Burnham&Flower
INSURANCE GROUP

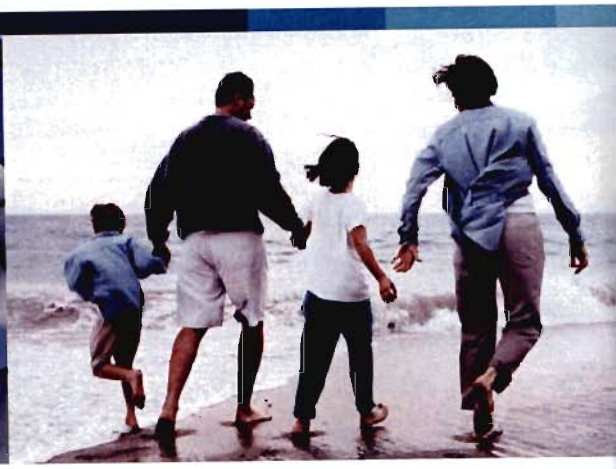
ACRISURE | AGENCY PARTNER

Benefits & Enrollment Guide

Charter Township of
Comstock

Effective Date: November 1, 2021

Employee Benefits & Enrollment
GUIDE



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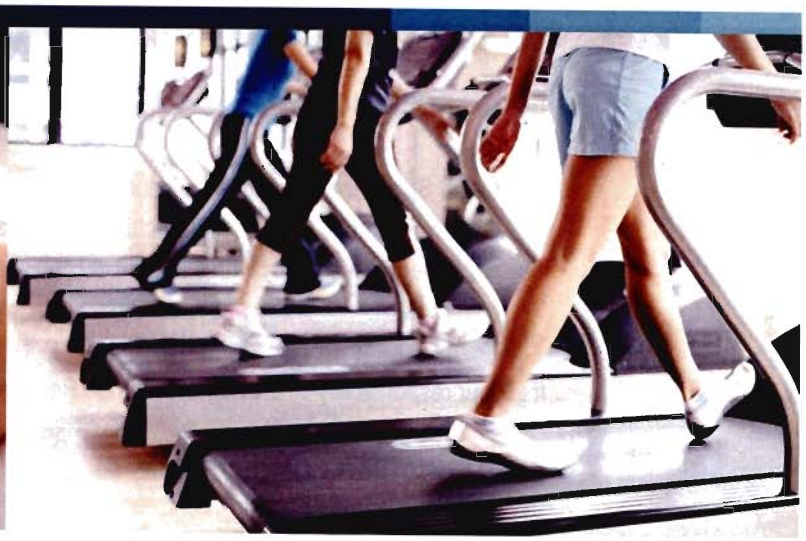
PLAN OVERVIEW

Coverage	Insurance Company
Medical & Rx	Blue Cross Blue Shield
Dental (Vol. & Ped.)	Blue Cross Blue Shield
Vision	Blue Cross Blue Shield
Life AD&D	MedMutual Life
Short Term Disability	Mutual of Omaha
Long Term Disability	Mutual of Omaha

Federal Law requires Health Savings Accounts to be partnered with High Deductible Health Plans. If you or your spouse have health coverage that is not a High Deducible Health Plan you should contact your accountant regarding the IRS approved use of HSA funds and the tax consequences for misuse.

Comstock Charter Township funds the HSA plan with $2,500 for single coverage and $5,000 per family coverage.

Comstock Charter Township funds the HSA plan with $3,250 for single coverage and $6,500 per familiy coverage for library employees.



ENROLLMENT GUIDE

OPEN ENROLLMENT

Enrollment is only available from **October 1, 2021 through October 31, 2021.** During this period you may enroll, or choose to waive coverage. You will be locked into the plan selections for one year unless there is a qualifying event (marriage, divorce, birth, adoption or change in custody of a child, death of a dependent, change in employment status). All changes must be made within 30 days of the event or you will need to wait until the next annual open enrollment period.

ANNUAL ELECTIONS & QUALIFYING EVENT

It is important that you make your choices carefully, since changes to those elections can generally only be made during the annual open enrollment period. Exceptions will be made for changes in family status during the year, allowing you to make a mid-year benefit change. A qualifying event change includes:

- Marriage
- Divorce
- Birth or adoption
- Death of a dependent
- Change in your spouse and/or dependent's employment or
- Loss of coverage by a spouse and/or dependent

If you have a family status change, you must change your benefit elections within 30 days of the qualifying event, or you will need to wait until the next annual open enrollment period.

NEW HIRE COVERAGE

As a new hire, your benefits begin **after 90 days** of employment. Once the necessary enrollment form has been completed, benefits are effective on that date. New employees have up to 30 days after their eligibility date to enroll. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period.

ELIGIBLE DEPENDENTS

- **Legal Spouse**, as defined by Federal Law;
- **Children** (natural, adopted, step-children or legal guardianship) up to age 26 regardless of marital status, financial dependency, residency with the Eligible Employee, student status, employment status, or eligibility for other coverage.

It is your responsibility to provide the Human Resource Department with proof of your dependent's eligibility.

COBRA CONTINUATION COVERAGE

When you or any of your dependents no longer meet the eligibility requirements for health and welfare plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 if your company has 20 or more employees.

ONLINE RESOURCES

TOOLKIT

Toolkit is an on-line virtual warehouse of all of the insurance coverage that you have with Burnham & Flower. You can use the Toolkit to view your benefit plan information, perform hospital and physician searches, print prescription mail order forms and HIPAA privacy release forms, State & Federal Disclosures, and access many other resources. You can access your toolkit at: **https:// toolkit.bfgroup.com/comstock**

ADMINISTRATION

Burnham & Flower's online administration portal provides up-to-the-minute account information. You can view pending, paid, and denied FSA, HRA and/or HSA claims, access balances and transactions as they are incurred, file claims by uploading scanned receipts, manage usernames and passwords, benefits during open enrollment, direct deposit information, and more.

CONTACT INFORMATION

Our talented team is here to help you. If you need assistance updating your personal information, filing a claim, or have a question, please contact us. **800.748.0554**

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Manager of Group Benefits Team

KEY TERMS

ANNUAL DEDUCTIBLE

A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using out of network providers. EOB (Explanation of Benefits): EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it be payment, denial, or pending) to a medical claim
processed on your behalf.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum is the total amount a covered person must pay before his or her benefits are paid at 100%. Depending on the policy, it may or may not include charges applied to the deductible and copays.

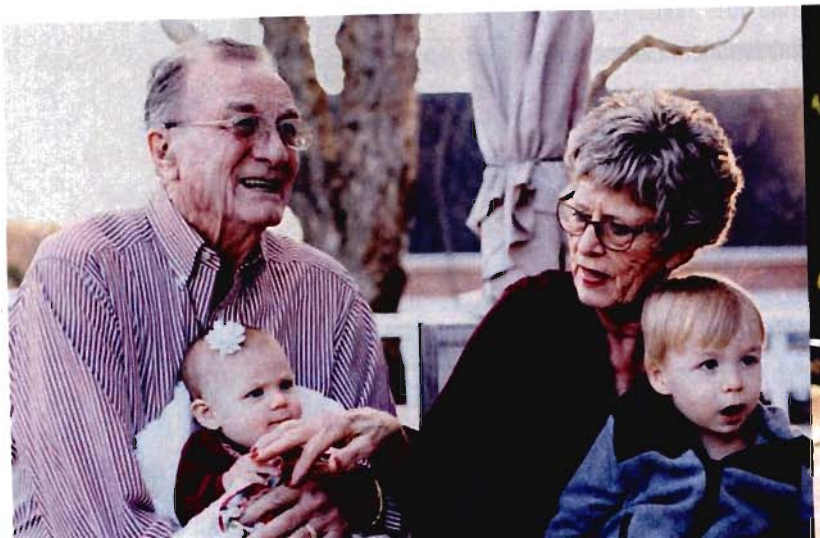
*Except for Grandfathered medical plans

COPAYS AND COINSURANCE

These expenses are your share of cost paid for covered health care services. **Copay** is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company. **Coinsurance** is a payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

PLAN TYPES

POS - Combines aspect of a PPO and HMO
HDHP - A plan that has higher annual deductibles in exchange for lower premiums. An HSA is a HDHP.



NEW. IMPROVED. EASY.

bcbsm.com

How to register at the new bcbsm.com

Registering for the new, improved and easy **bcbsm.com** member site is simple!

Step 1:

To start your registration process, have your Blues member ID card handy and go to **bcbsm.com**.

Step 2:

Click *LOGIN* in upper right corner of the blue bar. Then click on *Register now*.

Step 3:

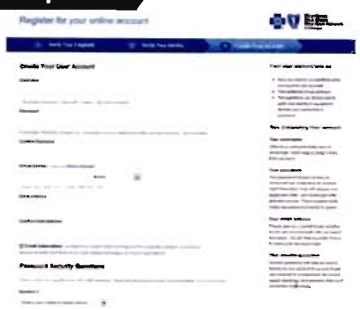
Carefully read the information on the *Verify Your Eligibility* screen before beginning the registration process.

Fill in all the fields. When complete, check the box in the middle of the page to verify your identity and then click *Continue*.

Step 4:

On the next page, carefully read the questions and click the appropriate answers. Your answers will help us verify your identity and ensure the privacy and safety of your health information. Click *Continue* to proceed to the next page.

Step 5:



Read the *Create Your Account* screen carefully and fill in the boxes.

Your password must be a minimum of eight characters, at least one upper case, one lower case and one number, all of which are case sensitive. You will need to set up password security questions, so please make sure you remember your answers.

Step 6:

When your registration is complete, click *Continue* to access your member home page.

Congratulations! You are now a registered Blues member!

If, for some reason, you cannot register using this process, you will be sent a letter with a personal PIN to complete your registration process.

Member discounts with Blue365

Take advantage of discounts from the businesses listed below and many more.

Get monthly updates and details about new offers delivered directly to your email inbox. Just log in to your member

You can conveniently access discounts from any device — anytime, anywhere.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Program information valid as of January 2017.

The Blue365 program is brought to you by the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield plans. Blue365 offers access to savings on items that members may purchase directly from independent vendors, which are different from items that are covered under health care plan policies with Blue Cross Blue Shield of Michigan or Blue Care Network, its contracts with Medicare or any other applicable federal health care program. Neither Blue Cross Blue Shield of Michigan, Blue Care Network nor the Blue Cross and Blue Shield Association recommends, endorses, warrants or guarantees any specific vendor or item.

Blue Cross
Online Visits℠

Medical and behavioral health

Getting health care online: What you need to know

When you use **Blue Cross Online Visits℠** (previously called 24/7 online health care), you'll have access to online medical and behavioral health services anywhere in the U.S.

You can rest assured knowing you and your covered family members can see and talk to:

- A doctor for minor illnesses such as a cold, flu or sore throat when their primary care doctor isn't available.
- A behavioral health clinician or psychiatrist to help work through different challenges such as anxiety, depression and grief.

Here's what you need to do to use online visits:

- **Mobile** – Download the BCBSM Online Visits℠ app
- **Web** – Visit **bcbsmonlinevisits.com**
- **Phone** – Call **1-844-606-1608**

If you're new to online visits, sign up after Jan. 1, 2018. Be sure to add your Blue Cross or Blue Care Network health plan information.

If you currently use Blue Cross' 24/7 online health care from Amwell®, use the new app, website or phone number after Jan. 1, 2018. You don't need a service key. Your login information stays the same and will be transferred to our new site. Verify your password and your account information. You may need to re-enter some information.

Online medical care doesn't replace primary doctor relationships.

The website and app use the American Well® technology platform and provider network. American Well® is an independent company that provides online visits for Blue Cross and BCN members.

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

MML/COMSTOCK CHARTER TOWNSHIP

Simply Blue[SM] HSA PPO Silver $3500 0% Medical Coverage with Prescription Drugs Benefits-at-a-Glance

Effective for groups on their plan year

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services – Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

Note: A List of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo.** Select ***Approving covered services***.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals – BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician **must** contact BCBSM to request preauthorization of the drugs. If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

* Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Benefits	In-network	Out-of-network *
Member's responsibility (deductibles, copays, coinsurance and dollar maximums)		
Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.		
Deductibles **Note**: Your deductible combines deductible amounts paid under your Simply Blue HSA medical coverage and your Simply Blue prescription drug coverage.	$3,500 per member, $7,000 for the family (when two or more members are covered under your contract) (no 4th quarter carry-over)	$7,000 per member, $14,000 for the family (when two or more members are covered under your contract) (no 4th quarter carry-over)
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) **Note**: Coinsurance amounts apply once the deductible has been met.	50% of approved amount for bariatric surgery	• 50% of approved amount for bariatric surgery • 20% of approved amount for most other covered services
Annual out-of-pocket maximums Applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drugs cost-sharing amounts.	$5,500 for one member, $11,000 for the family (when two or more members are covered under your contract)	$11,000 per member, $22,000 for the family (when two or more members are covered under your contract)
Lifetime dollar maximum	None	None
Preventive care services		
Health maintenance exam Includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note**: Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note**: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening Laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices Includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

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Benefits	In-network	Out-of-network *
Preventive care services		
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note**: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance. One per member per calendar year.	80% after out-of-network deductible **Note**: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider. One per member per calendar year.
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy **Note**: Medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance. One routine colonoscopy per member per calendar year	80% after out-of-network deductible One routine colonoscopy per member per calendar year
Physician office services		
Office visits Must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits Must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations Must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

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MML/COMSTOCK CHARTER TOWNSHIP

Benefits	In-network	Out-of-network *
Physician office services		
Online visits **By physician must be medically necessary.** **Note**: Online visits by a non-BCBSM selected vendor are not covered.	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits		
Urgent care visits Must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Emergency medical care		
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services Must be medically necessary	100% after in-network deductible	100% after in-network deductible
Diagnostic services		
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible
Maternity services provided by a physician or certified nurse midwife		
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care	100% after in-network deductible	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note**: Nonemergency services must be rendered in a participating hospital.	100% after in-network deductible Unlimited days	80% after out-of-network deductible Unlimited days
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care Must be in a participating skilled nursing facility	100% after in-network deductible Limited to a maximum of 90 days per member per calendar year	100% after in-network deductible Limited to a maximum of 90 days per member per calendar year

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Benefits	In-network	Out-of-network *
Alternatives to hospital care		
Hospice care	100% after in-network deductible Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% after in-network deductible Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)
Home health care • must be medically necessary • must be provided by a participating home health care agency	100% after in-network deductible	100% after in-network deductible
Infusion therapy • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization – consult with your doctor	100% after in-network deductible	100% after in-network deductible
Surgical services		
Surgery Includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males **Note**: For voluntary sterilizations for females, see "Preventive care services."	100% after in-network deductible	80% after out-of-network deductible
Elective Abortions	Covered 100% after in-network deductible	Covered 80% after out-ofnetwork deductible
Bariatric surgery	50% after in-network deductible Limited to a lifetime maximum of one bariatric procedure per member.	50% after out-of-network deductible Limited to a lifetime maximum of one bariatric procedure per member.
Human organ transplants		
Specified human organ transplants Must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% after in-network deductible In designated facilities only
Bone marrow transplants Must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials **Note**: BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

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Benefits	In-network	Out-of-network *
Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)		
Inpatient mental health care and inpatient substance use disorder treatment	100% after in-network deductible Unlimited days	80% after out-of-network deductible Unlimited days
Residential psychiatric treatment facility • covered mental health services must be performed in a residential psychiatric treatment facility • treatment must be preauthorized • subject to medical criteria	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: **• Facility and clinic**	100% after in-network deductible	100% after in-network deductible In participating facilities only
Outpatient mental health care: **• Online visits** **Note**: Online visits by a non-BCBSM selected vendor are not covered	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: **• Physician's office**	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance use disorder treatment In approved facilities only	100% after in-network deductible	80% after out-of-network deductible (In-network cost-sharing will apply if there is no PPO network)
Autism spectrum disorders, diagnoses and treatment		
Applied behavioral analysis (ABA) treatment **When rendered by an approved board-certified behavioral analyst – is covered through age 18 subject to preauthorization.** **Note**: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	100% after in-network deductible	100% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited.	80% after out-of-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited.
Other covered services, including mental health services, for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible
Other covered services		
Outpatient Diabetes Management Program (ODMP) **Note**: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	100% after in-network deductible	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Rehabilitative care: **Outpatient physical and occupational therapy**	100% after in-network deductible	80% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered.

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Benefits	In-network	Out-of-network *
Other covered services		
Rehabilitative care: **Chiropractic and osteopathic manipulation**	100% after in-network deductible **Limited to a 30-visit maximum per member per calendar year** **Note**: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy	80% after out-of-network deductible **Limited to a 30-visit maximum per member per calendar year** **Note**: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy
Outpatient speech therapy – when provided for rehabilitative care	100% after in-network deductible Limited to a 30-visit maximum per member per calendar year.	80% after out-of-network deductible Limited to a 30-visit maximum per member per calendar year.
Habilitative care: **Outpatient physical and occupational therapy (excludes chiropractic and osteopathic manipulation)**	100% after in-network deductible **Limited to a 30-visit maximum per member per calendar year** **Note**: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical and occupational therapy	80% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered. Limited to a 30-visit maximum per member per calendar year Note: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy and occupational therapy.
Outpatient speech therapy - when provided for habilitative care	100% after in-network deductible Limited to a 30-visit maximum per member per calendar year.	80% after out-of-network deductible Limited to a 30-visit maximum per member per calendar year.
Durable medical equipment **Note**: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	100% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing care	Not covered	Not covered

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Prescription Drug Coverage
Benefits-at-a-glance
Effective for groups on their plan year

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. AllianceRx Walgreens Prime will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a **90-Day Retail Network provider or** mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the initial quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at **bcbsm.com/pharmacy**.

Member's responsibility (copays and coinsurance amounts)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until after you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are required to pay applicable prescription drug copays and coinsurance amounts which are subject to your annual out-of-pocket maximums.

Note: The 20% member liability for covered drugs obtained from an out-of-network pharmacy will not contribute to your annual out-of-pocket maximum.

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy(not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic drugs	1 to 30-day period	After deductible, you pay $20 copay	After deductible, you pay $20 copay	After deductible, you pay $20 copay	After deductible, you pay $20 copay plus an additional 20% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible, you pay $40 copay	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible, you pay $50 copay	No coverage	No coverage
	84 to 90-day period	After deductible, you pay $50 copay	After deductible, you pay $50 copay	No coverage	No coverage

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy(not part of the 90-day retail network)	Out-of-network pharmacy
Tier 2 - Preferred brand-name drugs	1 to 30-day period	After deductible, you pay $60 copay	After deductible, you pay $60 copay	After deductible, you pay $60 copay	After deductible, you pay $60 copay plus an additional 20% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible, you pay $120 copay	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible, you pay $170 copay	No coverage	No coverage
	84 to 90-day period	After deductible, you pay $170 copay	After deductible, you pay $170 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	After deductible, you pay $80 copay or 50% of the approved amount (whichever is greater), but no more than $100	After deductible, you pay $80 copay or 50% of the approved amount (whichever is greater), but no more than $100	After deductible, you pay $80 copay or 50% of the approved amount (whichever is greater), but no more than $100	After deductible, you pay $80 copay or 50% of the approved amount (whichever is greater), but no more than $100 plus an additional 20% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible, you pay $160 copay or 50% of the approved amount (whichever is greater), but no more than $200	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible, you pay $230 copay or 50% of the approved amount (whichever is greater), but no more than $290	No coverage	No coverage
	84 to 90-day period	After deductible, you pay $230 copay or 50% of the approved amount (whichever is greater), but no more than $290	After deductible, you pay $230 copay or 50% of the approved amount (whichever is greater), but no more than $290	No coverage	No coverage
Tier 4 - Generic and preferred brand-name specialty drugs	1 to 30-day period	After deductible, you pay 20% of the approved amount, but no more than $200	After deductible, you pay 20% of the approved amount, but no more than $200	After deductible, you pay 20% of the approved amount, but no more than $200	After deductible, you pay 20% of the approved amount, but no more than $200 plus an additional 20% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage
Tier 5 - Nonpreferred brand-name specialty drugs	1 to 30-day period	After deductible, you pay 25% of approved amount, but no more than $300	After deductible, you pay 25% of approved amount, but no more than $300	After deductible, you pay 25% of approved amount, but no more than $300	After deductible, you pay 25% of the approved amount, but no more than $300 plus an additional 20% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers

Covered services				
Benefits	**90-day retail network pharmacy**	*** In-network mail order provider**	**In-network pharmacy(not part of the 90-day retail network)**	**Out-of-network pharmacy**
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand name** prescription preventive drugs, supplements and vitamins as required by PPACA	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA.	100% of approved amount	No coverage	100% of approved amount	80% of approved amount
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug plus an additional 20% prescription drug out-of-network penalty

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers

Features of your prescription drug plan

BCBSM Custom Select Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Select Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay for these drugs. • **Tier 4 (generic and preferred brand-name specialty)** - Tier 4 includes covered specialty drugs listed as generic drugs (Tier 1) or preferred brand-name drugs (Tier 2) from the Custom Select Drug List. These drugs have a proven record for safety and effectiveness, and offer the best value to our members. They have the lowest specialty drug copay. • **Tier 5 (nonpreferred brand-name specialty)** - Tier 5 includes covered specialty drugs listed as nonpreferred brand name (Tier 3). These drugs may not have a proven record for safety or their clinical value may not be as high as the specialty drugs in Tier 4. They have the highest specialty drug copay.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Drug interchange and generic copay/coinsurance waiver	BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Exclusions	The following drugs are not covered: • Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service • State-controlled drugs • Brand-name drugs that have a generic equivalent available • Drugs to treat erectile dysfunction and weight loss • Prenatal vitamins (prescribed and over-the-counter) • Brand-name drugs used to treat heartburn • Compounded drugs, with some exceptions • Cosmetic drugs

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Download your Clever RX card or Clever RX App to unlock exclusive savings.

Present your Clever RX App or Clever RX card to your pharmacist.

FREE to use. Save up to 80% off prescription drugs and beat copay prices.

STEP 1:

Download the FREE Clever RX App. From your App Store search for "Clever RX" and hit download. Make sure you enter in Group ID and in Member ID during the on-boarding process. This will unlock exclusive savings for you and your family!

STEP 2:

Find where you can save on your medication. Using your zip code, when you search for your medication Clever RX checks which pharmacies near you offer the lowest price. Savings can be up to 80% compared to what you're currently paying.

STEP 3:

Click the voucher with the lowest price, closest location, and/or at your preferred pharmacy. Click "share" to text yourself the voucher for easy access when you are ready to use it. Show the voucher on your screen to the pharmacist when you pick up your medication.

STEP 4:

Share the Clever RX App. Click "Share" on the bottom of the Clever RX App to send your friends, family, and anyone else you want to help receive instant discounts on their prescription medication. Over 70% of people can benefit from a prescription savings card.

NOW THAT IS NOT ONLY CLEVER, IT IS CLEVER RX.

DID YOU KNOW?

70%

Over 70% of people can benefit from a prescription savings card due to high deductible health plans, high copays, and being underinsured or uninsured.

30%

Over 30% of prescriptions never get filled due to high costs.

40%

40% of the top ten most prescribed drugs have increased in cost by over 100%

70%

Clever RX prices are lower than competitor prices 70% of the time.

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MML/CHARTER TOWNSHIP OF COMSTOCK

Blue Dental[SM] PPO 100/80/50 (80/50/50) SG Voluntary

Benefits-at-a-Glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Note: Pediatric members are members who are age 18 or younger on the plan's effective date. They remain pediatric members through the end of the calendar year in which they turn 19.

Network access information
With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll have the greatest coverage and savings when they choose a dentist who is a member of the Blue Dental PPO network.[1]

Blue Dental PPO network – Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services – members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**

[1] *Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.*
[2] *A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.*

Members who go to non-PPO dentists can still save money through our Blue Par Select arrangement.

Blue Par Select[SM] arrangement – Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services – members pay only applicable coinsurance and deductible amounts. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com.**

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Member's responsibility (deductible, copays and dollar maximums)		
Benefits	**In-network**	**Out-of-network**
Deductibles Applies to Class II and Class III services only	$25 per member, $50 for two memebers, $75 per family per calendar year	$50 per member, $100 for two members, $150 per family per calendar year
Coinsurance (percentage of BCBSM's approved amount for covered services)		
Class I services	None (covered at 100%)	20%
Class II services	20%	50%
Class III services	50%	50%
Class IV services	Not Covered	Not Covered
Dollar Maximums		

Member's responsibility (deductible, copays and dollar maximums)

Benefits	In-network	Out-of-network
Annual maximum for Class I, II and III services	$1000 per member The annual benefit maximum does not apply to pediatric members.	$800 per member The annual benefit maximum does not apply to pediatric members.
Lifetime maximum for Class IV services	Not covered For members up to their 19th birthday	Not covered For members up to their 19th birthday
Out-of-pocket maximum The maximum out-of-pocket expense pediatric members will pay in a calendar year for deductible and coinsurance amounts applied to most covered in-network dental services. The out-of-pocket maximum does not apply to charges that exceed our approved PPO fee, services provided by non-PPO dentists, non-covered services, or orthodontic services.	$350 for one pediatric member or $700 for two or more pediatric members per calendar year. There is no out-of-pocket maximum for non-pediatric members. **Note**: This out-of-pocket maximum is separate from the annual out-of-pocket maximum that applies under your hospital and medical coverage (if any).	Not applicable
Waiting period	Not Applicable **12 months for Class III and IV services (except root canals and extractions of non-impacted teeth). The Class III waiting period does not apply to pediatric members.** **Note**: Your group's waiting period may be waived with proof of prior dental coverage. However, members who enroll after the initial enrollment period will be subject to the group's 12-month waiting period.	Not Applicable **12 months for Class III and IV services (except root canals and extractions of non-impacted teeth). The Class III waiting period does not apply to pediatric members.** **Note**: Your group's waiting period may be waived with proof of prior dental coverage. However, members who enroll after the initial enrollment period will be subject to the group's 12-month waiting period.

Plan's responsibility

The plan's responsibility is subject to a review of the reported diagnosis, dental necessity verification and the availability of dental benefits at the time the claim is processed, as well as the conditions, exclusions and limitations, and deductible and coinsurance requirements under the applicable BCBSM certificates and riders.

Plan's responsibility

The plan's responsibility is subject to a review of the reported diagnosis, dental necessity verification and the availability of dental benefits at the time the claim is processed, as well as the conditions, exclusions and limitations, and deductible and coinsurance requirements under the applicable BCBSM certificates and riders.

Class I services

Benefits	In-network	Out-of-network
Most Diagnostic and preventive services:		
Routine oral examinations/evaluations – twice per calendar year	100% of approved amount	80% of approved amount
Routine prophylaxes (cleanings) – three times per calendar year for pediatric members; two times per calendar year for all other members	100% of approved amount	80% of approved amount
Fluoride treatment or topical application of fluoride - twice every calendar year for members to the end of the month of their 19th birthday	100% of approved amount	80% of approved amount
Sealants - once per first permanent molar every 36 months for members to the end of the month of their ninth birthday; once per second permanent molar every 36 months for members to the end of the month of their 14th birthday	100% of approved amount	80% of approved amount
Bitewing X-rays One set (up to four films) per calendar year	100% of approved amount	80% of approved amount
Oral brush biopsy sample collection Twice per calendar year	100% of approved amount	80% of approved amount

Class II services

Benefits	In-network	Out-of-network
Other Diagnostic and preventive services:		
Diagnostic tests and laboratory examinations	80% of approved amount after deductible	50% of approved amount after deductible
Space maintainers - for missing posterior primary teeth for members to the end of the month of their 15th birthday	80% of approved amount after deductible	50% of approved amount after deductible
Panoramic or full-mouth X-rays Once per 60 months	80% of approved amount after deductible	50% of approved amount after deductible
Emergency palliative treatment	80% of approved amount after deductible	50% of approved amount after deductible
Minor restorative services:		
Amalgam and resin-based composite fillings and fillings of similar materials – once per tooth and surface per 48 months for permanent teeth; once per tooth and surface per 24 months for primary teeth	80% of approved amount after deductible	50% of approved amount after deductible

Class II services

Benefits	In-network	Out-of-network
Adjunctive general services:		
General anesthesia or IV sedation	80% of approved amount after deductible	50% of approved amount after deductible
Office visits for observation (during regularly scheduled hours) for non-pediatric members only	80% of approved amount after deductible	50% of approved amount after deductible
Office visits after regularly scheduled hours	80% of approved amount after deductible	50% of approved amount after deductible
House and hospital calls for non-pediatric members only	80% of approved amount after deductible	50% of approved amount after deductible
Antibiotic injections for non-pediatric members only	80% of approved amount after deductible	50% of approved amount after deductible
Periodontal maintenance Three times per calendar year in place of routine dental prophylaxis for pediatric members; two times per calendar year in place of routine dental prophylaxis for all other members	80% of approved amount after deductible	50% of approved amount after deductible

Class III services

Note: There is a 12-month waiting period for Class III benefits. The waiting period will be satisfied on the last day of the 12-month period with benefits becoming effective on the first date following. For example, if the member's coverage becomes effective on January 1, 2015, the last date of the waiting period will be December 31, 2015, with benefits becoming active on January 1, 2016. This waiting period does not apply to pediatric members.

Root canals and extractions of non-impacted teeth are not subject to the 12-month waiting period.

Benefits	In-network	Out-of-network
Endodontic services:		
Root canal treatments – once per tooth per lifetime (retreatment of a root canal 12 or more months after the initial root canal treatment is payable once per tooth per lifetime)	50% of approved amount after deductible	50% of approved amount after deductible
Therapeutic pulpotomies or pulpal debridement	50% of approved amount after deductible	50% of approved amount after deductible
Vital pulpotomies on primary teeth	50% of approved amount after deductible	50% of approved amount after deductible
Apexification	50% of approved amount after deductible	50% of approved amount after deductible
Apical surgeries on permanent teeth	50% of approved amount after deductible	50% of approved amount after deductible

Class III services

Note: There is a 12-month waiting period for Class III benefits. The waiting period will be satisfied on the last day of the 12-month period with benefits becoming effective on the first date following. For example, if the member's coverage becomes effective on January 1, 2015, the last date of the waiting period will be December 31, 2015, with benefits becoming active on January 1, 2016. This waiting period does not apply to pediatric members.

Root canals and extractions of non-impacted teeth are not subject to the 12-month waiting period.

Benefits	In-network	Out-of-network
Periodontic services:		
Periodontal scaling and root planing – once per quadrant per 24 months for pediatric members; once per quadrant per 36 months for all other members	50% of approved amount after deductible	50% of approved amount after deductible
Localized delivery of antimicrobial agents – one surface per tooth and three teeth per quadrant with a maximum of 12 teeth per year for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Limited occlusal adjustments – up to five times per 60 months for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Occlusal biteguards (and relines and repairs to occlusal biteguards) – once per 60 months for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Gingivectomies and gingivoplasties	50% of approved amount after deductible	50% of approved amount after deductible
Osseous surgeries for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Gingival flap procedures	50% of approved amount after deductible	50% of approved amount after deductible
Soft tissue grafts	50% of approved amount after deductible	50% of approved amount after deductible
Bone replacement grafts for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Major restorative services:		
Onlays, crowns and veneers – once per permanent tooth per 60 months for members age 12 and older only	50% of approved amount after deductible	50% of approved amount after deductible
Substructures, including cores and posts	50% of approved amount after deductible	50% of approved amount after deductible
Recementation or repair of posts, crowns, veneers, inlays and onlays – three times per tooth per calendar year	50% of approved amount after deductible	50% of approved amount after deductible
Oral surgery services:		
Extractions and surgical removal of non-impacted teeth	50% of approved amount after deductible	50% of approved amount after deductible
Surgical exposure and facilitation of eruption of unerupted teeth	50% of approved amount after deductible	50% of approved amount after deductible

Class III services

Note: There is a 12-month waiting period for Class III benefits. The waiting period will be satisfied on the last day of the 12-month period with benefits becoming effective on the first date following. For example, if the member's coverage becomes effective on January 1, 2015, the last date of the waiting period will be December 31, 2015, with benefits becoming active on January 1, 2016. This waiting period does not apply to pediatric members.

Root canals and extractions of non-impacted teeth are not subject to the 12-month waiting period.

Benefits	In-network	Out-of-network
Incision and drainage of celluliitis or fascial space abscesses of intraoral soft tissue	50% of approved amount after deductible	50% of approved amount after deductible
Removal of exostoses (excess bony growths of the upper and lower jaw)	50% of approved amount after deductible	50% of approved amount after deductible
Excision of hyperplastic tissue per arch	50% of approved amount after deductible	50% of approved amount after deductible
Soft tissue biopsies for pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Frenulectomies	50% of approved amount after deductible	50% of approved amount after deductible
Prosthodontic services:		
Complete dentures – once per 84 months	50% of approved amount after deductible	50% of approved amount after deductible
Removable partial dentures and fixed partial dentures (bridges), including abutment crowns and pontics – once per 84 months for members age 16 and older only	50% of approved amount after deductible	50% of approved amount after deductible
Relines or rebases of partial dentures or complete dentures – once per 36 months per arch	50% of approved amount after deductible	50% of approved amount after deductible
Tissue conditioning – once per 36 months per arch	50% of approved amount after deductible	50% of approved amount after deductible
Adjustments, repairs and recementation	50% of approved amount after deductible	50% of approved amount after deductible
Stayplates to replace recently extracted permanent anterior (front) teeth	50% of approved amount after deductible	50% of approved amount after deductible
Endosteal implants and implant-related services – once per tooth per lifetime for teeth numbered 2 through 15 and 18 through 31 for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible

Class IV services – Orthodontic services for dependents under age 19

Note: There is a 12-month waiting period for Class IV benefits. The waiting period will be satisfied on the last day of the 12-month period with benefits becoming effective on the first date following. For example, if the member's coverage becomes effective on January 1, 2015, the last date of the waiting period will be December 31, 2015, with benefits becoming active on January 1, 2016. This waiting period does apply to pediatric members.

Benefits	In-network	Out-of-network
Orthodontics and related services	Not Covered	Not Covered

Member's responsibility (deductible, copays and dollar maximums)	
Benefits	**Coverage**
Lifetime maximum for Class IV services	Not applicable
Out-of-pocket maximum The maximum out-of-pocket expense pediatric members will pay in a calendar year for deductible and coinsurance amounts applied to most covered in-network dental services. The out-of-pocket maximum does not apply to charges that exceed our approved PPO fee, services provided by non-PPO dentists, or non-covered services.	$350 for one pediatric member or $700 for two or more pediatric members per calendar year **Note**: This out-of-pocket maximum is separate from the annual out-of-pocket maximum that applies under your hospital and medical coverage (if any).

Plan's responsibility

The plan's responsibility is subject to a review of the reported diagnosis, dental necessity verification and the availability of dental benefits at the time the claim is processed, as well as the conditions, exclusions and limitations, and deductible and coinsurance requirements under the applicable BCBSM certificates and riders.

Class I services	
Benefits	**Coverage**
Most diagnostic and preventive services:	
Routine oral examinations/evaluations – twice per calendar year	80% of approved amount
Routine prophylaxes (cleanings) – three times per calendar year	80% of approved amount
Fluoride treatment or topical application of fluoride - twice every calendar year for members to the end of the month of their 19th birthday	80% of approved amount
Sealants - once per first permanent molar every 36 months for members to the end of the month of their ninth birthday; once per second permanent molar every 36 months for members to the end of the month of their 14th birthday	80% of approved amount
Bitewing X-rays One set (up to four films) per calendar year	80% of approved amount
Oral brush biopsy sample collection Twice per calendar year	80% of approved amount

Class II services

Benefits	Coverage
Other diagnostic and preventive services:	
Diagnostic tests and laboratory examinations	50% of approved amount after deductible
Space maintainers - for missing posterior primary teeth for members to the end of the month of their 15th birthday	50% of approved amount after deductible
Panoramic or full-mouth X-rays Once per 60 months	50% of approved amount after deductible
Emergency palliative treatment	50% of approved amount after deductible
Minor restorative services:	
Amalgam and resin-based composite fillings and fillings of similar materials – once per tooth and surface per 48 months for permanent teeth; once per tooth and surface per 24 months for primary teeth	50% of approved amount after deductible
Recementation or repair of posts, crowns, veneers, inlays and onlays – three times per tooth per calendar year	50% of approved amount after deductible
Extractions and surgical removal of non-impacted teeth	50% of approved amount after deductible
Non-surgical endodontic services:	
Root canal treatments – once per tooth per lifetime (retreatment of a root canal 12 or more months after the initial root canal treatment is payable once per tooth per lifetime)	50% of approved amount after deductible
Therapeutic pulpotomies or pulpal debridement	50% of approved amount after deductible
Vital pulpotomies on primary teeth	50% of approved amount after deductible
Apexification	50% of approved amount after deductible
Non-surgical periodontic services:	
Periodontal maintenance – three times per calendar year in conjunction with routine dental prophylaxis	50% of approved amount after deductible
Periodontal scaling and root planing – once per quadrant per 24 months	50% of approved amount after deductible
Adjustments, repairs, relines, rebases and tissue conditioning for removable prosthetic appliances:	
Relines or rebases of partial dentures or complete dentures – once per 36 months per arch	50% of approved amount after deductible
Tissue conditioning – once per 36 months per arch	50% of approved amount after deductible
Adjunctive general services:	
General anesthesia or IV sedation	50% of approved amount after deductible
Office visits after regularly scheduled hours	50% of approved amount after deductible

Class III services

Benefits	Coverage
Major restorative services:	
Onlays, crowns and veneers – once per permanent tooth per 60 months for members age 12 and older only	50% of approved amount after deductible
Substructures, including cores and posts	50% of approved amount after deductible
Oral surgery services:	
Surgical exposure and facilitation of eruption of unerupted teeth	50% of approved amount after deductible
Incision and drainage of celluliitis or fascial space abscesses of intraoral soft tissue	50% of approved amount after deductible
Removal of exostoses (excess bony growths of the upper and lower jaw)	50% of approved amount after deductible
Excision of hyperplastic tissue per arch	50% of approved amount after deductible
Soft tissue biopsies	50% of approved amount after deductible
Frenulectomies	50% of approved amount after deductible
Surgical endodontic services:	
Apical surgeries on permanent teeth	50% of approved amount after deductible
Hemisections – once per tooth per lifetime	50% of approved amount after deductible
Surgical periodontic services:	
Gingivectomies and gingivoplasties	50% of approved amount after deductible
Clinical crown lengthening – hard tissue	50% of approved amount after deductible
Gingival flap procedures	50% of approved amount after deductible
Soft tissue grafts	50% of approved amount after deductible
Prosthodontic services:	
Complete dentures – once per 84 months	50% of approved amount after deductible
Removable partial dentures and fixed partial dentures (bridges), including abutment crowns and pontics – once per 84 months for members age 16 and older only	50% of approved amount after deductible
Recementation and repairs of bridges	50% of approved amount after deductible
Stayplates to replace recently extracted permanent anterior (front) teeth	50% of approved amount after deductible

Blue Vision℠ SG, VSP Choice Network 12/12/12 $5/$10 Copay
Vision Coverage
Benefits-at-a-glance
Effective for groups on their plan year

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Vision benefits are only available to covered members (subscribers, spouses and dependent children) age 19 and older. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

Member's responsibility (copays)

Benefits	In-network	Out-of-network
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay
Medically necessary contact lenses	$10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay

Eye exam

Benefits	In-network	Out-of-network
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $34 less $5 copay (member responsible for any difference)
	One eye exam every calendar year	

Lenses and Frames

Benefits	In-network	Out-of-network
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note:** Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	$10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $10 copay (member responsible for any difference)
	One pair of lenses, with or without frames, once every calendar year	

Benefits	In-network	Out-of-network
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to $38.25 less $10 copay (member responsible for any difference)
	One frame every calendar year	

Contact Lenses

Benefits	In-network	Out-of-network
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$10 copay	Reimbursement up to $210 less $10 copay (member responsible for any difference)
	One pair of contact lenses once every calendar year	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Contact lenses are covered up to allowance once every calendar year	

SCHEDULE OF BENEFITS

Policyholder:	Insurance Trust for Michigan Public Entities
Policy Number:	000008
Participating Employer:	Charter Township of Comstock
Group Number:	215073
Eligibility: Class (if Applicable):	1 - All eligible full-time Firefighters and all other full-time Employees, excluding Trustees and Supervisors
Group Term Life Insurance	
Employee Life Benefit Amount:	$30,000
Non-Medical Maximum Benefit Limit:	$30,000
Accelerated Death Benefit:	Refer to Accelerated Death Benefit
Accidental Death & Dismemberment (AD&D)	
Employee AD&D Benefit Principal Sum	$30,000

Other AD&D Features

- Seat Belt Benefit
- Air Bag Benefit
- Repatriation Benefit
- Dependent Education Benefit
- Exposure and Disappearance Benefit
- Coma Benefit

Reduction of Benefits

Basic Life and AD&D benefits reduce by 50% of the face amount upon the Employee's attainment of age 70.

THIS SCHEDULE OF BENEFITS CANCELS AND REPLACES ALL OTHER SCHEDULES PREVIOUSLY ISSUED TO YOU UNDER THE POLICY. IT OUTLINES THE POLICY FEATURES. THE FOLLOWING PAGES PROVIDE A COMPLETE DESCRIPTION OF THE PROVISIONS OF YOUR CERTIFICATE.

Short-Term Disability Insurance

FOR EMPLOYEES OF CHARTER TOWNSHIP OF COMSTOCK

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 32 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Elimination Period	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin: • On the day of your disabling injury. • On the 8th day of your disabling illness.
Weekly Benefit	Your benefit is equivalent to 66 2/3% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount less other income sources.
Maximum Benefit Period	Up to 13 weeks
Maximum Weekly Benefit	$500
Minimum Weekly Benefit	None
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
DEFINITIONS	
Definition of Disability	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings which exceed 99% of your weekly earnings from your regular job. You can be totally or partially disabled during the elimination period.
Definition of Weekly Earnings	Week Prior to Disability
FEATURES	
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 5%.
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

› Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 32 hours per week.

How long will my benefits be paid?

Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.

Will my benefits be reduced by other sources of income?

Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, other group disability plans, salary continuance/sick leave, settlements on payments received and no-fault benefits.

Does this plan cover me if I become disabled due to an injury at work?

No, your STD insurance only provides benefits for off-the-job coverage for disabilities due to injury or sickness.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

- Benefits are not payable for any disability or loss that:
  - Results from an act of declared or undeclared war or armed aggression
  - Results from participation in a riot or commission of or attempt to commit a felony
  - Arises out of or in the course of employment with the policyholder for benefits under any workers' compensation or occupational disease law, or receives any settlement from the workers' compensation carrier
  - Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, suicide, or attempted suicide
  - Occurs while incarcerated or imprisoned for any period exceeding 31 days
  - Is solely a result of a loss of a professional license, occupation license or certification

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this summary, the certificate booklet will prevail. Benefits availability is subject to final acceptance and approval of the group application by the underwriting company. Disability insurance is underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, 1-800-769-7159. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Policy form number 7000GM-U-EZ-2010.

Long-Term Disability Insurance

FOR EMPLOYEES OF CHARTER TOWNSHIP OF COMSTOCK

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 32 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Elimination Period	Your benefits begin on the later of 90 calendar days after the onset of your disabling injury or illness or the date your short term disability ends.
Monthly Benefit	Your benefit is equivalent to 66 2/3% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount less other income sources. The premium for your long-term disability coverage is waived while you are receiving benefits.
Maximum Monthly Benefit	$4,000
Minimum Monthly Benefit	$100
Maximum Benefit Period	If you become disabled prior to age 62, benefits are payable to age 65, your Social Security Normal Retirement Age or 3.5 years, whichever is longest. At age 62 (and older), the benefit period will be based on a reduced duration schedule.
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits.
DEFINITIONS	
Own Occupation	2 Years
Own Occupation Earnings Test	99%
FEATURES	
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 5%.
Survivor Benefit	If you pass away while receiving disability benefits, a lump sum equal to 3 times your monthly benefit will be paid to your eligible survivor.
Retirement Income Protection	Provides a benefit to the employer to apply toward an employer-sponsored pension, savings or investment plan for you if you are disabled.
SERVICES	
Employee Assistance Program (EAP)	The EAP program provides you and your loved ones access to trained professionals and resources for assistance with personal and workplace issues.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

› Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 32 hours per week.

How long will my benefits be paid?

Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.

Will my benefits be reduced by other sources of income?

Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, other group disability plans, salary continuance/sick leave, settlements on payments received and no-fault benefits.

Does this plan cover me if I become disabled due to an injury at work?

Yes, your LTD insurance provides benefits for both on-the-job and off-the-job coverage for disabilities due to injury or sickness.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

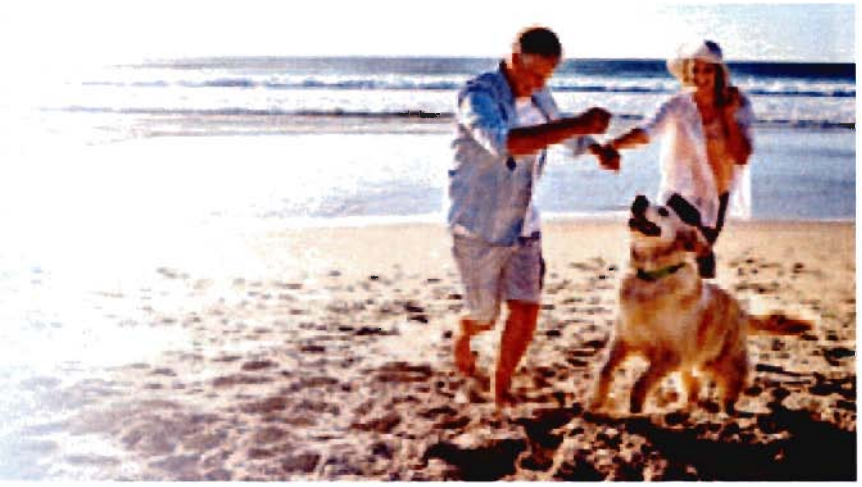
- Disabilities related to alcohol and drug abuse are only payable for up to 24 months while insured under the policy.
- Disabilities related to mental disorders are only payable for up to 24 months while insured under the policy.
- Your plan is subject to a pre-existing condition limitation. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 3/12 which means any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.
- Benefits are not payable for any disability or loss that:
  - Results from an act of declared or undeclared war or armed aggression
  - Results from participation in a riot or commission of or attempt to commit a felony
  - Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, suicide, or attempted suicide
  - Results from alcohol and drug abuse and/or substance abuse, except as noted above
  - Results from a mental disorder, except as noted above
  - Is caused by alcohol and drug abuse and/or substance abuse, while not being actively supervised by and receiving continuing treatment from a rehabilitation center or designated institution approved for such treatment by an appropriate body in the governing jurisdiction
  - Occurs while incarcerated or imprisoned for any period exceeding 31 days
  - Is solely a result of a loss of a professional license, occupation license or certification

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this summary, the certificate booklet will prevail. Benefits availability is subject to final acceptance and approval of the group application by the underwriting company. Disability insurance is underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, 1-800-769-7159. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Policy form number 7000GM-U-EZ-2010.

Employee Assistance Program

We're Here to Help



Life's not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life. Your Employee Assistance Program (EAP) can be the answer for you and your family.

We're Here to Help

Mutual of Omaha's EAP assists employees and their eligible dependents with personal or job-related concerns, including:

- Emotional well-being
- Family and relationships
- Legal and financial matters
- Healthy lifestyles
- Work and life transitions

EAP Benefits

- Access to EAP professionals 24 hours a day, seven days a week
- Provides information and referral resources
- Service for employees and eligible dependents
- Robust network of licensed mental health professionals
- Three face-to-face sessions* with a counselor (per household per calendar year)

*Face-to-face visits can also be used toward legal consultations

*California Residents: Knox-Keene Statute limits no more than three face-to-face sessions per six-month period.

- Legal assistance and financial resources
  - Online will preparation
  - Legal library & online forms
  - Financial tools and resources
- Resources for:
  - Substance use and other addictions
  - Dependent and elder care resources
- Access to a library of educational articles, handouts and resources via *mutualofomaha.com/eap*

What to Expect

You can trust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solutions that are responsive to your needs.

Your EAP benefits are provided through your employer. There is ***no cost*** to you for utilizing EAP services. If additional services are needed, your EAP will help locate appropriate resources in your area.

Don't delay if you need help

Visit *mutualofomaha.com/eap* or call 800-316-2796 for confidential consultation and resource services.

Mutual of Omaha

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Employee Benefits

Our New Financial Wellness Tool Can Benefit You

How do you feel about your current financial situation? Nearly half of all employees nationwide say they worry about their personal finances while at work.* We don't want you to be part of that statistic.

To help you make better informed financial decisions, you now have access to a new financial wellness tool that's part of Mutual of Omaha's Employee Assistance Program.

The financial wellness tool from Enrich is a convenient, one-stop shop that provides you access to a variety of informational and educational resources with one goal in mind – to help you become financially healthy.

Here are the resources you'll find in the financial wellness tool:

- Online courses
- Webinars and financial coaching videos
- Budgeting tools and calculators
- Career development tools
- Chat functionality for technical support
- *And more!*

The availability of this tool comes at a great time as you are putting more focus and effort into exploring solutions to your financial situation.

Here's how it works:

Go to **mutualofomaha.com/eap**.

Click on **Managing Finances** to locate the Enrich link.

Click **Sign Up**.

Complete **registration** information and begin.

Set up your profile:

It's as easy as 1-2-3!

1. Complete your Financial Wellness Checkup. This will help Enrich make personalized recommendations for content, tools and courses.
2. Choose a cover photo of your top financial goals.
3. Upload a profile photo.

Mutual of Omaha

* Source: PwC's 9th annual Employee Financial Wellness Survey, PwC US, 2020.

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Mutual Solutions

Your Hearing Discount Program

Program Benefits Include

- ☑ **Custom hearing solutions** – we find the solution that best fits your lifestyle and your budget from one of our 10 manufacturers
- ☑ **Risk-free 60-day trial** – 100 percent money-back guarantee on hearing aid purchase
- ☑ **Hearing aid low price guarantee** – if you find the same product at a lower price, bring us the local quote and we'll not only match it, we'll beat it by 5 percent
- ☑ **Continuous Care** – one year free follow-up, two years of free batteries and a three-year warranty

Accessing Your Benefits is as Easy as...

1. Call Amplifon at 1-888-534-1747 and a Patient Care Advocate will assist you in finding a hearing care provider near you.
2. Our advocate will explain the Amplifon process, request your mailing information and assist you in making an appointment with a hearing care provider.
3. Amplifon will send information to you and the hearing care provider. This will ensure your Amplifon discounts are activated.

To learn more visit amplifonusa.com/mutualofomaha

✂

Keep this card for future access to:

- Discounted hearing testing
- Low price guarantee
- 60-day risk-free trial period
- 2 years batteries with purchase

To activate your benefit, call 1-888-534-1747 today!

amplifon

Special money-saving offer!

Call today for your FREE hearing screening appointment!
Please bring this offer with you to your appointment.

Call 1-888-534-1747 Today!

This is not a medical exam and is only intended to assist with amplification selection.

Mutual of Omaha | amplifon

This is not health insurance. Hearing services are administered by Amplifon Hearing Health Care, Corp. Amplifon Hearing Health Care is solely responsible for the administration of hearing health care services, and its own financial and contractual obligations. Mutual of Omaha Insurance Company has been authorized to provide marketing services including sales. Mutual of Omaha Insurance Company and Amplifon are independent, unaffiliated companies.

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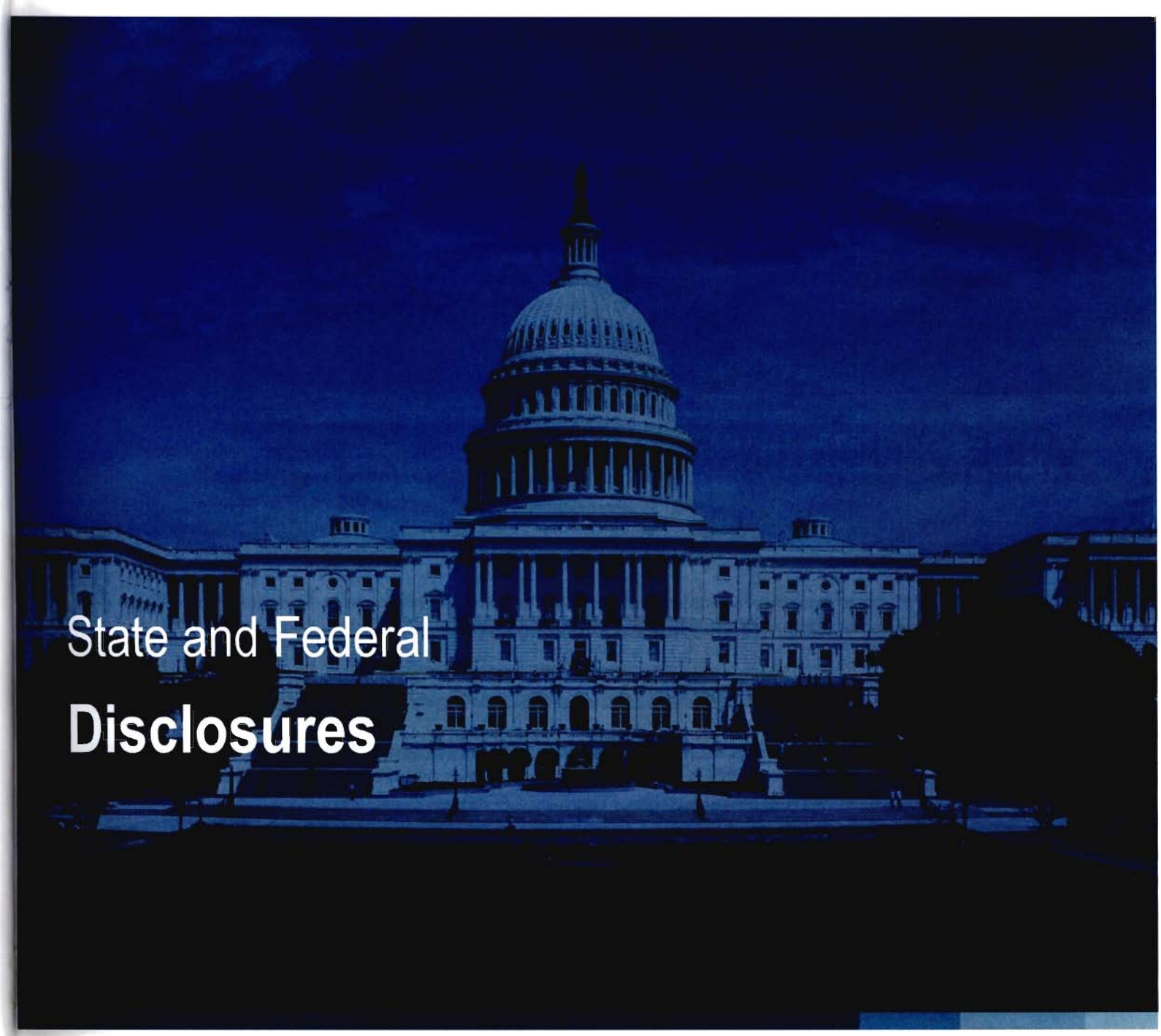
Burnham&Flower
INSURANCE GROUP



State and Federal
Disclosures

Presented by:

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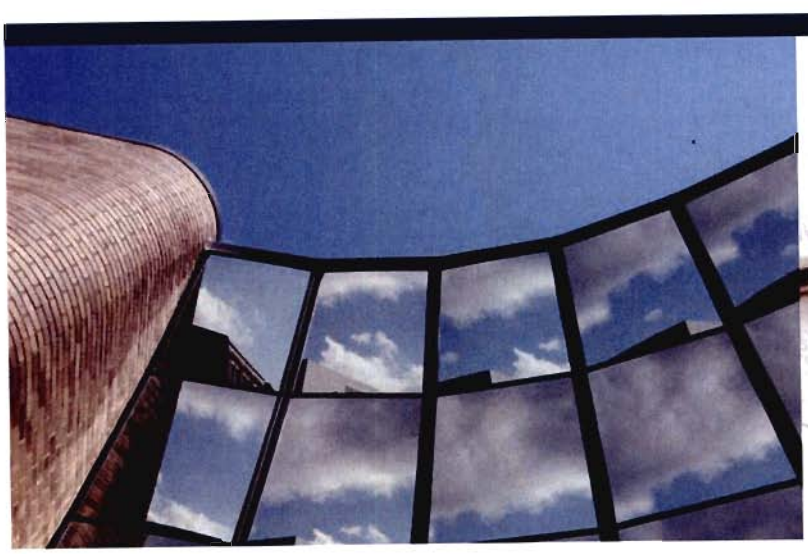
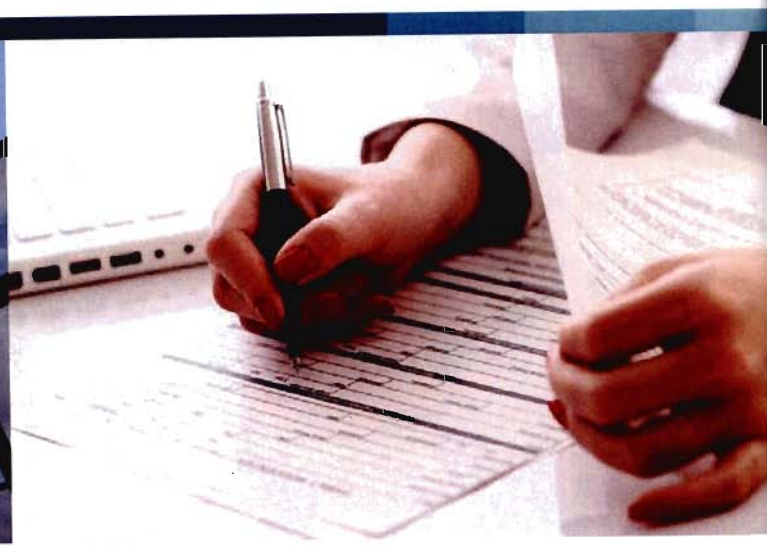
Kalamazoo, MI 49007
800.748.0554
www.bfgroup.com





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SECTION 1: HEALTH INSURANCE EXCHANGE NOTICE

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. you may also be eligible for a new kind of tax credit that lowers your monthly premiums right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reductions in certain cost-sharing if you employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more that 9.5% of your household income for the year, or if the coverage you employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. *

> **Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employers, then you may lose the employer contributions (if any) to the employer-offered coverage- is often excluded from income for Federal and State income tax purposes. You payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by you employer, please check your summary plan description. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online police for the health insurance coverage and contact information for a Health Insurance market plan in your area.

* An employer -sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

SECTION 2: NOTICE TO EMPLOYEES

Certain State and Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with all of the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator.

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoptions, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after marriage, birth, adoption or placement for adoption.

SECTION 3: EMPLOYER'S CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) NOTICE

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility —

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447 3739

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
- Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/
State Relay 711

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/publicassistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-weserve/seniors/health-care/health-care-programs/programsand-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website: http://dhs.iowa.gov/ime/members/medicaid-a-toz/hipp
Phone: 1-888-346-9562

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/ombp/nhhpp/
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

NEW JERSEY – Medicaid and CHIP
Medicaid Website:http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/
Medicaid Phone: 1-800-992-0900

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-healthcare/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

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

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

SECTION 4: GENERAL NOTICE OF COBRA RIGHTS

INTRODUCTION

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Burnham & Flower Agency, Inc., and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage
under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hour of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the
Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

SECTION 5:

CREDITABLE COVERAGE. JANET'S & MICHELLE'S LAW

HIPAA also requires any medical program offered by the Employer to provide certificates of creditable coverage to you after you lose coverage under such medical program. This certificate allows you to use your coverage under the medical program to reduce or eliminate any pre-existing condition exclusion period that might otherwise apply to you when you change health care plans. You also may request a certificate of creditable coverage for periods of coverage on and after July 1, 1996, within 24 months of your loss of coverage.

HOW TO REQUEST A CERTIFICATION OF CREDITABLE COVERAGE FROM THIS PLAN:

HIPAA also requires any medical program offered by the Employer to provide certificates of creditable coverage to you after you lose coverage under such medical program. This certificate allows you to use your coverage under the medical program to reduce or eliminate any pre-existing condition exclusion period that might otherwise apply to you when you change health care plans. You also may request a certificate of creditable coverage for periods of coverage on and after July 1, 1996, within 24 months of your loss of coverage. To request a HIPAA Certificate of Creditable Coverage, please contact the insurance company customer service department by calling the phone number on your healthcare identification card.

NOTICE REGARDING NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT (JANET'S LAW)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. Under the Women's Health and Cancer Rights Act, group health plans and insurers offering mastectomy coverage must also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These services are payable to a patient who is receiving benefits in connection with a mastectomy and elects reconstruction. The physician and patient determine the manner in which these services are performed.

The plan may apply deductibles and co-payments consistent with other coverage within the plan. This notice serves as the official annual notice and disclosure of that the fact that the company's health and welfare plan has been designed to comply with this law. This notification is a requirement of the act.

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Services Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

NOTICE REGARDING MICHELLE'S LAW

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans. The dependent child's change in college enrollment must meet the following requirements:

- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law become effective for plan years beginning on or after October 9, 2009.

NOTICE REGARDING CONTINUED ELIGIBILITY FOR DEPENDENT CHILDREN UNTIL AGE 26

As set forth by the PPACA of 2010, effective as of the first day of the first plan year beginning on or after September 23, 2010 dependent coverage is extended for dependent children to the age of 26 (regardless of Grandfathered Status except as noted below). Under the Health Care Reform Act, if the Plan permits an Eligible Employee to enroll his/her Child for coverage under the Plan, the Child must be permitted to continue such coverage until attainment of 26 years of age. The Plan shall not condition a Child's eligibility for dependent coverage on the basis of marital status, financial dependency, residency with the Eligible Employee, student status, employment status, eligibility for other coverage and shall not vary the terms of the Plan based on the age of a Child. You are eligible to enroll your dependents in the Health Plan if:

(i) your dependent was denied coverage, or coverage ended, or was not eligible for coverage due to the dependent provisions previously in place;

(ii) and your dependent is under the age of 26. You may request enrollment for your eligible dependents within 30 days from this notice. For more information contact your Plan Administrator.

With respect to a Plan with Grandfathered Status for all Plan Years prior to January 1, 2014, these Plans may elect to exclude a Child who is eligible to enroll in an employer-sponsored health plan (other than a group health plan of a parent).

NOTICE REGARDING LIFETIME LIMITS

Effective for Plan Years beginning on or after September 23, 2010, the lifetime limits on the dollar amount of benefits for any covered individual under the Plan (regardless of its Grandfathered Status) no longer apply. If your coverage (or your Eligible Dependent's coverage) ended by reason of reaching a lifetime limit under the Plan, you are eligible to re-enroll in the Plan. You will have 30 days from the date of this notice to request enrollment in the Plan and your coverage generally will become effective as of the first day of the Plan Year beginning on or after September 23, 2010
(even if your timely request for enrollment within the 30-day period is made after the first day of the Plan Year).

NOTICE REGARDING PATIENT PROTECTION RIGHTS

One of the provisions in the PPACA of 2010 is for plans and insurers that require or allow for the designation of primary care providers by participants to inform the participants of their rights beginning on the first day of the first plan year on or after September 23, 2010. You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals or notifying primary care provider or Plan of treatment decisions. If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology health care professionals, please contact the insurer.

MEDICARE NOTICE

You must notify your employer when you or your dependents become Medicare eligible. Your employer is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other then the Medicare beneficiary or their legal guardian. The toll free number to Medicare Coordination of Benefits 1-800-999-1118.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Non-Creditable Coverage Notice.

SECTION 6:

PRESCRIPTION DRUG COVERAGE AND MEDICARE

If you are covered by Medicare 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. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage.

IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please note that the following notice only applies to individuals who are eligible for Medicare. Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to End Stage Renal Disease (ESRD)

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. The Plan has determined that the prescription drug coverage offered by The Plan Benefits 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 through 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 coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage.

If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the 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 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 November to join.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

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

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

SECTION 7: STATE SPECIFIC INFORMATION

Effective October 15, 2012 mandates treatment of autism spectrum disorders until age 19 (treatment may continue past age 19 where shown medically necessary) for fully insured plans. Treatment applies to Autistic Disorder, Asperger's Disorder and Pervasive Development Disorder not otherwise specified and has an annual benefit limit of $50,000. Please see your insurance certificate or Summary of Benefits and Coverage for more details.

SECTION 8: INSURANCE DEFINITIONS

CARRIER: The insurance company.

CLAIM: The request for payment for benefits received in accordance with an insurance policy.

COPAY: A co-payment, or copay, is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

COINSURANCE: A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

DEDUCTIBLE: A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using out of network providers. EOB (Explanation of Benefits): EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it be payment, denial, or pending) to a medical claim processed on your behalf.

HMO: Health Maintenance Organization, this type of medical plan is Network exclusive. A participant must receive services from in-network providers except in a case of medical emergency.

IN NETWORK: Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

MAIL ORDER PRESCRIPTIONS: Used as an alternative to retail pharmacies, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.

MAINTENANCE DRUGS: A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma.

MAXIMUM OUT OF POCKET: The total amount a covered person must pay before his or her benefits are paid at 100%. Depending on the policy, it may or may not include charges applied to the deductible and copays.

MAXIMUM OUT OF POCKET: The total amount a covered person must pay before his or her benefits are paid at 100%. Depending on the policy, it may or may not include charges applied to the deductible and copays.

OPEN ENROLLMENT: Designated period of time during which an employee may enroll in group health coverage. Also, designated period of time during the year when individuals without group coverage may enroll in health coverage without needing medical underwriting.

OUT OF NETWORK: The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverage can go out-of-network, but will pay higher out-of-pocket costs.

PARTICIPATING PROVIDER: Individual physicians, hospitals and professional health care providers who have a contract to provide services to its members at a discounted rate and to be paid directly for covered services.

PCP (PRIMARY CARE PHYSICIAN): A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist or pediatrician. PPO: Benefits paid for both in and out of a network of doctors. Member makes choice with knowledge that better benefits are available in network. Plans feature office visit copays, deductibles at a variety of levels and then coinsurance to a maximum out of pocket expense. Usually includes copays for prescription drugs.

PREVENTATIVE CARE: Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

REFERRAL: A written recommendation by a physician that a member may receive care from a specialty physician or facility.

SPECIALIST: A participating physician who provides non-routine care, such as a dermatologist or orthopedist.

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