DEADLINE IS AT 5:00 PM, 14 DAYS AFTER YOUR DATE OF HIRE AS A GENTEX EMPLOYEE**

## **DO I HAVE TO ENROLL IF I DON'T WANT GENTEX INSURANCE?**

If you are receiving this packet, you must go online to enroll in the waive program within 14 days of hire, even if you have other medical insurance. You only receive the \$9.62 weekly credit for having other medical coverage if you opt-out of Gentex medical coverage.

## **WHEN AM I COVERED UNDER GENTEX INSURANCE?**

Your medical coverage starts on your first day as a Gentex employee. Premiums will come out of your first paycheck based on the default package, but will be adjusted after the enrollment deadline. The coverage you chose at this time will be effective through December 31, 2020.

## **WHAT HAPPENS IF I DO NOT ENROLL BEFORE THE DEADLINE?**

If you do not enroll during the 14 day timeframe you will be defaulted into Plan 2 medical coverage, basic life insurance and 50% long-term disability, with all other voluntary benefits declined.

## **WHEN WILL I GET MY INSURANCE CARD?**

You should receive your medical cards at the home address listed in Workday in 3 – 4 weeks. If you have a medical need before you receive your insurance card, please contact Traci Streeter at 616-772-1590 ext. 4070.

## **CAN I MAKE CHANGES TO MY BENEFITS LATER THIS YEAR?**

Changes cannot be made to your 2020 benefits outside of this enrollment period unless you have a Qualifying Life Status Change throughout the year (including getting married, having a baby, losing or gaining other insurance for you or a dependent, etc.) You have 30 days from the date of the event to go online and make changes to your benefits. You will be required to submit documentation as proof of the event.

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# YOUR EMPLOYEE BENEFITS AND CONTACTS

Gentex offers a comprehensive benefits program to eligible team members. Your health and wellness are important to us. Please review the coverage options to determine which plan will best suit you or your family.

Please note, this booklet is a summary of our coverage options. You can find detailed information on each benefit plan at [benefits.gentex.com](http://benefits.gentex.com) under the medical tab. If you would prefer to talk about the options on the phone, you can call Gentex Human Resources or the insurance carrier (e.g., Priority Health, Delta Dental).

Each benefit has a Summary Plan Description document that provides a complete listing of services, limitations, exclusions, and a description of all the terms and conditions of coverage. If this booklet's description conflicts in any way with the Summary Plan Description issued to the enrolling group, the Summary Plan Description document prevails.

Online Enrollment		866-524-5063 Monday – Friday 9 AM – 7 PM <a href="http://www.gentex.bswift.com">www.gentex.bswift.com</a>
<b>Health Plan 1:</b> \$500 Deductible		616-956-1954 Monday - Thursday 7:30 AM – 7 PM Friday 9 AM – 5 PM Saturday 8:30 AM – noon <b>Group #:</b> 783589 <a href="http://www.priorityhealth.com">www.priorityhealth.com</a>
<b>Health Plan 2:</b> \$1,000 Deductible		
<b>Health Plan 3 HDHP (HSA Eligible):</b> \$1,500 Deductible		
Dental Plan		800-524-0149 Monday - Friday 8:30 AM – 8 PM <b>Group #:</b> 1081 <a href="http://www.deltadentalmi.com">www.deltadentalmi.com</a>
Voluntary Vision Plan		800-877-7195 Monday – Friday 8 AM – 11 PM Saturday and Sunday 10 AM – 11 PM <a href="http://www.vsp.com">www.vsp.com</a>
Health Savings Bank Account (HSA)		616-748-9856 <a href="http://www.macatawabank.com">www.macatawabank.com</a>
Flexible Spending Account (FSA)		855-516-8593 Monday – Friday 8 AM – 8 PM <a href="http://www.payflex.com">www.payflex.com</a>
Smart Health Wellness Program		888-848-3723 Monday – Thursday 8 AM – 8:30 PM Friday 8 AM – 7 PM <a href="http://connect.simplywell.com">connect.simplywell.com</a>
Life/AD&D Insurance		<b>Claims:</b> 866-461-1733 Monday – Thursday 8 AM – 6:30 PM Friday 8 AM – 6 PM <b>Group #:</b> G000AQMV
Long Term Disability Insurance		
Voluntary Short Term Disability		
Voluntary Group Critical Illness		<b>Claims:</b> 800-348-4489 Monday – Friday 8 AM – 8 PM <b>Critical Illness &amp; Accident Group #:</b> V6557 <b>Hospital Indemnity Group #:</b> 92371 <a href="http://www.allstatebenefits.com/mybenefits">www.allstatebenefits.com/mybenefits</a>
Voluntary Group Accident Insurance		
Voluntary Hospital Indemnity Plan		

# BENEFIT PLAN ELIGIBILITY

**EMPLOYEES**

Employees with 30 or more standard hours per week are eligible for Gentex benefit plans on their first day of employment. After your initial elections, you will have the opportunity to change those elections each year during open enrollment. The decisions you make during the open enrollment period will be effective on January 1st and will remain in effect for the remainder of the year.

**SPOUSES**

If your spouse works full-time and is eligible for medical coverage through his or her employer, your spouse will not be eligible for medical and prescription drug coverage under the Gentex Benefit Plan. You can cover your dependent children on all Gentex benefit plans regardless of your spouse's eligibility. If both spouses work at Gentex, dual coverage is not allowed.

**CHILDREN**

Children by birth, marriage, legal adoption or guardianship can be covered on Gentex insurance plans until the end of the month in which they reach age 26. The child does not need to be a full-time student or a dependent on your tax return. Special rules apply for permanently and totally disabled dependent children.

**DISABLED CHILDREN**

Unmarried children who are mentally or physically handicapped and incapable of engaging in self-sustaining employment due to such incapacity and claimed as a dependent on your IRS tax return are eligible for coverage after completing authorizing paperwork through Priority Health.

**DEPENDENT CHILDREN**

(Working at Gentex)

The dependent child of a Gentex employee who becomes an employee of Gentex can continue to be covered under their parent's plan until the end of the month during which the child reaches age 26. The dependent child must elect their own coverage in order to cover a spouse or dependent child.

# MID-YEAR PLAN CHANGES

The IRS has established rules for your elections and dictates that once you have made your elections for the plan year, you may not change them until the next open enrollment period, unless a Qualifying Life Status Change (QLSC) occurs.

A Qualifying Life Status Change includes, but is not limited to, the following events:

## CHANGE IN HOUSEHOLD

- Marriage or Divorce
- Birth or adoption of a child
- Death of a spouse or child

## LOSS OF HEALTH COVERAGE

- Loss of parent coverage at age 26
- Loss of other existing health coverage
- Losing eligibility for Medicare, Medicaid or CHIP

## OTHER EVENTS

- Change in spouse's employment
- Change in residence that affects coverage
- Change in worksite that affects coverage

If you experience a QLSC and would like to make changes to your benefit elections, please elect these changes through the online enrollment portal [www.gentex.bswift.com](http://www.gentex.bswift.com) within 30 days of the event. If you miss this opportunity to enroll within that period, you are required to wait until the next open enrollment period to make changes.

**QUALIFYING EVENT DOCUMENTATION:** Documentation must be submitted to Human Resources within 30 days of the event to approve any changes made to insurance elections. Documentation such as a marriage certificate, birth certificate, loss of coverage letter, etc. can be uploaded to bswift or emailed to [benefits@gentex.com](mailto:benefits@gentex.com).

**ADDING A BABY:** Congratulations on the birth of your child! It is important to remember to add your child to your benefit plan within the first 30 days of birth. The requirement for a social security number is waived to complete the change. When you do receive the social security number, log back into the system to record the number to assist with correct medical billing and IRS reporting.

If your share of the cost for any coverage increases or decreases due to a change in premium, the amount withheld from your paycheck will be automatically adjusted.

## ASK EMMA

### FIND THE BENEFITS THAT FIT YOU BEST!

Ask Emma is bswift's interactive decision support tool. She represents a whole new approach to benefits shopping, enrollment, and education. Ask Emma provides team members with a guided explanation of team member total costs and recommended plans at the end of the Health/Medical interview.

Ask Emma will guide you through the enrollment process by asking a few simple questions. When answering Emma's questions honestly, she will suggest plans that fit your individual needs. She takes the guesswork out of the plan selection process.

Plus, she's easy to understand and fun to use! Just visit [www.gentex.bswift.com](http://www.gentex.bswift.com)!



# MEDICAL PLAN

Our health plan offering includes three Preferred Provider Organization (PPO) plans administered by Priority Health. All plans offer in- and out-of-network benefits; by choosing a Priority Health network provider, you will have lower out-of-pocket expenses. Each plan has the same access to all doctors in Priority Health's network. Team members may choose one of the following medical plan options:

If your spouse works full-time and is eligible for medical coverage through his/her employer, your spouse will NOT be eligible for medical coverage. Dependents are eligible until the end of the month in which they turn 26.

- **PLAN 1 – \$500 DEDUCTIBLE/\$1,250 COINSURANCE MAX:** Plan 1 has lower out-of-pocket expenses with higher weekly premium deductions. Flat dollar copays apply for office visits, urgent care, and prescriptions until the \$6,000 out-of-pocket maximum is reached.
- **PLAN 2 – \$1,000 DEDUCTIBLE/\$1,500 COINSURANCE MAX:** Plan 2 has higher out-of-pocket potential cost with lower weekly premium deductions. Flat dollar copays apply for office visits, urgent care, and prescriptions until the \$6,000 out-of-pocket maximum is reached.
- **PLAN 3 HDHP (HSA ELIGIBLE) - \$1,500 DEDUCTIBLE/\$1,000 COINSURANCE MAX:** Plan 3 is a High Deductible Health Plan (HDHP) and has the lowest weekly premium, but the highest deductible. Flat dollar copays do not apply to this plan; the cost of the services, including office visits and prescriptions, are the team members responsibility until the deductible is met. Once the deductible is met, 20% coinsurance applies to services and flat copay applies to prescriptions. Once the out-of-pocket maximum is met, all services and prescriptions are covered at 100% for the rest of the year. This plan qualifies for contributions to a pre-tax Health Savings Account (HSA).

Please review the Health Insurance Plan information (pages 10 – 12) for more detailed information on specific coverage. Once you have made a plan and dependent election, you must remain on that plan until the next open enrollment period, even if you experience a Qualifying Life Status Change.

# MICHIGAN NO-FAULT AUTO INSURANCE REFORM

Starting July 1, 2020, when you renew your auto insurance, it is important that you continue to maintain personal injury protection (PIP) insurance medical benefits of at least \$250,000 to avoid a gap in coverage.

Currently, Michigan drivers are required to carry no-fault PIP benefits which provide unlimited lifetime coverage for medical expenses related to an automobile accident. Because of this requirement, the Gentex Health Plan excludes coverage for auto-related medical claims.

Beginning July 1, 2020, Michigan residents will no longer be required to carry unlimited PIP coverage but may choose a more limited medical benefit for auto insurance. While a lower medical benefit on your auto insurance may reduce your premiums, it is important to understand that any medical bills relating to an auto accident will not be covered by the Gentex Health Plan until after you have incurred at least \$250,000 in eligible claims. Likewise, while PIP benefits cover medical expenses for your lifetime regardless of your employment status, the Gentex Health Plan only covers eligible claims while you are covered under the Gentex Medical plan.



# PRESCRIPTION DRUG PLAN

Prescription drug coverage is included with the election of any medical plan and administered by Priority Health. Simply show your Priority Health Medical Card at the pharmacy to ensure accurate coverage and pricing. Please review the Health Insurance Plan information (pages 10 – 12) for more detailed information on specific coverage through each plan.

## SAVINGS OPPORTUNITIES

Fill your prescriptions at SpartanNash Pharmacies, such as D&W or Family Fare for preferred pricing.

**ARE YOU ON A MAINTENANCE MEDICATION THAT YOU TAKE ON A REGULAR BASIS?** You can work with your physician to obtain up to a 90-day prescription to reduce the copay amount and frequency of refills. You can only receive this extended supply through SpartanNash pharmacies or mail order. Please note for those enrolled in Plan 3, you must meet your deductible before copays apply.

**MAIL ORDER:** 35 – 90 day supply of medication is available through Express Scripts home delivery. Order online at [www.express-scripts.com](http://www.express-scripts.com) or call 888-378-2589.

## PHARMACY PRESCRIPTION TIERS

Some prescription drugs require prior authorization. Your physician should obtain priority authorization from Priority Health as necessary. If you or your physician elect to receive a brand name drug when an equivalent generic drug is reasonably available, you may be responsible for the difference in cost between the brand name drug and the generic drug. Drugs are added to, or removed from, the approved drug list on a regular basis. Please see below for common definition of prescription tiers.

### TIER 1

**Generic:** Equivalent or alternative option to brand-name drugs, but at a lower cost.

### TIER 2

**Preferred brand-name:** Usually brand-name drugs that require higher copays than generic, but lower copays than a non-preferred brand drug. These drugs are commonly prescribed and selected.

### TIER 3

**Non-preferred brand-name:** Brand-name drugs that require higher copays. These drugs usually have lower cost alternatives with the same or better effectiveness.

### TIER 4 AND 5

**Preferred specialty:** Specialty drugs that are selected based on effectiveness, safety and cost-effectiveness. Specialty drugs that require special handling, are self-administered, and used for chronic illnesses. They require higher copays than a brand-name drug.

**Non-preferred specialty:** Specialty drugs that require the highest level of copay. These drugs usually have lower cost alternatives with the same or better effectiveness.

# PLAN 1: \$500 DEDUCTIBLE PPO

PREMIUMS	EMPLOYEE	EMPLOYEE & SPOUSE/CHILD	EMPLOYEE & FAMILY/CHILDREN
<i>Includes Wellness credits</i>	\$1,488.76 per year (\$28.63 per week)	\$2,893.80 per year (\$55.65 per week)	\$4,150.64 per year (\$79.82 per week)

BENEFITS	IN-NETWORK		OUT-OF-NETWORK	
<b>Calendar Year Deductible</b>	\$500 person	\$1,000 per family	\$1,000 person	\$2,000 per family
<i>Each family member will not pay more than the single deductible, but all family members contribute to the family deductible – in aggregate.</i>				
<b>Coinsurance (Paid by member)</b>	20%		30%	
<b>Coinsurance Maximum</b>	\$1,250 person	\$2,500 per family	\$1,500 person	\$3,000 per family
<b>Max Out-Of-Pocket Limit</b> <i>(Includes deductible, coinsurance &amp; copays)</i>	\$6,000 person	\$12,000 per family	Unlimited	Unlimited
<b>Lifetime Max</b>	Unlimited		Unlimited	

OFFICE VISIT COPAYS	LAKESHORE HEALTH PARTNERS	HOLLAND PHO	PRIORITY HEALTH	OUT-OF-NETWORK
Primary Care Physician	\$10 copay	\$20 copay	\$25 copay	30% after deductible
On-Site Clinic	No charge	N/A	N/A	N/A
Specialist	\$20 copay	\$30 copay	\$35 copay	30% after deductible
Preventive Care	No charge	No charge	No charge	30% after deductible
Urgent Care	\$20 copay	\$35 copay	\$35 copay	30% after deductible
<b>Virtual Visit</b>	N/A	N/A	\$10 copay	30% after deductible

**Ambulance and Emergency Room** 20% after in-network deductible

#### Other Services

Lab, X-ray, and Hospital Services	20% after deductible	20% after deductible	20% after deductible	30% after deductible
<b>Mental Health &amp; Substance Abuse</b>	<b>Inpatient:</b> 20% after deductible <b>Outpatient:</b> \$10 copay	<b>Inpatient:</b> 20% after deductible <b>Outpatient:</b> \$20 copay	<b>Inpatient:</b> 20% after deductible <b>Outpatient:</b> \$25 copay	30% after deductible

TIERS	PRESCRIPTION DRUGS Days	SPARTAN STORE PHARMACIES		NON-SPARTAN STORE PHARMACIES	
		Retail 1 - 34	Retail 35 - 90	Retail 1 - 34	Mail Order 35 - 90
	\$4/\$10 Generics (copays)	\$0	\$0	\$4	N/A
<b>1</b>	Generic Drugs (copays)	\$10	\$20	\$20	\$20
<b>2</b>	Formulary Brand Drugs (copays)	\$25	\$50	\$50	\$50
<b>3</b>	Non-Formulary Drugs (copays)	\$50	\$100	\$75	\$100
<b>4 &amp; 5</b>	Specialty Prescription Drugs	20% up to a maximum of \$75			
	Lifestyle Drugs	20% up to \$75	20% up to \$150	20% up to \$100	20% up to \$150

# PLAN 2: \$1,000 DEDUCTIBLE PPO

PREMIUMS	EMPLOYEE	EMPLOYEE & SPOUSE/CHILD	EMPLOYEE & FAMILY/CHILDREN
<i>Includes Wellness credits</i>	\$797.68 per year (\$15.34 per week)	\$1,491.36 per year (\$28.68 per week)	\$2,114.84 per year (\$40.67 per week)

BENEFITS	IN-NETWORK		OUT-OF-NETWORK	
<b>Calendar Year Deductible</b>	\$1,000 person	\$2,000 per family	\$2,000 person	\$4,000 per family

*Each family member will not pay more than the single deductible, but all family members contribute to the family deductible – in aggregate.*

<b>Coinsurance (Paid by member)</b>	20%		30%	
<b>Coinsurance Maximum</b>	\$1,500 person	\$3,000 per family	\$2,000 person	\$4,000 per family
<b>Max Out-Of-Pocket Limit</b> <i>(Includes deductible, coinsurance &amp; copays)</i>	\$6,000 person	\$12,000 per family	Unlimited	Unlimited
<b>Lifetime Max</b>	Unlimited		Unlimited	

OFFICE VISIT COPAYS	LAKESHORE HEALTH PARTNERS	HOLLAND PHO	PRIORITY HEALTH	OUT-OF-NETWORK
Primary Care Physician	\$10 copay	\$20 copay	\$25 copay	30% after deductible
On-Site Clinic	No charge	N/A	N/A	N/A
Specialist	\$20 copay	\$30 copay	\$35 copay	30% after deductible
Preventive Care	No charge	No charge	No charge	30% after deductible
Urgent Care	\$20 copay	\$35 copay	\$35 copay	30% after deductible
<b>Virtual Visit</b>	N/A	N/A	\$10 copay	30% after deductible

**Ambulance and Emergency Room** 20% after in-network deductible

#### Other Services

Lab, X-ray, and Hospital Services	20% after deductible	20% after deductible	20% after deductible	30% after deductible
<b>Mental Health &amp; Substance Abuse</b>	<b>Inpatient:</b> 20% after deductible <b>Outpatient:</b> \$10 copay	<b>Inpatient:</b> 20% after deductible <b>Outpatient:</b> \$20 copay	<b>Inpatient:</b> 20% after deductible <b>Outpatient:</b> \$25 copay	30% after deductible

TIERS	PRESCRIPTION DRUGS	SPARTAN STORE PHARMACIES		NON-SPARTAN STORE PHARMACIES	
Days		Retail 1 - 34	Retail 35 - 90	Retail 1 - 34	Mail Order 35 - 90
	\$4/\$10 Generics (copays)	\$0	\$0	\$4	N/A
<b>1</b>	Generic Drugs (copays)	\$10	\$20	\$20	\$20
<b>2</b>	Formulary Brand Drugs (copays)	\$25	\$50	\$50	\$50
<b>3</b>	Non-Formulary Drugs (copays)	\$50	\$100	\$75	\$100
<b>4 &amp; 5</b>	Specialty Prescription Drugs	20% up to a maximum of \$75			
	Lifestyle Drugs	20% up to \$75	20% up to \$150	20% up to \$100	20% up to \$150

# PLAN 3: HDHP (HSA ELIGIBLE)

PREMIUMS	EMPLOYEE	EMPLOYEE & SPOUSE/CHILD	EMPLOYEE & FAMILY/CHILDREN
Includes Wellness credits	\$554.32 per year (\$10.66 per week)	\$1,005.16 per year (\$19.33 per week)	\$1,410.76 per year (\$27.13 per week)

BENEFITS	IN-NETWORK		OUT-OF-NETWORK	
<b>Calendar Year Deductible</b>	\$1,500 person	\$3,000 per family	\$3,000 person	\$6,000 per family
<b>Coinsurance</b> (Paid by member)	20%		40%	
<b>Coinsurance Maximum</b>	\$1,000 person	\$2,000 per family	\$1,000 person	\$2,000 per family
<b>Max Out-Of-Pocket Limit</b> (Includes deductible, coinsurance & copays)	\$2,500 person	\$5,000 per family	\$4,000 person	\$8,000 per family
<b>Lifetime Max</b>	Unlimited		Unlimited	

Member deductible and out-of-pocket (OOP) max applies to member only contracts. If there are 2 or more people enrolled in the High Deductible Plan, the member deductible and OOP max does not apply. All family members will contribute to the family deductible and OOP max – in aggregate.

OFFICE VISIT COPAYS	IN-NETWORK	OUT-OF-NETWORK
On-site Clinic	\$22 charge for non-preventative visit	N/A
Primary Care Physician	20% after deductible	40% after deductible
Specialist	20% after deductible	40% after deductible
Preventive Care	No charge	40% after deductible
Urgent Care	20% after deductible	40% after deductible
<b>Virtual Visit</b>	\$45 fee	40% after deductible
<b>Ambulance and Emergency Room</b>	20% after in-network deductible	
<b>Other Services</b>		
Lab, X-ray, and Hospital Services	20% after deductible	40% after deductible
<b>Mental Health &amp; Substance Abuse</b>	20% after deductible	40% after deductible

TIERS	PRESCRIPTION DRUGS Days	SPARTAN STORE PHARMACIES		NON-SPARTAN STORE PHARMACIES	
		Retail 1 - 34	Retail 35 - 90	Retail 1 - 34	Mail Order 35 - 90
	\$4/\$10 Generics (copays)	\$4	\$10	\$4 if available	N/A
<b>1</b>	Generic Drugs (copays)	\$10 after deductible	\$20 after deductible	\$20 after deductible	\$20 after deductible
<b>2</b>	Formulary Brand Drugs (copays)	\$25 after deductible	\$50 after deductible	\$50 after deductible	\$50 after deductible
<b>3</b>	Non-Formulary Drugs (copays)	\$50 after deductible	\$100 after deductible	\$75 after deductible	\$100 after deductible
<b>4 &amp; 5</b>	Specialty Prescription Drugs	20% up to \$75 after deductible			
	Lifestyle Drugs	20% up to \$75 after deductible	20% up to \$150 after deductible	20% up to \$100 after deductible	20% up to \$150 after deductible

# HEALTH SAVINGS BANK ACCOUNT (HSA)

A Health Savings Account is an opportunity for team members to make tax-free payroll contributions to a medical savings account to use for qualified medical, dental, and vision expenses. You own the account and the money, which rolls over year to year, even if you change plans or leave Gentex. You must be enrolled in the qualified medical Plan 3 HDHP (HSA Eligible) in order to be eligible for the HSA. See the table for the 2020 HSA contribution maximums per IRS regulations.

## ANNUAL MAXIMUMS *(includes employee and employer contributions)*

	MAXIMUM YEARLY HSA Contribution Limit	POTENTIAL GENTEX MATCH	EMPLOYEE ADJUSTED MAX CONTRIBUTION
Employee	\$3,550	\$500	\$3,050
Employee +1	\$7,100	\$1,000	\$6,100
Family	\$7,100	\$1,000	\$6,100
HSA catch up for ages 55+	\$1,000		

## GENTEX CONTRIBUTION MATCH OF \$500 OR \$1,000 IN 2020 TO HEALTH SAVINGS BANK ACCOUNT

All team members enrolled in Plan 3 HDHP (HSA Eligible), who save for medical expenses through a Health Savings Account at Macatawa Bank are eligible to receive a Gentex match on their contributions in 2020. This yearly contribution will help build up the savings account for out-of-pocket medical costs. Gentex will match a team member's weekly contribution dollar for dollar up to \$500 a year for single coverage and up to \$1,000 a year for family coverage. In order to receive the Gentex matching contribution you must enroll in Plan 3 HDHP (HSA Eligible), enroll in weekly employee contributions and open a Health Savings Account with Macatawa Bank.

### HSA BENEFITS

- Contributions in the HSA will be deducted on a pre-tax basis and withdrawals for qualified health care expenses are tax-free.
- Online account management is available at [www.macatawabank.com](http://www.macatawabank.com) and there is no bank fee for an HSA account.
- Unused balances roll over from year to year to save for future health care needs.
- You can maximize your savings by participating in the Limited Flex Plan which covers dental and vision exclusively.
- The HSA is a convenient way to pay for qualified health expenses with the debit card issued when you open the account.
- Once the account exceeds \$2,500, Macatawa Bank has other financial options to maximize the performance of the account.

### THINGS YOU SHOULD KNOW BEFORE SIGNING UP

- To qualify for an HSA, you must be under age 65 and not enrolled in Medicare.
- You must be enrolled in a high-deductible health plan.
- The high deductible plan does not have copays for office visits and Urgent Care. All services are subject to deductible and 20% coinsurance and the full retail price of prescriptions are your responsibility until your deductible is met, then copay pricing applies.
- Funds withdrawn for nonmedical expenses are subject to income taxes.
- If you were previously enrolled in an FSA, any rollover funds (up to \$500) will roll over into a Limited FSA to use for dental and vision services only. Refer to the next page for rollover guidelines.

# FLEXIBLE SPENDING ACCOUNT (FSA) — HEALTH CARE

Flexible Spending Accounts offer you an opportunity to save money by paying for your out-of-pocket health care eligible expenses with pre-tax dollars. You do not pay taxes or Social Security on the amounts of your FSA payroll deductions which increases your disposable income!

The debit card system (PayFlex Card) associated with the FSA is for convenience at time of purchase, but it is not completely paperless. PayFlex administers the FSA plans for Gentex Corporation and may request documentation to satisfy IRS requirements.

## HEALTH CARE FSA

**MEDICAL PLAN 1 OR 2** enrollees are eligible for a Health Care FSA to use for qualified medical, dental and vision expenses. This includes, but is not limited to, deductibles, copays, prescription medication, dental expenses and orthodontia, glasses and contacts.

**MEDICAL PLAN 3 HDHP (HSA ELIGIBLE)** enrollees are eligible for a Limited Health Care FSA to use only for qualified dental and vision out-of-pocket expenses; you are eligible to set aside funds in an HSA to pay for medical expenses.

The minimum deposit is \$2 per week and the maximum deposit is \$2,750/year. This benefit is funded with pre-tax dollars and is non-taxable. The health care FSA may not be used for expenses that are covered by your insurance or other means.

## RUN-OUT PERIOD AND ROLLOVER DOLLARS

The run-out period is the deadline to submit eligible expenses for reimbursement. The run-out deadline for 2020 is 3/31/2021. You may rollover up to \$500 of unused FSA funds from one plan year to the next as long as you have elected to make FSA contributions for the next plan year. If you have more than \$500 in your account after the run-out period, the remaining money will be forfeited. Example: If your FSA account balance is \$625 on 3/31/21, you will be able to rollover \$500 but will lose \$125.

## KNOW THE RULES

FSA is a voluntary plan and does not automatically renew. You must re-elect the plan during Open Enrollment each year to continue the benefit.

- Plan Year: January 1 – December 31
- Once you elect to participate in a flexible spending account, you must continue to participate throughout the year unless you have a Qualifying Life Status Change (QLSC).
- FSA can be used for eligible expenses for you or your dependents — even those not enrolled in the Gentex Health Insurance plan.
- This is a use it or lose it plan. Please be conservative in your estimates as only \$500 can be rolled over to the next plan year.
- Over-the-counter medications require a prescription from your doctor to be eligible.
- You cannot be reimbursed for expenses incurred before the plan effective date, before your enrollment date, after you terminate from the plan, or for expenses that occurred after the close of the plan year.
- FSA monies may not be used for expenses that are reimbursable by your insurance or other means.
- Retain your receipts for proof of eligible expenses until the plan year is over.

View our Frequently Asked Questions document on [benefits.gentex.com](https://benefits.gentex.com) for more information about managing your FSA.

# FLEXIBLE SPENDING ACCOUNT (FSA) — DEPENDENT CARE

Flexible Spending Accounts offer you an opportunity to save money by paying for your out-of-pocket dependent care eligible expenses with pre-tax dollars. You do not pay taxes or Social Security on the amounts of your FSA payroll deductions which increases your disposable income.

- Dependents under the age of 13 living with you and whom you can claim as a dependent on your federal tax return.
- A dependent or spouse who is mentally or physically incapable of personal care.

## THE FOLLOWING TYPES OF CARE ARE ELIGIBLE UNDER A DEPENDENT CARE FSA:

- Care for dependents under the age of 13 living with you and whom you can claim as a dependent on your federal tax return.
- Care can be provided in or outside your home, but must be reported on your tax returns.
- A childcare center with more than six (6) children enrolled. The center must also be in compliance with state and local regulations.
- A housekeeper, au pair, or nanny whose services include providing care for a qualifying dependent.
- A preschool the child/dependent attends while you (and a spouse, if applicable) are working.
- A before and after school care program for children under the age of 13.

PayFlex administers the FSA plans for Gentex Corporation and follows IRS regulations. Once you elect to participate in an FSA, you must continue to participate throughout the plan year, unless you experience a Qualifying Life Status Change (QLSC) or have a significant cost change in dependent care expenses.

## CLAIMS PROCESSING AND DOCUMENTATION: HOW TO FILE A CLAIM FOR REIMBURSEMENT

After you pay out-of-pocket for eligible dependent care expenses, complete the Request for Reimbursement Form (claim form) and submit to PayFlex. You must also attach an itemized receipt from your provider or have the provider sign the form. After your claims form and documentation is received and reviewed, a tax-free reimbursement will be issued to you. Reimbursement forms can be found online at [benefits.gentex.com](https://benefits.gentex.com).

## KNOW THE RULES

- Plan year: January 1 – December 31
- The expenses must be for services rendered after the effective date of your election and before the close of the plan year.
- Funds do not roll over for Dependent Care FSA, so any money left in the account when the plan year ends will be forfeited.
- Receipts for 2020 must be received by 3/31/2021.
- The minimum deposit is \$520/year and the maximum deposit per family is \$5,000/year. If you are married and file separate tax returns the maximum deposit is \$2,500. This benefit is funded with pre-tax dollars and is non-taxable.
- FSA is a voluntary plan and does not automatically renew. You must re-elect the plan during Open Enrollment each year to continue the benefit.
- Your expenses for care must be work-related. In other words, you must pay child and dependent care expenses so you (and your spouse if filing jointly) can work or look for work.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further information or clarification.

# DENTAL INSURANCE

The PPO (Preferred Provider Organization) plan offers an in-network and out-of-network benefit. The Dental plan offers enhanced benefits and reduced out-of-pocket exposure when utilizing a participating Delta Dental dentist. For more information on participating providers, please visit [www.deltadentalmi.com](http://www.deltadentalmi.com) or call 800-524-0149.

## BENEFITS

**DEDUCTIBLE**                      \$50 person      |      \$150 per family      Does not apply to preventative and orthodontic services

### COINSURANCE *(Paid by employee)*

Preventative	0%
Basic Services	20%
Major Services	50%
Orthodontia	50%

### MAXIMUM BENEFITS

*(PPO/Premier/OON benefit maximum are combined)*

\$1,000 per person per calendar year

\$2,000 lifetime

## SAVINGS OPPORTUNITIES

- PPO DENTIST** 30% – 35% off of billed charges; no balance billing
- PREMIER DENTIST** 18% – 22% off of billed charges; no balance billing
- OUT-OF-NETWORK DENTIST** 90% of Reasonable and Customary; potential for balance billing

**NO DENTAL CARDS**  
 Just mention you have Delta Dental.  
**GROUP #1081**

## WHO CAN PARTICIPATE

Spouse (even if they do not qualify for medical) and legal dependents under the age of 26.

## WEEKLY CONTRIBUTION

Employee	\$3.37
Employee +1	\$6.73
Family Coverage	\$11.10



# VISION INSURANCE

The vision coverage is voluntary which means you pay 100% of the monthly premium with pre-tax dollars. For more information on participating providers, please visit [www.vsp.com](http://www.vsp.com).

## COVERAGE

BENEFIT	DESCRIPTION	FREQUENCY	BASIC		PREMIER	
			ALLOWANCE	COPAY	ALLOWANCE	COPAY
WellVision Exam	Focuses on your eyes and overall wellness	Every calendar year	—	\$10	—	\$10
<b>RX GLASSES</b>			—	\$25	—	\$25
Frame	<ul style="list-style-type: none"> <li>• Allowance for a wide selection of frames</li> <li>• Basic coverage allows frames every other calendar year. Premier coverage allows frames every calendar year.</li> </ul>		\$150	Included in Rx glasses	\$225	Included in Rx glasses
Lenses	<ul style="list-style-type: none"> <li>• Single vision, lined bifocal and lined trifocal lenses</li> <li>• Polycarbonate lenses for dependent children</li> </ul>	Every calendar year	—	Included in Rx glasses	—	Included in Rx glasses
Lens Options	<ul style="list-style-type: none"> <li>• Standard progressive lenses &amp; UV protection</li> <li>• Premium progressive lenses</li> <li>• Custom progressive lenses</li> </ul>	Every calendar year	<b>STANDARD</b> <b>PREMIUM</b> <b>CUSTOM</b>	\$0 \$95 - \$105 \$150 - \$175	<b>STANDARD</b> <b>PREMIUM</b> <b>CUSTOM</b>	\$0 \$0 \$0
Contacts <i>(instead of glasses)</i>	<ul style="list-style-type: none"> <li>• Allowance for contacts; copay does not apply</li> <li>• Contact lens exam (fitting and evaluation)</li> </ul>	Every calendar year	\$130	Up to \$60	\$200	Up to \$60

## EXTRA SAVINGS AND DISCOUNTS

**DIABETIC EYECARE PLUS PROGRAM:** Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. \$20 copay; frequency as needed. Ask your VSP doctor for details.

**GLASSES AND SUNGLASSES:** 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision exam.

**FEATURED FRAMES:** Additional \$20 off VSP featured frames including NIKE, Nine West, and more. Ask your VSP provider for details.

**LASER VISION CORRECTION:** Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

**TRUHEARING ENROLLMENT:** Free enrollment (\$108 value) in the TruHearing MemberPlus Program for yourself and covered dependents. Enroll at [vsp.truhearing.com](http://vsp.truhearing.com) and identify yourself as a VSP member to save.

## WHO CAN PARTICIPATE

Spouse (even if they do not qualify for medical) and legal dependents under the age of 26.

### NO VISION CARDS

Just mention you have VSP.

## WEEKLY CONTRIBUTION

	BASIC	PREMIER
Employee	\$1.27	\$2.84
Employee +1	\$2.54	\$5.68
Family Coverage	\$4.08	\$9.14

# EMPLOYEE LIFE/AD&D INSURANCE

Gentex Corporation provides all eligible team members with a Basic Life and Accidental Death and Dismemberment (AD&D) insurance benefit.

## EMPLOYEE COVERAGE

Your amount of life insurance is equal to one time your annual earnings, at the time of hire, rounded to the next higher \$5,000 (no cost to employee).

Contact Human Resources or email [benefits@gentex.com](mailto:benefits@gentex.com) for a certificate of coverage from Mutual of Omaha that includes the full schedule of insurance.

## FEATURES

- **PORTABILITY** – If you leave Gentex you have the option to take the term life with you at group term rates. You must be insurable in order to qualify for this provision.
- **CONVERSION** – If you leave Gentex you also have the option to convert the term life to a whole life policy. This option is guarantee issue with no underwriting.
- **ACCELERATED BENEFIT** – In the event life expectancy is less than 12 months, employees can accelerate the payment of their life insurance for amounts up to 75% of your life insurance election, not to exceed \$500,000. **NOTE:** There may be tax ramifications associated with accelerated benefit. Please consult a tax advisor regarding this option.
- **AGE REDUCTION** – At age 70 the life insurance benefit will be reduced to 50%.
- Mutual of Omaha Insurance Company administers the life insurance plans.
- **IMPUTED INCOME** – If your basic life insurance value is higher than \$50,000 the IRS requires that the access premiums are included in your yearly income for tax purposes.

# VOLUNTARY EMPLOYEE LIFE/AD&D INSURANCE

Employee Voluntary Life Insurance with equal amount of Accidental Death and Dismemberment (AD&D). Weekly premium rates will be based on your age and amount of coverage selected. Rates will display as you enroll through the online portal.

## OPTIONS

*(rounded to the next higher \$5,000)*

- 1X annual earnings
  - 2X annual earnings
  - 3X annual earnings
- OPEN ENROLLMENT** – You can increase one increment of voluntary life insurance.
- NEW HIRE** – You can elect any level of coverage without medical exams or testing required.
- COVERAGE MAXIMUM** – You can elect up to \$900,000 for combined Basic and Voluntary Life coverage.

# VOLUNTARY DEPENDENT LIFE

To qualify for electing dependent (spouse and/or child) life insurance, you must elect voluntary life insurance for yourself. The value of your dependent life insurance cannot be greater than the amount of voluntary life insurance you elect for yourself. We do not require evidence of insurability for dependent life insurance.

## FEATURES

- **PORTABILITY** – If you leave Gentex you have the option to take the term life with you at group term rates. You must be insurable in order to qualify for this provision.
- **CONVERSION** – If you leave Gentex you also have the option to convert the term life to a whole life policy. This option is guarantee issue with no underwriting.
- **ACCELERATED BENEFIT** – In the event life expectancy is less than 12 months, employees can accelerate the payment of their life insurance for amounts up to 75% of your life insurance election, not to exceed \$500,000. **NOTE:** There may be tax ramifications associated with accelerated benefit. Please consult a tax advisor regarding this option.

## VOLUNTARY SPOUSE LIFE INSURANCE

Elect coverage in \$5,000 increments\*

Able to elect up to 100% of employee voluntary life election up to the maximum coverage level of \$50,000

Age limit for coverage is 80

## VOLUNTARY CHILD(REN) LIFE INSURANCE

Elect coverage in \$2,500 increments\*\*

Maximum coverage level: \$25,000

Age limit for coverage is 26

**\*NEW HIRE** – You can elect any level of coverage without medical exams or testing required.

**\*OPEN ENROLLMENT AND QLSC** – You can increase one increment of voluntary life insurance.

**\*\*NEW HIRE, OPEN ENROLLMENT, AND QLSC** – You can elect any level of coverage during open enrollment.

## WEEKLY PREMIUM

Rates for spousal life are based on an employee's age and coverage amount. Rates for child life are \$.10 per \$1000 of coverage, regardless of the number of children covered. The cost will display as you enroll through the online portal.

Mutual of Omaha Insurance Company administers the life insurance plans. Contact Human Resources or email [benefits@gentex.com](mailto:benefits@gentex.com) for a certificate of coverage from Mutual of Omaha that includes the full schedule of insurance.

# VOLUNTARY SHORT TERM DISABILITY INSURANCE

Voluntary Short Term Disability Insurance offers temporary income replacement in the event you are ill or injured outside of the workplace. The Short Term Disability income replacement insurance is voluntary, which means you pay 100% of the premiums which can be conveniently paid through payroll deduction on an after-tax basis. Benefits are tax-free in the event of a short-term disability claim.

## FEATURES

- **ELIMINATION PERIOD** – In the event you become disabled due to illness or injury, benefits begin on the 8th calendar day of disability.
- **COVERAGE** – This coverage will provide you with 50% of your weekly earnings to a maximum benefit of \$1,000 per week.
- **ELIGIBILITY STATEMENT**
  - Hourly benefit eligible team members are eligible for Voluntary Short Term Disability.
  - Salaried non-exempt and exempt benefit eligible team members with less than 5 years of service are eligible for Voluntary Short Term Disability. **NOTE:** You are eligible for this benefit but are only able to submit a claim after using your available Short Term Income Protection.

**MAXIMUM  
BENEFIT  
DURATION:  
12 WEEKS**

## PRE-EXISTING LIMITATIONS REMOVED DURING OPEN ENROLLMENT

There will be no pre-existing limitations applied during open enrollment. During a mid-year change, enrollment in the Short Term Disability policy will apply a 3-month look-back to determine if you have been treated or taken medication for any disability that occurs during the first 12 months of the policy. No benefit will be payable for any pre-existing conditions treated during the 3 months prior to your enrollment.

## HOW TO FILE A SHORT TERM DISABILITY CLAIM

Call 866-461-1733 to file a claim with a Mutual of Omaha representative and provide them with our Group ID number: GOOOAQMV.

# LONG TERM DISABILITY INSURANCE

We understand that for most of us our income is the most important financial resource. To be without income for an extended period of time would most likely be devastating for you and your family. Gentex recognizes the importance of protecting your income against the possibility of long-term disability and we have utilized our economies of scale to bring competitive group Long Term Disability (LTD) insurance for your consideration.

## FEATURES

- **PRE-EXISTING CONDITION** – Limitation is applicable to this coverage. Namely, if you have received treatment for any condition 3 months prior to the coverage effective date, that condition will not be covered until you have been on the plan for 12 months. Note: if you have been on the Gentex LTD plan for the past year this provision is waived.
- **MENTAL HEALTH BENEFIT** – Period is limited to 24 months unless you are confined in a hospital.
- **DISABILITY BENEFIT** – Should you become permanently disabled and unable to return to work, or partially disabled, this benefit would continue until age 65, at which time Social Security benefits would be taken into consideration. If you are over age 62 and become disabled, a graded schedule is applicable to your benefits. (Please see the Long Term Disability Certificate of Coverage for the graded schedule.)
- **SURVIVORSHIP AND CONVERSION BENEFIT** – Should your disability result in death, a Survivorship Benefit of three months disability benefits would be paid to your surviving spouse. You also have the option to convert the group LTD to an individual policy in the event you leave employment with Gentex.
- **GROSS UP** – The LTD premium is deducted from your paycheck with after-tax dollars. Gentex pays this premium back each week as an adjustment in your paycheck. By following this process you will receive the benefits tax-free at point of claim.

## HOURLY EMPLOYEES

**CORE COVERAGE:** Gentex grosses-up salary to cover 100% of the premium amount.

- **ELIMINATION PERIOD** – In the event you become disabled off the job for over 90 days, the Gentex LTD benefit will provide you with 50% of your monthly earnings, as of October 1, 2019, to a monthly maximum benefit of \$2,500.

**BUY-UP COVERAGE:** You pay 100% of the additional coverage amount – no subsidy from Gentex for the additional 10% benefit.

- **ELIMINATION PERIOD** – In the event you become disabled off the job for over 90 days, the Gentex LTD benefit will provide you with 60% of your monthly earnings to a monthly maximum benefit of \$6,000.

## SALARY EMPLOYEES

Gentex grosses-up salary to cover 100% of the premium amount.

- **ELIMINATION PERIOD** – In the event you become disabled off the job for over 90 days, the Gentex LTD benefit will provide you with 60% of your monthly earnings to a monthly maximum benefit of \$8,000.

# VOLUNTARY GROUP CRITICAL ILLNESS INSURANCE

Critical Illness coverage can pay you a lump sum benefit in the instance of a serious illness such as a stroke, heart attack, or a complete loss of hearing. Team members are responsible for filing claims. Visit Allstate's website at [allstatebenefits.com/mybenefits](http://allstatebenefits.com/mybenefits) for more information.

## FEATURES

- Employee options: \$5,000, \$10,000 or \$20,000; spouse benefit of 50% of your plan
- Automatic coverage for dependent children (50% of employee coverage amount)
- Level premiums do not increase as you age (age banded; tobacco/non-tobacco user)
- Level benefit to age 70 (50% thereafter on the policy anniversary following your 70th birthday)
- 100% portable
- Pre-existing condition exclusion: if you are in current treatment, that condition will not be covered.

**COLLECT FOR ANNUAL WELLNESS TEST:** Earn \$50 by having a preventative test done such as biopsy for skin cancer, blood test for triglycerides, colonoscopy, echocardiogram, lipid panel, mammography, pap smear, or a stress test on a bike or treadmill. Refer to the Critical Illness Plan Documents for a full listing of options.

## EXAMPLE SITUATION:

COVERED CONDITION	LOW PLAN	MEDIAN PLAN	HIGH PLAN
Heart Attack	\$5,000	\$10,000	\$20,000
Major Organ Transplant	\$5,000	\$10,000	\$20,000
End Stage Renal Failure	\$5,000	\$10,000	\$20,000
Cancer	\$5,000	\$10,000	\$20,000
Coma	\$5,000	\$10,000	\$20,000
Stroke	\$5,000	\$10,000	\$20,000
Paralysis	\$5,000	\$10,000	\$20,000
Advanced Alzheimer's Disease	\$1,250	\$2,500	\$5,000
Second Evaluation	\$1,000	\$1,000	\$1,000
Wellness Test	\$50	\$50	\$50

## SAMPLE RATES:

### CRITICAL ILLNESS PLAN WITH CANCER BENEFIT (NON-SMOKER RATES) — EMPLOYEE ONLY

AGE	Weekly Premium For LOW PLAN	Weekly Premium For MEDIAN PLAN	Weekly Premium For HIGH PLAN
18 – 29	\$0.87	\$1.35	\$2.29
30 – 39	\$1.34	\$2.27	\$4.15
40 – 49	\$2.23	\$4.05	\$7.71
50 – 59	\$3.73	\$7.05	\$13.71
60 – 63	\$5.88	\$11.36	\$22.31
63+	\$7.61	\$14.81	\$29.22

Actual rates will be based on your age, dependents covered, and tobacco status.

# VOLUNTARY GROUP ACCIDENT INSURANCE

Group Accident Insurance pays you a lump sum benefit based on a schedule of benefits. It can be used however you choose for the expenses health insurance does not cover, such as deductibles and copays. The Group Accident Insurance is voluntary, which means you pay 100% of the premium. Premiums can be conveniently paid through payroll deduction on an after-tax basis.

Team members are responsible for filing claims. Visit Allstate's website at [allstatebenefits.com/mybenefits](http://allstatebenefits.com/mybenefits) for more information.

## FEATURES

- Plan covers a wide variety of non work-related injuries and accident related expenses. For the complete list of instances and amounts, see [benefits.gentex.com](http://benefits.gentex.com).
- Coverage is guaranteed issue; there is no medical exams or testing required.
- Pre-existing condition exclusion: if you are in current treatment, that condition will not be covered.

## WEEKLY CONTRIBUTION

	LOW PLAN	HIGH PLAN
Employee	\$2.83	\$4.28
Employee +1	\$4.34	\$6.59
Employee and Child(ren)	\$6.65	\$10.02
Family Coverage	\$8.33	\$12.55

### EXAMPLE SITUATION:

	LOW PLAN	HIGH PLAN
Hospital Confinement	\$1,000	\$1,500
Regular Ambulance	\$200	\$300
X-ray	\$200	\$300
Emergency Room Services	\$200	\$300
Physical Therapy	\$30	\$60
Fractures	\$280 – \$4,000	\$420 – \$6,000
Visit Outpatient Physician	\$150 – \$300	\$150 – \$300

# VOLUNTARY HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity coverage can pay you a lump sum benefit for out-of-pocket medical expenses associated with a planned or unplanned hospital stay. Team members are responsible for filing claims. Visit Allstate's website at [allstatebenefits.com/mybenefits](http://allstatebenefits.com/mybenefits) for more information.

## FEATURES

- Coverage is guaranteed issue; there are no medical exams or testing required
- Benefits include hospitalization due to pregnancy
- Portability, if you leave your job, you can take the coverage with you as long as you make payment to Allstate benefits

## WEEKLY CONTRIBUTION

Employee	\$2.16
Employee +1	\$5.05
Employee and Child(ren)	\$3.73
Family Coverage	\$6.64

## HOSPITALIZATION BENEFITS

- First day hospital confinement (per 24-hour period, once per confinement, per year) . . . . . \$1,000
- Daily hospital confinement (per 24-hour period) . . . . . \$200

# SMART HEALTH WELLNESS PROGRAM

The Gentex Wellness program is called Smart Health. Smart Health rewards team members, and covered spouses, for taking ownership of their health by offering wellness credits toward your weekly medical premium. Wellness activities and points are tracked and recorded through the vendor SimplyWell.



SimplyWell has a mobile app which you can download from the App Store or Google Play. If you prefer to access the program online, go to [connect.simplywell.com](http://connect.simplywell.com) for registering, taking the member health assessment and participating in activities.

## WHO IS ELIGIBLE?

All team members and spouses who are covered by the Gentex Health Plan are eligible for medical premium credits.

All team members are eligible to participate in the program for their personal wellness journey. If there is a chance that you may need to enroll in the Gentex Health Plan in the future due to a qualifying life event, please consider participating in the program so you are able to receive the premium credits when you become covered.

## WHAT IS REQUIRED TO EARN THE 2020 INCENTIVE?

Complete the following requirements by the deadline:

- Member Health Assessment (MHA) online
- Non-Tobacco Affidavit or the online Tobacco Cessation Program

HIRED	DEADLINE FOR 2020 CREDIT
January 2020	April 1, 2020
February 2020	May 1, 2020
March 2020	June 1, 2020
April 2020	July 1, 2020
May 2020	August 1, 2020
June 2020	September 1, 2020
July 2020	October 1, 2020
August 2020	November 1, 2020
September – December	Automatically earned as part of the grace period

## WHAT IS REQUIRED TO EARN THE 2021 CREDIT?

Complete as many tiers as possible by the deadline to receive your premium credit. The tier level you achieve will equal the amount of dollars you receive toward your 2021 premium credits.

HIRED	DEADLINE FOR 2021 CREDIT
January – May 2020	September 30, 2020
June – August 2020	November 30, 2020
September – November 2020	Complete Online MHA within 30 days of hire
December 2020	Complete Online MHA by April 1, 2021



# SMART HEALTH WELLNESS PROGRAM (CONTINUED)

## WHAT ARE THE TIER LEVELS?

<b>TIER 1</b> 200 – 599 points \$200	<b>TIER 2</b> 600 – 899 points \$600	<b>TIER 3</b> 900 + points \$900
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## HOW DO I EARN POINTS?

You can earn point by completing a variety of program activities. The three main actions are:

1. Filling out a Member Health Assessment.
2. Self-identify if you are tobacco-free or you can complete the tobacco reasonable alternative videos/articles.
3. Complete an annual physical with biometric screening.

You can also earn points by completing any of the alternative program activities. **EXAMPLES:**

- If you don't meet the health metric for blood pressure, you can complete online featured content to earn the additional points.
- If you don't participate in a biometric screening, you can earn points by completing a healthy event or employer challenges.

ACTION	POINTS
<b>Member Health Assessment</b> Member Health Assessment (MHA)	200
<b>Tobacco-Free</b> Self-Report Tobacco-Free <b>OR</b> Targeted Tobacco Cessation Program Passed	200
<b>Annual Physical</b> Biometric Screening/SimplyWell Physician Lab Form Preventative Care Exam (medical, dental, or vision)	100 25 each/150 max
<b>Health Metrics Bonus Points</b>	
Body Mass Index (BMI) / Waist Measurement <b>BMI</b> ≤ 25.0 <b>OR WAIST MEASUREMENT</b> ≤ 35 inches (females); ≤ 40 inches (males)	75
Total Cholesterol ≤ 200 mg/dL	75
Blood Pressure <b>SYSTOLIC</b> < 120 mmHg <b>AND</b> <b>DIASTOLIC</b> < 80 mmHg	75
Glucose <b>FASTING</b> ≤ 100 mg/dL <b>OR</b> <b>NON-FASTING/UNKNOWN</b> ≤ 140 mg/dL	75
<b>Alternative Program Activities</b>	
Featured Content: Videos	5 each/50 max
Featured Content: Articles	5 each/50 max
Employer Challenges (Goal met)	100 each/500 max
Peer Challenges	25 each/100 max
250,000/2,000,000 Steps	25 each/200 max
Healthy Events	25 each/200 max

# HOW TO REGISTER FOR SMART HEALTH

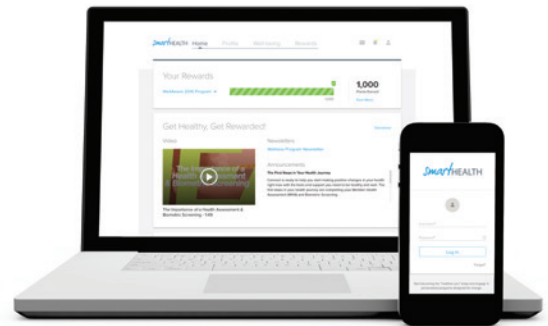


It's easy to get started on your Smart Health wellness journey. First, visit [connect.simplywell.com](https://connect.simplywell.com) or download the SimplyWell app. Now, you can create your personal account.

Smart Health helps make wellness fun. When you register for the program, you can dive in and find resources to build healthy habits for a lifetime or take part in challenges to compete against your co-workers.

## GETTING STARTED

- Visit [connect.simplywell.com](https://connect.simplywell.com) or the SimplyWell app
- Click REGISTER
- Enter your last name (as it is entered in Workday) and date of birth (DOB)
- Enter your identifier: DOB + last 4 of Social Security Number (SSN)  
**EXAMPLE:** DOB (01/01/1990) + SSN (123-45-6789) = (010119906789)
- Enter the registration code: gentex (lowercase)
- Follow the prompts to complete your registration



## SYNC YOUR DEVICE

To sync your app or device, visit [connect.simplywell.com](https://connect.simplywell.com):

- Select the PREFERENCES ICON in the top right corner
- Select APPS & DEVICES
- Select the "+" icon
- Follow the prompts to sync your app or device  
**NOTE:** Sync your Apple Health app or Apple Watch using the SimplyWell mobile app.  
If you have any trouble connecting, contact the SimplyWell Support Center at 1-888-848-3723.



## START EARNING POINTS

Now that you are in the Smart Health portal, you can start earning points. Employees covered by the Gentex Health Plan can earn premium credit toward a lower weekly medical premium based on the number of points earned. Those who waive Gentex medical insurance may still participate in the program for their personal wellness journey. For a detailed explanation on how to earn points, visit [www.benefits.gentex.com](https://www.benefits.gentex.com).

If you have any questions, please reach out to [benefits@gentex.com](mailto:benefits@gentex.com).

# NOTICE REGARDING GENTEX WELLNESS PROGRAM

Gentex Smart Health Program is a voluntary wellness program available to all employees and spouses covered under a Gentex Corporation medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a variety of voluntary wellness activities to earn points towards tier levels of premium credits. Each activity has an assigned point value, so you have the ability to combine many different activity options to earn points. Examples of activities to earn points include a voluntary Member Health Assessment or "MHA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease); a routine physical with biometric screening, which will include a blood test for Blood Glucose and LDL cholesterol; online courses and targeted programs (e.g. Tobacco Cessation and Healthy Maternity); as well as employer challenges, peer challenges, and participating in healthy events. You are not required to complete any of these programs.

However, employees who choose to participate in the wellness program will receive an incentive of reduction in medical premiums by earning points for completing any activities to reach the tier levels. Although you are not required to participate in the Smart Health program and earn points for healthy behaviors, only employees who do so are eligible to receive a reduction in medical premiums.

If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Gentex Benefits Team at [benefits@gentex.com](mailto:benefits@gentex.com).

The information from your MHA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as Case Management services for diabetes. You also are encouraged to share your results or concerns with your own doctor.

## PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Gentex Corporation may use aggregate information it collects to design a program based on identified health risks in the workplace, Smart Health Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are Priority Health Case Managers in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Gentex Legal team at [legal@gentex.com](mailto:legal@gentex.com).

# CASE MANAGEMENT PROGRAM

Case Management is a voluntary program available to employees/spouse/dependents who are enrolled in the Gentex Health Plan. Case Management includes, but is not limited to, assistance in finding the right doctor, managing treatment plans and evaluating available options for our team members and/or their Gentex medical plan covered family members who are experiencing complex medical situations. Pregnancy, chronic conditions, specialty medications or prior authorization requirement, are just a few examples in which a case manager can assist you.

A personalized program to meet your needs is available by contacting our care manager, Bethany, RN, CDE. She can be reached at 616-464-8373 or [Bethany.w@priorityhealth.com](mailto:Bethany.w@priorityhealth.com).

# DIABETES MANAGEMENT PROGRAM

The Diabetes Management program is a partnership with Priority Health and SpartanNash Pharmacies to help individuals who have pre-diabetes or diabetes. The program offers confidential support from a Registered Nurse/Certified Diabetes Educator and a Clinical Pharmacist who will collaborate with you and your health care provider so you can be your healthiest. To learn more about this program or sign up, please contact our Care Manager, Bethany, RN,CDE at 616-464-8373 or [Bethany.w@priorityhealth.com](mailto:Bethany.w@priorityhealth.com).

## BENEFITS

Those who participate in the program will receive the following benefits:

- Reduced copays
  - Medications to control your blood sugar (oral, insulin and non-insulin injectables) will be \$10 or less for team members enrolled in Medical Plan 1 or 2 at SpartanNash Pharmacies (for up to a 34 day supply)
  - Medications to control your cholesterol and blood pressure are also reduced at SpartanNash Pharmacies
- Waived deductible for Medical Plans 1 and 2 – All insulin pumps, continuous glucose monitors and associated supplies will be covered 80% even before you've met your deductible
- Free laboratory tests – Tests related to optimal care of diabetes will be covered in full
- Waived copay – Your copay for an annual diabetic eye exam will be waived at any local Grand Rapids Ophthalmology office

## ACTIVE PARTICIPATION

Members must meet with the clinical team at least quarterly and follow the prescription and guidance of the care management team.

# ON-SITE HEALTH SERVICES

Gentex works with Lakeshore Health Partners to bring easily accessible health services to our team members. The clinic is located on the second floor of Centennial East and is for non-work related health concerns for those enrolled in any Gentex medical plan. View the monthly schedule in The Loop, bulletin boards or GNN screens in the cafeteria for monthly hours. Call 616-772-7314 to make an appointment.

# OTHER RESOURCES

## VIRTUAL CARE

As a Priority Health member, you have 24/7 access to virtual care through Spectrum Health Now. Consider virtual care for non-emergent medical or counselling services and get the help you need from the comfort of your couch, bed, office, or hotel. When you need care, log in to your Priority Health account at [priorityhealth.com](https://priorityhealth.com) or by downloading the Spectrum Health Now app. For Plan 1 and 2 the copay is \$10 and only \$45 for Plan 3 HDHP (HSA Eligible).

## COST ESTIMATOR

Even when you are “covered” for a test or procedure, you may still need to pay for part of it yourself. You can save money by searching procedures performed at a lower-cost Michigan facility, without sacrificing the quality of your care. Get started with *Cost Estimator* today by logging in to your Priority Health account at [priorityhealth.com](https://priorityhealth.com) and selecting *Cost Estimator*.

# GENTEX CARES+

Gentex has partnered with Pine Rest Employee Assistance Program to provide you and your family members with a variety of services. Your wellbeing is important to us. These services are provided for free to help ease stress related to common issues.

- 5 free, confidential counseling visits in two ways: 1) at an outpatient clinic location or 2) via an online teletherapy session.  
Call 800.442.0809
- Legal consultation – 30 minutes free.  
Rhoades McKee/Thomas Saxe 616.233.5219
- Financial consultation – 30 minutes free.  
VDME/Dan Groenveld 616.949.9030 ext. 37
- Elder care consultation – unlimited.  
616.281.6363 ext. 2450
- Online library that provides you access to thousands of health and wellness, financial, tax and legal articles, videos, forms, calculators, etc. Visit <https://pinterest.personaladvantage.com> (password: Gentex)

All contacts and visits are confidential. Reports made to your employer do not contain any names or specific details.

# MEDICARE PART D CREDITABLE COVERAGE

## IMPORTANT NOTICE FROM GENTEX CORPORATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE & 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 Gentex 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. Gentex has determined that the prescription drug coverage offered by the Priority Health Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

**When Can You Join A Medicare Drug Plan?** You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

**What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?** If you decide to join a Medicare drug plan, your current Gentex coverage will not be affected. As long as you are actively working for Gentex, coverage under the Medical Plans will usually be your primary coverage. Therefore, you may not need to enroll in a Medicare prescription drug plan while you are actively working for Gentex. If you do decide to join a Medicare drug plan and drop your current Gentex coverage, be aware that you and your dependents will be able to get this coverage back but generally only at your next open enrollment period.

**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 Gentex 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 or call Human Resources at 616-772-1590 ext. 6000 or at [benefits@gentex.com](mailto:benefits@gentex.com). **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 Gentex Corporation 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 INFO ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE:

- Visit [www.medicare.gov](http://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](http://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** 09/30/19 **ADDRESS** 600 N. Centennial St, Zeeland, MI 49464 **ENTITY/SENDER** Gentex Corporation

**CONTACT** Human Resources at [benefits@gentex.com](mailto:benefits@gentex.com) **PHONE** 616-772-1590 ext. 6000

**CMS Form 10182-CC Updated April 1, 2011** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

# HIPAA NOTICE

## NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice is being provided to you pursuant to the federal law known as HIPAA and an amendment to that law known as HITECH. If you have any questions about this notice, please contact the Privacy Officer at Gentex Corporation, Scott Ryan, 600 N Centennial St, Zeeland, MI, 49464, or by phone 616-772-1800.

## WHO WILL FOLLOW THIS NOTICE

This notice describes the medical information practices of all of the group health plans (collectively, the "Plan") maintained by Gentex Corporation (the "Plan Sponsor") and that of any third party that assists in the administration of Plan claims. The Plan has been amended to incorporate the requirements of this notice.

## OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION

We understand that medical information about you and your health is personal. We are required by law to protect medical information about you. This notice applies to the medical records and information we maintain concerning the Plan. Your health care provider may have different policies or notices regarding the use and disclosure of your medical information created in the health provider's facility.

This notice, which is required by law, will tell you about the ways in which we may use and disclose medical information about you (known as "protected health information" under federal law). It also describes our obligations and your rights regarding the use and disclosure of protected health information.

## HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment.** We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, or other hospital personnel who are involved in taking care of you.

**For Payment.** We may use and disclose your protected health information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, or to determine benefit payment under the Plan. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

**For Health Care Operations.** We may use and disclose your protected health information for Plan operations purposes. These uses and disclosures are necessary to run the Plan. For example, we may use your protected health information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

**To Business Associates and Subcontractors.** We may contract with individuals and entities known as Business Associates to perform various functions or provide certain services. In order to perform these functions or provide these services, Business Associates may receive, create, maintain, use and/or disclose your protected health information, but only after they sign an agreement with us requiring them to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, but only after the Business Associate enters into a Business Associate Agreement with us. Similarly, a Business Associate may hire a Subcontractor to assist in performing functions or providing services in connection with the Plan. If a Subcontractor is hired, the Business Associate may not disclose your protected health information to the Subcontractor until after the Subcontractor enters into a Subcontractor Agreement with the Business Associate.

**As Required by Law.** We will disclose your protected health information when required to do so by federal, state or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

**Disclosure to Health Plan Sponsor.** Information may be disclosed to another health plan maintained by Plan Sponsor for purposes of facilitating claims payments under that plan. In addition, your protected health information may be disclosed to Plan Sponsor and its personnel for purposes of administering benefits under the Plan or as otherwise permitted by law and Plan Sponsor's HIPAA privacy policies and procedures.

## SPECIAL SITUATIONS

**Organ and Tissue Donation.** If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans.** If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation.** We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

**Public Health Risks.** We may disclose your protected health information for public health activities, such as to prevent or control disease, injury or disability, report births and deaths, or notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

**Health Oversight Activities.** We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Law Enforcement.** We may release protected health information if asked to do so by a law enforcement official in certain situations, such as:

- in response to a court order, subpoena, warrant, or summons;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; or
- about criminal conduct.

**Coroners and Medical Examiners.** We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

## YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding your protected health information which we maintain:

**Right to Access.** You have the right to request access to the portion of your protected health information containing your enrollment, payment and other records used to make decisions about your Plan benefits. This includes the right to inspect the information as well as the right to a copy of the information. You may request that the information be sent to a third party. You must submit a request for access in writing to the Privacy Officer. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request (such as a thumb drive in the case of a request for electronic information – see next paragraph). We may deny your request to inspect and copy in certain circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

If the Plan maintains your protected health information electronically in a designated record set, the Plan will provide you with access to the information in the electronic form and format you request if readily producible or, if not, in a readable electronic form and format as agreed to by the Plan and you.

**Right to Amend.** If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures of your protected health information. The accounting will not include disclosures to carry out treatment, payment and health care operations, disclosures to you about your own protected health information,



disclosures pursuant to an individual authorization or other disclosures as set forth in Plan Sponsor's HIPAA privacy policies and procedures. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the reasonable costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Effective at the time prescribed by federal regulations, you may also request an accounting of uses and disclosures of your protected health information maintained as an electronic health record in the event the Plan maintains such records.

**Right to Request Restrictions.** You have the right to request a restriction or limitation regarding your protected health information we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on your protected health information we disclose to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us: (1) What information you want to limit; (2) Whether you want to limit our use, disclosure or both; and (3) To whom you want the limits to apply, for example, disclosures to your spouse.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of this Notice.** If you received this notice electronically, you have the right to a paper copy of this notice. You may ask us to give you a paper copy of this notice at any time. To obtain a paper copy of this notice, contact the Privacy Officer.

## GENETIC INFORMATION

If we use or disclose protected health information for underwriting purposes with respect to the Plan, we will not (except in the case of any long term care benefits) use or disclose protected health information that is your genetic information for such purposes.

## BREACH NOTIFICATION REQUIREMENTS

In the event unsecured protected health information about you is "breached," unless we determine that there is a low probability that the protected health information has been compromised, we will notify you of the situation. We will also inform HHS and take any other steps required by law.

## CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for protected health information we already have about you as well as any information we receive in the future. We will notify you in the event of a change.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan by contacting the Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

## OTHER USES OF YOUR PROTECTED HEALTH INFORMATION

Other uses and disclosures of your protected health information not covered by this notice or applicable laws will be made only with your written permission. If you provide us permission to use or disclose your protected health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

## EFFECTIVE DATE

This notice is effective September 30, 2019.

# WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 NOTICE OF RIGHTS

In October 1998, the United States Government enacted the federal Women's Health & Cancer Rights Act. This law requires us to inform our plan members each year about major provisions of the law. In accordance with that requirement, please be advised of the following:

The Priority Health plan that Gentex Corporation offers its employees will not restrict benefits if you, or your eligible dependent, receive benefits for a mastectomy and you, or your eligible dependent, elect breast reconstruction in connection with the mastectomy.

Benefits will not be restricted provided that the breast reconstruction is performed in a manner determined in consultation with your, or your eligible dependent's, physician. The benefits may include:

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 all stages of mastectomy, including lymph edemas.

Benefits for breast reconstruction may be subject to appropriate plan coverage provisions and limitations including; annual deductibles, co-pays and coinsurance provisions that are consistent with those established for other benefits under the plan.

If you have any questions regarding the above information, please contact Human Resources at 616-772-1800 ext. 6000.

# CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 ("CHIPRA")

On February 4, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) was signed into law.

## SPECIAL ENROLLMENT RIGHTS

Effective April 1, 2009, employees and their dependents who are eligible but not enrolled for coverage under the plan, are permitted to enroll in the plan for coverage under the two following scenarios:

1. The employee's or their dependent's coverage under Medicaid or CHIPRA is terminated because of loss of eligibility.
2. The employee or their dependents become eligible for a subsidy under Medicaid or CHIPRA.

Under the first scenario, an employee must request special enrollment within sixty (60) days after the loss of coverage. Under the second scenario, the employee must request special enrollment within sixty (60) days of when eligibility is determined.

# NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Under the Affordable Care Act, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by Gentex Corporation.

## PART A: GENERAL INFORMATION

### WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly insurance premium right away. Enrollment in health insurance coverage through the Marketplace occurs during an annual open enrollment period and coverage may begin as early as the following January.

### CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

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

### DOES EMPLOYER HEALTH COVERAGE AFFECT PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health insurance coverage from Gentex Corporation that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in Gentex Corporation’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of health insurance coverage from Gentex Corporation that would cover you (and not any other members of your family) is more than 9.5% (as adjusted) of your household income for the year, or if the coverage provided by Gentex Corporation does not cover the “minimum value standard” set forth in the Affordable Care Act, then you may be eligible for a tax credit. An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

If you purchase health insurance coverage through the Marketplace instead of accepting health insurance coverage offered by Gentex Corporation, then you may lose Gentex Corporation’s contribution (if any) to the employer-offered coverage. Both Gentex Corporation’s contribution and your contribution to employer-offered health insurance coverage is often excluded from income for Federal and State income tax purposes. Your payments for health insurance coverage through the Marketplace are made on an after-tax basis.

### HOW CAN I GET MORE INFORMATION?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please call 1-800-318-2596 or 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. For more information about your coverage through Gentex Corporation, please check your summary plan description or contact Gentex Corporation Human Resources at (616) 772-1800 x6000 .

## PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY GENTEX CORPORATION

This section contains information about any health care offered by Gentex Corporation. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information.

<b>EMPLOYER NAME:</b> Gentex Corporation	<b>EMPLOYER ID NUMBER (EIN):</b> 38-2030505	<b>EMPLOYER PHONE:</b> 616-772-1800	
<b>EMPLOYER ADDRESS:</b> 600 N. Centennial Street	<b>EMPLOYER CITY:</b> Zeeland	<b>EMPLOYER STATE:</b> MI	<b>EMPLOYER ZIP:</b> 49464
<b>HEALTH COVERAGE CONTACT NAME:</b> Gentex Corporation Human Resources			
<b>HEALTH COVERAGE CONTACT PHONE NUMBER:</b> 616-772-1800 x6000		<b>HEALTH COVERAGE CONTACT EMAIL ADDRESS:</b> <a href="mailto:benefits@gentex.com">benefits@gentex.com</a>	

### BASIC INFORMATION ABOUT HEALTH COVERAGE OFFERED BY THIS EMPLOYER:

As your employer, we offer coverage to:  All employees  Some employees  
Eligible dependents are full-time employees regularly scheduled to work 30 hours per week.

**WITH RESPECT TO DEPENDENTS:**  We do offer coverage  We do not offer coverage

Eligible dependents are: Legally married spouse and dependent child(ren) by birth, marriage, legal adoption or guardianship up to the end of the month in which they turn 26 years of age.

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

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

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# APPENDIX A

## SUMMARY OF BENEFITS AND COVERAGE (SBC)

Gentex is complying with Health Care Reform (PPACA) by providing Summary of Benefits and Coverage for all health plans offered during the 2020 plan year. Included:

**PLAN 1 (POS PLAN OPTION 1)**

\$500 Deductible Health Plan SBC

**PLAN 2 (POS PLAN OPTION 2)**

\$1,000 Deductible Health Plan SBC

**PLAN 3 (POS HDHP OPTION 3)**

Gentex HSA Health Plan SBC

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**  
**Gentex Corporation: PPO Plan 1**

**Coverage Period: 01/01/2020 - 12/31/2020**  
**Coverage for: Subscriber/Dependent | Plan Type: PPO**

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. Note: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage or to get a copy of the complete terms of coverage, visit us at [PriorityHealth.com](http://PriorityHealth.com) or call 1-800-956-1954. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-956-1954 to request a copy.

Important Questions	Answers	Why this Matters
<b>What is the overall deductible?</b>	For Lakeshore Health Partners, Holland PHO, and other network providers \$500 person / \$1,000 family For non-network providers \$1,000 person / \$2,000 family. The deductible for each benefit level is calculated separately. Amounts you pay toward the deductible do not count toward any co-insurance maximums.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
<b>Are there services covered before you meet your deductible?</b>	Yes, the network benefits deductible doesn't apply to preventive care, or certain services subject to flat dollar co-pays and prescription drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Yes. For Lakeshore Health Partners, Holland PHO, and other network providers \$6,000 person / \$12,000 family For non-network providers unlimited person / unlimited family. Your plan also has a co-insurance maximum. For Lakeshore Health Partners, Holland PHO and other network providers \$1,250 person / \$2,500 family For non-network providers \$1,500 person / \$3,000 family The co-insurance maximum limits the total amount of co-insurance you will pay for certain covered services during a coverage period. The co-insurance maximum is included in the out-of-pocket limit. The out-of-pocket limit for each benefit level is calculated separately.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, health care this plan doesn't cover, services that exceed an annual day/visit limit, and prior certification penalties.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
<b>Does this plan use a network of providers?</b>	Yes. See <a href="http://PriorityHealth.com">PriorityHealth.com</a> or call 1-800-956-1954 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
<b>Do I need a referral to see a specialist?</b>	No.	You can see the in-network specialist you choose without a referral.

All <u>co-payment</u> and <u>co-insurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.					
Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Lakeshore Health Partners Provider (You will pay the least)	Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$10 co-pay/ visit	\$25 co-pay/ visit	30% co-insurance/ visit	Network benefit level deductible does not apply to services subject to flat dollar co-pays. Prescription drug co-pay may also apply when selected injectable drugs are provided. \$25 co-pay/visit for spinal manipulation services provided by a network provider.  Deductible does not apply. Covered up to a combined contract year maximum of 30 visits.
	Specialist visit	\$20 co-pay/ visit	\$35 co-pay/ visit	30% co-insurance/ visit	
	Other practitioner office visit	<ul style="list-style-type: none"> <li>•20% co-insurance/ visit for family planning/infertility services</li> <li>•20% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery</li> </ul>	<ul style="list-style-type: none"> <li>•20% co-insurance/ visit for family planning/infertility services</li> <li>•20% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery</li> </ul>	<ul style="list-style-type: none"> <li>•30% co-insurance/ visit for Family planning/infertility services</li> <li>•30% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery</li> </ul>	
<b>If you have a test</b>	Preventive care/screening/immunization	No charge	No charge	30% co-insurance/ visit	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services. Network benefit level deductible does not apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.  Appropriate office visit co-pay (PCP or specialist) may apply for physician office services. No charge for diagnostic test if performed at Holland Hospital – Zeeland location, preferred benefit level deductible does not apply.
	Diagnostic test (x-ray, blood work)	20% co-insurance	20% co-insurance	30% co-insurance	
	Imaging (CT/PET scans, MRIs)	20% co-insurance	20% co-insurance	30% co-insurance	

\* For more information about limitations and exceptions, see the plan or policy document at [PriorityHealth.com](http://PriorityHealth.com).



Common Medical Events	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Lakeshore Health Partners Provider (You will pay the least)	Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="https://www.priorityhealth.com/prog_pharmacy/pharmacy.cgi">https://www.priorityhealth.com/prog_pharmacy/pharmacy.cgi</a>	Generic drugs	Not covered	\$20 co-pay/ retail prescription \$20 co-pay/ mail order prescription	Not covered	Prescription medications obtained from a SpartanNash are subject to the following co-pays: Generic drugs: \$10 co-pay/ retail prescription; Preferred brand drugs: \$25 co-pay/ retail prescription; Non-preferred brand drugs: \$50 co-pay/ retail prescription Lifestyle medications: SpartanNash: 20% co-insurance/ retail prescription (\$75 max); SpartanNash 90 day: 20% co-insurance/ mail order prescription (\$150 max) Network Pharmacy: 20% co-insurance/ retail prescription (\$100 max); Costs shown in the "Your Cost" columns apply to drugs on the approved drug list. Covers up to a 34-day supply (retail prescription); Covers up to a 90-day supply (mail order prescription) Up to a 90-day supply of medication (excluding Specialty Drugs) may be obtained at one time for two applicable Copayments at a SpartanNash Retail Pharmacy. Medications provided in Priority Health Preventive Health Care Guidelines, including certain women's prescribed contraceptive medications are covered at no charge. Deductible does not apply.
	Preferred brand drugs	Not covered	\$50 co-pay/ retail prescription \$50 co-pay/ mail order prescription	Not covered	
<b>If you have outpatient surgery</b>	Non-preferred brand drugs	Not covered	\$75 co-pay/ retail prescription \$100 co-pay/ mail order prescription	Not covered	The maximum co-pay for preferred specialty drugs is \$75 per fill. The maximum co-pay for non-preferred specialty drugs is \$75 per fill. Deductible does not apply.
	Preferred specialty drugs	Not covered	20% co-insurance/ retail prescription	Not covered	
<b>If you need immediate medical attention</b>	Facility fee (e.g., ambulatory surgery center)	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Including outpatient care, observation care and ambulatory surgery center care. Prior certification may be required. Prior certification is required for bariatric surgery. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.
	Physician/surgeon fees	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	
<b>If you need immediate medical attention</b>	Emergency room services	20% co-insurance/ visit	20% co-insurance/ visit	Covered at the network benefit level	-----none----- -----none-----
	Emergency medical transportation	20% co-insurance	20% co-insurance	Covered at the network benefit level	
	Urgent care	\$20 co-pay/ visit only at Holland Hospital Zeeland location	\$35 co-pay/ visit	30% co-insurance/ visit	

\* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.



Common Medical Events	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Lakeshore Health Partners Provider (You will pay the least)	Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Prior certification is required at least 5 working days in advance, except in emergencies or for Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Penalty applies if not prior certified. Notification must be provided for all admissions following emergency room care. Prior certification is required for bariatric surgery. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.
	Physician/surgeon fee	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$10 co-pay/ visit	\$25 co-pay/ visit	30% co-insurance/ visit	Including medication management visits. Network benefit level deductible does not apply.
	Mental/Behavioral health inpatient services	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Including subacute residential treatment and partial hospitalization. Except in an emergency, Prior certification required. Penalty applies if not prior certified.
	Substance use disorder outpatient services	\$10 co-pay/ visit	\$25 co-pay/ visit	30% co-insurance/ visit	Prior certification required for intensive outpatient treatment. Including medication management visits. Network benefit level deductible does not apply.
	Substance use disorder inpatient services	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Including subacute Residential Treatment and partial hospitalization. Except in an emergency, Prior certification required. Penalty applies if not prior certified.
<b>If you are pregnant</b>	Routine prenatal and postnatal care	No charge	No charge	30% co-insurance/ visit	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. \$10 co-pay/ visit for approved maternity education program provided by a Lakeshore Health Provider. \$25 co-pay/ visit for approved maternity education program provided by other network providers. Network benefit level deductible does not apply. 30% co-insurance for approved maternity education program provided by a non-network provider.
	Delivery and all inpatient services	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Appropriate office visit charge (PCP or specialist) may apply for physician office services or home visits and consultations for complications of pregnancy.

\* For more information about limitations and exceptions, see the plan or policy document at [PriorityHealth.com](http://PriorityHealth.com).

Common Medical Events	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Lakeshore Health Partners Provider (You will pay the least)	Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	Home health care	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Excluding rehabilitation and habilitation services. Prior certification required. Penalty applies if not prior certified. Home health care services are limited to a combined 100 days per contract year and further limited to 1 visit/ day.
	Rehabilitation services not for the treatment of Autism Spectrum Disorder	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Includes physical and occupational therapy, speech therapy and cardiac rehabilitation & pulmonary rehabilitation. Speech therapy for developmental delay is not covered.
	Habilitation services for treatment of Autism Spectrum Disorder <b>only</b>	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Prior certification required for Applied Behavior Analysis (ABA). Covered services include Physical, Occupational, Speech Therapy and Applied Behavior Analysis (ABA). Services are covered for children and adolescents through the age 18 only. Multiple charges may apply during one day of service.
	Habilitation services not for the treatment of Autism Spectrum Disorder	Not covered	Not covered	Not covered	Not covered
	Skilled nursing care	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Services received in a skilled nursing care facility, or subacute facility, inpatient rehabilitation care facility are limited to a combined 90 days per contract year. Prior certification required. Penalty applies if not prior certified.
	Durable medical equipment (DME)	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Including rental, purchase or repair. Prior certification required for equipment over \$1,000, all rentals and all shoe inserts. Penalty applies if not prior certified.
	Prosthetics & orthotics	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Prior certification required. Penalty applies if not prior certified.
	Hospice service	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Prior certification required. Penalty applies if not prior certified.
	Child eye exam	Not covered	Not covered	Not covered	Not covered
	Child glasses	Not covered	Not covered	Not covered	Not covered
Child dental check-up	Not covered	Not covered	Not covered	Not covered	

\* For more information about limitations and exceptions, see the plan or policy document at [PriorityHealth.com](http://PriorityHealth.com).

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan documents for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Habilitation services not for the treatment of Autism Spectrum Disorder
- Hearing aids
- Long-term care
- Routine eye care (Adult & Child)
- Routine foot care

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan documents.)

- Bariatric surgery
- Chiropractic care
- Emergency services provided outside the U.S.
- Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility
- Private duty nursing
- Weight loss programs

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov); the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or [www.ccio.cms.gov](http://www.ccio.cms.gov); or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Priority Health at 1-800-446-5674 or [www.priorityhealth.com](http://www.priorityhealth.com); the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or the Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto:HICAP@michigan.gov).

### Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-446-5674.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-446-5674.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-446-5674.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-446-5674.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section-----

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, co-payments, and co-insurance) and excluded services under this plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$500
- Specialist co-insurance \$35
- Hospital (facility) co-insurance 20%
- Other co-insurance 20%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

**Total Example Cost** \$12,800

#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Co-payments	\$90
Co-insurance	\$1,250
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,900</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$500
- Specialist co-insurance \$35
- Hospital (facility) co-insurance 20%
- Other co-insurance 20%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

**Total Example Cost** \$7,400

#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Co-payments	\$905
Co-insurance	\$372
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,832</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$500
- Specialist co-insurance \$35
- Hospital (facility) co-insurance 20%
- Other co-insurance 20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*X-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

**Total Example Cost** \$1,900

#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Co-payments	\$105
Co-insurance	\$326
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$931</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**  
**Gentex Corporation: PPO Plan 2**

**Coverage Period: 01/01/2020 - 12/31/2020**  
**Coverage for: Subscriber/Dependent | Plan Type: PPO**

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. Note: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage or to get a copy of the complete terms of coverage, visit us at [PriorityHealth.com](http://PriorityHealth.com) or call 1-800-956-1954. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-956-1954 to request a copy.

Important Questions	Answers	Why this Matters
<b>What is the overall deductible?</b>	For Lakeshore Health Partners, Holland PHO, and other network providers \$1,000 person / \$2,000 family For non-network providers \$2,000 person / \$4,000 family The deductible for each benefit level is calculated separately. Amounts you pay toward the deductible do not count toward any co-insurance maximums.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
<b>Are there services covered before you meet your deductible?</b>	Yes, the network benefits deductible doesn't apply to preventive care, or certain services subject to flat dollar co-pays and prescription drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Yes. For Lakeshore Health Partners, Holland PHO, and other network providers \$6,000 person / \$12,000 family For non-network providers \$unlimited person / \$unlimited family Your plan also has a co-insurance maximum. For Lakeshore Health Partners, Holland PHO and other network providers \$1,500 person / \$3,000 family For non-network providers \$2,000 person / \$4,000 family The co-insurance maximum limits the total amount of co-insurance you will pay for certain covered services during a coverage period. The co-insurance maximum is included in the out-of-pocket limit. The out-of-pocket limit for each benefit level is calculated separately.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, health care this plan doesn't cover, services that exceed an annual day/visit limit, and prior certification penalties.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
<b>Does this plan use a network of providers?</b>	Yes. See <a href="http://PriorityHealth.com">PriorityHealth.com</a> or call 1-800-956-1954 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
<b>Do I need a referral to see a specialist?</b>	No	You can see the in-network specialist you choose without a referral.

All  co-payment and co-insurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Lakeshore Health Partners Provider (You will pay the least)	Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$10 co-pay/ visit	\$25 co-pay/ visit	30% co-insurance/ visit	Network benefit level deductible does not apply to certain services subject to flat dollar co-pays. Prescription drug co-pay may also apply when selected injectable drugs are provided. \$25 co-pay/visit for spinal manipulation when provided by network providers, deductible does not apply. Covered up to a combined contract year maximum of 30 visits.
	Specialist visit	\$20 co-pay/ visit	\$35 co-pay/ visit	30% co-insurance/ visit	
	Other practitioner office visit	<ul style="list-style-type: none"> <li>•20% co-insurance/ visit for family planning/infertility services</li> <li>•20% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery</li> </ul>	<ul style="list-style-type: none"> <li>•20% co-insurance/ visit for family planning/infertility services</li> <li>•20% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery</li> </ul>	<ul style="list-style-type: none"> <li>•30% co-insurance/ visit for Family planning/infertility services</li> <li>•30% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery</li> </ul>	
<b>If you have a test</b>	Preventive care/screening/immunization	No charge	No charge	30% co-insurance/ visit	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services. Preferred benefit level deductible does not apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Diagnostic test (x-ray, blood work)	20% co-insurance	20% co-insurance	30% co-insurance	
	Imaging (CT/PET scans, MRIs)	20% co-insurance	20% co-insurance	30% co-insurance	

\* For more information about limitations and exceptions, see the plan or policy document at [PriorityHealth.com](http://PriorityHealth.com).

Common Medical Events	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Lakeshore Health Partners Provider (You will pay the least)	Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="https://www.priorityhealth.com/prioritypharmacy/pharmacy.cgi">https://www.priorityhealth.com/prioritypharmacy/pharmacy.cgi</a></p>	Generic drugs	Not covered	\$20 co-pay/ retail prescription \$20 co-pay/ mail order prescription	Not covered	<p>Prescription medications obtained from a SpartanNash are subject to the following co-pays: Generic drugs: \$10 co-pay/ retail prescription; Preferred brand drugs: \$25 co-pay/ retail prescription; Non-preferred brand drugs: \$50 co-pay/ retail prescription</p> <p>Lifestyle medications: SpartanNash: 20% co-insurance/ retail prescription (\$75 max); SpartanNash 90 day: 20% co-insurance/ mail order prescription (\$150 max) Network Pharmacy: 20% co-insurance/ retail prescription (\$100 max);</p> <p>Costs shown in the "Your Cost" columns apply to drugs on the approved drug list. Covers up to a 34-day supply (retail prescription); Covers up to a 90-day supply (mail order prescription)</p> <p>Up to a 90-day supply of medication (excluding Specialty Drugs) may be obtained at one time for two applicable Copayments at a SpartanNash Retail Pharmacy. Medications provided in Priority Health Preventive Health Care Guidelines, including certain women's prescribed contraceptive medications are covered at no charge. Deductible does not apply</p>
	Preferred brand drugs	Not covered	\$50 co-pay/ retail prescription \$50 co-pay/ mail order prescription	Not covered	
	Non-preferred brand drugs	Not covered	\$75 co-pay/ retail prescription \$100 co-pay/ mail order prescription	Not covered	
<p><b>If you have outpatient surgery</b></p>	Preferred specialty drugs	Not covered	20% co-insurance/ retail prescription	Not covered	<p>The maximum co-pay for preferred specialty drugs is \$75 per fill. The maximum co-pay for non-preferred specialty drugs is \$75 per fill. Deductible does not apply.</p> <p>Including outpatient care, observation care and ambulatory surgery center care. Prior certification may be required. Prior certification is required for bariatric surgery.</p> <p>Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.</p>
	Facility fee (e.g., ambulatory surgery center)	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	
	Physician/surgeon fees	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	
<p><b>If you need immediate medical attention</b></p>	Emergency room services	20% co-insurance/ visit	20% co-insurance/ visit	Covered at the network benefit level	-----none-----
	Emergency medical transportation	20% co-insurance	20% co-insurance	Covered at the network benefit level	-----none-----
	Urgent care	\$20 co-pay/ visit only at Holland Hospital Zeeland location	\$35 co-pay/ visit	30% co-insurance/ visit	Co-pay applies to all urgent care visits. Network benefit level deductible does not apply.

\* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.



Common Medical Events	Services You May Need	What You Will Pay			Non-network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
		Lakeshore Health Partners Provider (You will pay the least)	Priority Health Network Provider (You will pay the least)			
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	<p>Prior certification is required at least 5 working days in advance, except in emergencies or for Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section.            Penalty applies if not prior certified.            Notification must be provided for all admissions following emergency room care. Prior certification is required for bariatric surgery.            Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.            Including medication management visits.            Network benefit level deductible does not apply.</p>	
	Physician/surgeon fee	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit		
	Mental/Behavioral health outpatient services	\$10 co-pay/ visit	\$25 co-pay/ visit	30% co-insurance/ visit		
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health inpatient services	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	<p>Including subacute residential treatment and partial hospitalization.            Except in an emergency, Prior certification required. Penalty applies if not prior certified.            Prior certification required for intensive outpatient treatment. Including medication management visits. Network benefit level deductible does not apply.            Including subacute Residential Treatment and partial hospitalization. Except in an emergency, Prior certification required.            Penalty applies if not prior certified.</p>	
	Substance use disorder outpatient services	\$10 co-pay/ visit	\$25 co-pay/ visit	30% co-insurance/ visit		
	Substance use disorder inpatient services	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit		
<b>If you are pregnant</b>	Routine prenatal and postnatal care	No charge	No charge	30% co-insurance/ visit	<p>Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. \$10 co-pay/ visit for approved maternity education program provided by a Lakeshore Health Provider. \$25 co-pay/ visit for approved maternity education classes provided by network provider.            Network benefit level deductible does not apply.            30% co-insurance for approved maternity education program provided by a non-network provider.            Appropriate office visit charge (PCP or specialist) may apply for physician office services or home visits and consultations for complications of pregnancy.</p>	
	Delivery and all inpatient services	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit		

\* For more information about limitations and exceptions, see the plan or policy document at [PriorityHealth.com](http://PriorityHealth.com).

Common Medical Events	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Lakeshore Health Partners Provider (You will pay the least)	Priority Health Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	Home health care	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Excluding rehabilitation and habilitation services. Prior certification required. Penalty applies if not prior certified. Home health care services are limited to a combined 100 days per contract year and further limited to 1 visit/ day.
	Rehabilitation services <i>not</i> for the treatment of Autism Spectrum Disorder	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Includes physical and occupational therapy, speech therapy and cardiac rehabilitation & pulmonary rehabilitation. Speech therapy for developmental delay is not covered.
	Habilitation services for treatment of Autism Spectrum Disorder <i>only</i>	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Prior certification required for Applied Behavior Analysis (ABA). Covered services include Physical, Occupational, Speech Therapy and Applied Behavior Analysis (ABA). Services are Covered for children and adolescents through the age of 18 only. Multiple charges may apply during one day of service.
	Habilitation services not for the treatment of Autism Spectrum Disorder	Not covered	Not covered	Not covered	Not covered
	Skilled nursing care	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Services received in a skilled nursing care facility, or subacute facility, inpatient rehabilitation care facility are limited to a combined 90 days per contract year. Prior certification required. Penalty applies if not prior certified.
	Durable medical equipment (DME)	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Including rental, purchase or repair. Prior certification required for equipment over \$1,000, all rentals and all shoe inserts. Penalty applies if not prior certified.
	Prosthetics & orthotics	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Prior certification required. Penalty applies if not prior certified.
	Hospice service	20% co-insurance/ visit	20% co-insurance/ visit	30% co-insurance/ visit	Prior certification required. Penalty applies if not prior certified.
	Child eye exam	Not covered	Not covered	Not covered	Not covered
	Child glasses	Not covered	Not covered	Not covered	Not covered
Child dental check-up	Not covered	Not covered	Not covered	Not covered	

\* For more information about limitations and exceptions, see the plan or policy document at [PriorityHealth.com](http://PriorityHealth.com).

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan documents for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Habilitation services not for the treatment of Autism Spectrum Disorder
- Hearing aids
- Long-term care
- Routine eye care (Adult & Child)
- Routine foot care

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan documents.)

- Bariatric surgery
- Chiropractic care
- Emergency services provided outside the U.S.
- Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility
- Private duty nursing
- Weight loss programs

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov); the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or [www.ccio.cms.gov](http://www.ccio.cms.gov); or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Priority Health at 1-800-446-5674 or [www.priorityhealth.com](http://www.priorityhealth.com); the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or the Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto:HICAP@michigan.gov).

### Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-446-5674.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-446-5674.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-446-5674.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-446-5674.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section-----

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, co-payments, and co-insurance) and excluded services under this plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** \$1,000
- **Specialist co-insurance** \$35
- **Hospital (facility) co-insurance** 20%
- **Other co-insurance** 20%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

**Total Example Cost** \$12,800

#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Co-payments	\$90
Co-insurance	\$1,500
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,650</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$1,000
- **Specialist co-insurance** \$35
- **Hospital (facility) co-insurance** 20%
- **Other co-insurance** 20%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

**Total Example Cost** \$7,400

#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,000
Co-payments	\$905
Co-insurance	\$372
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,332</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$1,000
- **Specialist co-insurance** \$35
- **Hospital (facility) co-insurance** 20%
- **Other co-insurance** 20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*X-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

**Total Example Cost** \$1,900

#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Co-payments	\$105
Co-insurance	\$326
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,431</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.

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**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**  
**Gentex Corporation: Plan 3 HDHP (HSA Eligible)**

**Coverage Period: 01/01/2020 - 12/31/2020**  
**Coverage for: Subscriber/Dependent | Plan Type: PPO**

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. Note: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage or to get a copy of the complete terms of coverage, visit us at [PriorityHealth.com](http://PriorityHealth.com) or call 1-800-956-1954. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-956-1954 to request a copy.

Important Questions	Answers	Why this Matters
<b>What is the overall deductible?</b>	For network providers \$1,500 person / \$3,000 family For non-network providers \$3,000 person / \$6,000 family The deductible for each benefit level is calculated separately.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
<b>Are there services covered before you meet your deductible?</b>	Yes, the network benefits deductible doesn't apply to preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Yes. For network providers \$2,500 person / \$5,000 family For non-network providers \$4,000 person / \$8,000 family The out-of-pocket limit for each benefit level is calculated separately.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, health care this plan doesn't cover, services that exceed an annual day/visit limit, and prior certification penalties.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
<b>Does this plan use a network of providers?</b>	Yes. See <a href="http://PriorityHealth.com">PriorityHealth.com</a> or call 1-800-956-1954 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
<b>Do I need a referral to see a specialist?</b>	No	You can see the in-network specialist you choose without a referral.

 All <u>co-payment</u> and <u>co-insurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.				
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	20% co-insurance/ visit	40% co-insurance/ visit	Prescription drug co-pay may also apply when selected injectable drugs are provided. 20% co-insurance/ visit for chiropractic services provided by a network provider. Covered up to a combined contract year maximum of 30 visits. 40% co-insurance/ visit for chiropractic services provided by a non-network provider. Covered up to a combined contract year maximum of 30 visits.
	Specialist visit	20% co-insurance/ visit	40% co-insurance/ visit	
	Other practitioner office visit	<ul style="list-style-type: none"> <li>•20% co-insurance/ visit for family planning/ infertility services</li> <li>•20% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery</li> </ul>	<ul style="list-style-type: none"> <li>•40% co-insurance/ visit for family planning/ infertility services not covered</li> <li>•40% co-insurance for Temporomandibular Joint Function (TMJ) treatment and Orthognathic surgery</li> </ul>	
<b>If you have a test</b>	Preventive care/screening/immunization	No charge	30% co-insurance/ visit	Preventive care services are those listed in Priority Health's Preventive Health Care Guidelines, including women's preventive health care services. Network benefit level deductible does not apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	-----none-----

\* For more information about limitations and exceptions, see the plan or policy document at [PriorityHealth.com](http://PriorityHealth.com).

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <b>prescription drug coverage</b> is available at <a href="https://www.priorityhealth.com/priorityhealth.com/pharmacy/pharmacy.cgi">https://www.priorityhealth.com/priorityhealth.com/pharmacy/pharmacy.cgi</a></p> <p>If you have outpatient surgery</p> <p>If you need immediate medical attention</p>	Generic drugs	\$20 co-pay/ retail prescription \$20 co-pay/ mail order prescription	Not covered	<p>Prescription medications obtained from a SpartanNash are subject to the following co-pays: Generic drugs: \$10 co-pay/ retail prescription; Preferred brand drugs: \$25 co-pay/ retail prescription; Non-preferred brand drugs: \$50 co-pay/ retail prescription</p> <p>Lifestyle medications: SpartanNash: 20% co-insurance/ retail prescription (\$75 max); SpartanNash 90 day : 20% co-insurance/ mail order prescription (\$150 max)</p> <p>Network Pharmacy: 20% co-insurance/ retail prescription (\$100 max);</p> <p>Costs shown in the "Your Cost" columns apply to drugs on the approved drug list. Covers up to a 34-day supply (retail prescription); Covers up to a 90 day supply (mail order prescription)</p> <p>Up to a 90-day supply of medication (excluding Specialty Drugs) may be obtained at one time for two applicable Copayments at a SpartanNash Retail Pharmacy. Medications provided in Priority Health Preventive Health Care Guidelines, including certain women's prescribed contraceptive medications are covered at no charge. Deductible applies.</p> <p>The maximum co-pay for preferred specialty drugs is \$75 per fill. The maximum co-pay for non-preferred specialty drugs is \$75 per fill.</p> <p>Including outpatient care, observation care and ambulatory surgery center care. Prior certification may be required. Prior certification is required for bariatric surgery. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.</p> <p>-----none-----</p> <p>-----none-----</p> <p>-----none-----</p>
	Preferred brand drugs	\$50 co-pay/ retail prescription \$50 co-pay/ mail prescription	Not covered	
	Non-preferred brand drugs	\$75 co-pay/ retail prescription \$100 co-pay/ mail prescription	Not covered	
	Preferred specialty drugs	20% co-insurance/ retail prescription	Not covered	
	Non-Preferred specialty drugs	20% co-insurance/ retail prescription	Not covered	
	Facility fee (e.g., ambulatory surgery center)	20% co-insurance/ visit	40% co-insurance/ visit	
	Physician/surgeon fees	20% co-insurance/ visit	40% co-insurance/ visit	
	Emergency room services	20% co-insurance/ visit	Covered at the preferred benefit level	
	Emergency medical transportation	20% co-insurance	Covered at the preferred benefit level	
	Urgent care	20% co-insurance/ visit	40% co-insurance/ visit	

\* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.



Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% co-insurance/ visit	40% co-insurance/ visit	Prior certification is required at least 5 working days in advance, except in emergencies or for Hospital stays for a mother and her Newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Penalty applies if not prior certified. Notification must be provided for all admissions following emergency room care. Prior certification is required for bariatric surgery. Coverage is limited to one bariatric surgery per lifetime. Unless medically necessary, a second bariatric surgery is not Covered, even if the first procedure occurred prior to joining this plan.
	Physician/surgeon fee	20% co-insurance/ visit	40% co-insurance/ visit	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	20% co-insurance/ visit	40% co-insurance/ visit	Including medication management visits.
	Mental/Behavioral health inpatient services	20% co-insurance/ visit	40% co-insurance/ visit	Including subacute residential treatment and partial hospitalization. Except in an emergency, prior certification required. Penalty applies if not prior certified.
	Substance use disorder outpatient services	20% co-insurance/ visit	40% co-insurance/ visit	Prior certification required for intensive outpatient treatment. Including medication management visits.
	Substance use disorder inpatient services	20% co-insurance/ visit	40% co-insurance/ visit	Including subacute residential treatment and partial hospitalization. Except in an emergency, prior certification required. Penalty applies if not prior certified.
<b>If you are pregnant</b>	Routine prenatal and postnatal care	No charge	40% co-insurance/ visit	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. 20% co-insurance for approved maternity education program provided by a network provider. 40% co-insurance for approved maternity education program provided by a non-network provider.
	Delivery and all inpatient services	20% co-insurance/ visit	40% co-insurance/ visit	-----none-----

\* For more information about limitations and exceptions, see the plan or policy document at PriorityHealth.com.

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Non-network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	Home health care	20% co-insurance/ visit	40% co-insurance/ visit	Excluding rehabilitation and habilitation services. Prior certification required. Penalty applies if not prior certified. Home health care services are limited to a combined 100 days per contract year and further limited to 1 visit/ day.
	Rehabilitation services <i>not</i> for the treatment of Autism Spectrum Disorder	20% co-insurance/ visit	40% co-insurance/ visit	Includes physical and occupational therapy, speech therapy and Cardiac rehabilitation & pulmonary rehabilitation. Speech therapy for developmental delay is not covered.
	Habilitation services for treatment of Autism Spectrum Disorder <b>only</b>	20% co-insurance/ visit	40% co-insurance/ visit	Prior certification required for Applied Behavior Analysis (ABA). Covered services include Physical, Occupational, Speech Therapy and Applied Behavior Analysis (ABA). Services are Covered for children and adolescents through the age of 18 only. Multiple charges may apply during one day of service.
	Habilitation services not for the treatment of Autism Spectrum Disorder	Not covered	Not covered	Not covered
	Skilled nursing care	20% co-insurance/ visit	40% co-insurance/ visit	Services received in a skilled nursing care facility, subacute facility, or inpatient rehabilitation care facility are limited to a combined 90 days per contract year. Prior certification required. Penalty applies if not prior certified.
	Durable medical equipment (DME)	20% co-insurance/ visit	40% co-insurance/ visit	Including rental, purchase or repair. Prior certification required for equipment over \$1,000, all rentals and all shoe inserts. Penalty applies if not prior certified.
	Prosthetics & orthotics	20% co-insurance/ visit	40% co-insurance/ visit	
	Hospice service	20% co-insurance/ visit	40% co-insurance/ visit	Prior certification required. Penalty applies if not prior certified.
	Child eye exam	Not covered	Not covered	Not covered
	Child glasses	Not covered	Not covered	Not covered
Child dental check-up	Not covered	Not covered	Not covered	

\* For more information about limitations and exceptions, see the plan or policy document at [PriorityHealth.com](http://PriorityHealth.com).

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan documents for more information and a list of any other excluded services.)**

<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult &amp; Child)</li> </ul>	<ul style="list-style-type: none"> <li>• Habilitation services not for the treatment of Autism Spectrum Disorder</li> <li>• Hearing aids</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult &amp; Child)</li> <li>• Routine foot care</li> </ul>
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan documents.)**

<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic care</li> <li>• Emergency services provided outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment - diagnostic, counseling and planning services for the underlying cause of infertility</li> </ul>	<ul style="list-style-type: none"> <li>• Private duty nursing</li> <li>• Weight loss programs</li> </ul>
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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov); the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or [www.ccio.cms.gov](http://www.ccio.cms.gov); or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Priority Health at 1-800-956-1954 or [www.priorityhealth.com](http://www.priorityhealth.com); the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or the Department of Insurance and Financial Services (DIFS) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto:difs-HICAP@michigan.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) at 1-877-999-6442 or [difs-HICAP@michigan.gov](mailto:HICAP@michigan.gov).

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-956-1954.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-956-1954.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-956-1954.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-956-1954.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section-----

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, co-payments, and co-insurance) and excluded services under this plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** \$1,500
- **Specialist co-insurance** 20%
- **Hospital (facility) co-insurance** 20%
- **Other co-insurance** 20%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

**Total Example Cost** \$12,800

#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Co-payments	\$0
Co-insurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,560</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$1,500
- **Specialist co-insurance** 20%
- **Hospital (facility) co-insurance** 20%
- **Other co-insurance** 20%

#### This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

**Total Example Cost** \$7,400

#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,500
Co-payments	\$473
Co-insurance	\$527
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,555</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$1,500
- **Specialist co-insurance** 20%
- **Hospital (facility) co-insurance** 20%
- **Other co-insurance** 20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*X-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

**Total Example Cost** \$1,900

#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Co-payments	\$0
Co-insurance	\$385
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,885</b>

The plan would be responsible for the other costs of these EXAMPLE covered services.

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## Gentex Corporation Retirement Savings Plan

### Plan features

The following provides answers to some of the most common questions about the plan. For more information, please ask your benefits representative for a copy of the Summary Plan Description.

#### **When can I enroll?**

You are eligible to participate in the plan after 60 days of service and you must be 18 years or older.

#### **How much can I contribute to the plan?**

You may contribute 1% to 100% of your salary with pretax contributions, Roth 401(k) contributions, or a combination of both. Together, both contribution types are subject to the annual IRS contribution limit of \$19,500 in 2020.

If you are age 50 or older by the end of the calendar year, you may qualify to make additional catch-up contributions of up to \$6,500 in 2020. In addition, as a way to help you save for retirement, your plan offers you the option to sign up for automatic contribution increases. Automatic contribution increases are a way to gradually save more. Sign up for automatic contribution increases any time online.

#### **Does Gentex Corporation make any contributions?**

For every dollar you put in the plan, pretax or Roth 401(k), your employer will contribute 1%, up to 3% of your certified compensation and \$0.50 for every \$1 you contribute up to the next 2% of your certified compensation. Make sure you are contributing at least 5% to receive the full corporate match amount of 4%. Your employer match also applies to catch-up contributions.

#### **Can I roll over money into my plan?**

You have multiple options available to you when it comes to the money in your plan. Provided the funds come from a qualified plan, they can be rolled over; or they can be deposited into an Individual Retirement Account (IRA), left in the prior employer's plan (if allowed), or cashed out. Each of these options has advantages and disadvantages and the one that is best depends on your individual circumstances. You should consider features such as investment options, fees and expenses, and services offered. Before taking any action, consider speaking with your current retirement plan administrator and tax professional.

#### **Is my account automatically rebalanced?**

Your plan provides you with an option to help you maintain your account's targeted asset allocation. Rebalancing your account on a regular basis may help to keep your investments in line with your chosen risk level and asset allocation.



If you choose to invest in target date funds, automatic rebalancing is taken care of for you since it is a built-in feature of the fund. If you select investments from the individual fund options in your plan, you have the option to add automatic rebalancing to your account. After you enroll in the plan, you can add automatic rebalancing by signing on to your account at **wellsfargo.com** or by calling 1-800-SAVE-123 (1-800-728-3123).

### **When do I become vested in my account?**

Vesting refers to your "ownership" of a benefit from your plan. You are always 100% vested in the money you contribute to the plan, the matching contribution from your employer and the earnings on that money.

### **Are loans permitted?**

You may borrow up to \$50,000 or 50% of your vested balance, whichever is less. The minimum loan amount is \$1,000. You may have one outstanding loan at a time.

### **Three ways to connect with your retirement**

#### **Smartphone: wellsfargo.com**

Manage your account using your smartphone. Visit **wellsfargo.com** on your phone's internet browser or download the Wells Fargo mobile app; sign on with the same username and password you use to access your account on a computer. Then select your retirement plan balance. For more detailed investment information, access your account on a computer.

#### **Computer: wellsfargo.com**

To get started, select **Enroll** at the top of the page to register for online access. If you have other Wells Fargo accounts that you access online, sign on using the same username and password you use for those accounts. After registering, select your retirement plan name from the Account Summary page and view your online retirement plan Dashboard.

#### **Call us: 1-800-SAVE-123 (1-800-728-3123)**

To access your account by phone, you'll need your Social Security number (SSN) and your personal identification number (PIN), which is initially the last four digits of your SSN. Representatives are available to answer questions Monday through Friday from 7:00 a.m. to 11:00 p.m. Eastern Time.

#### **Stay informed**

##### **Sign up to receive retirement plan information by email.**

While online, receive account statements, plan information, and retirement planning resources by signing up for e-delivery.

#### **Investments in Retirement Plans:**

**NOT FDIC INSURED • NO BANK GUARANTEE • MAY LOSE VALUE**

This communication piece is intended to summarize some of the benefits and requirements of the plan. It is not intended to provide a full description of all of the plans, programs, policies, terms of eligibility, or restrictions. All statements made in this brochure are subject to the terms of the official plan, program, and policy documents. In the event of a conflict between the official documents and this brochure, the official plan documents are controlling. The Plan Sponsor reserves the right to amend, modify, or terminate each of its employer-sponsored plans, programs, and policies at any time, in whole or part, without notice for any reason. The information shown is not intended to provide any suggestion that you engage in or refrain from taking a particular course of action.

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