

Benefits & Enrollment Guide

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Kalamazoo, MI 49007
800.748.0554



Charter Township of
Comstock

Effective Date: November 1, 2023



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PLAN OVERVIEW

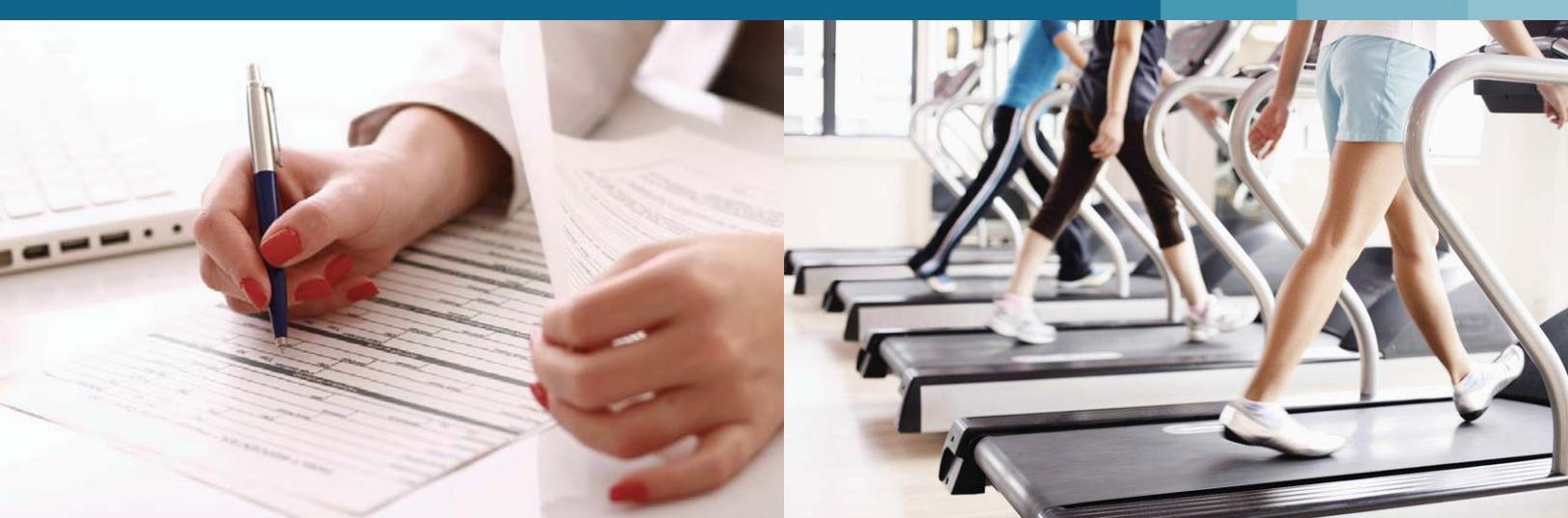
Coverage	Insurance Company
Medical & Rx	Blue Cross Blue Shield
Dental	Blue Cross Blue Shield
Vision	Blue Cross Blue Shield
Life AD&D	MedMutual Life
Short Term Disability	Mutual of Omaha
Long Term Disability	Mutual of Omaha

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

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

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 Deductible Health Plan, you should contact your accountant regarding the IRS approved use of HSA funds and the tax consequences for misuse.

LEGAL DISCLOSURE: This booklet is intended for illustrative and information purposes only. The plan documents, insurance certificates and policies will serve as the governing documents. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern.



ENROLLMENT GUIDE

OPEN ENROLLMENT

Enrollment is only available from **October 1, 2023 through October 31, 2023**. 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 **on your date of hire**. 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

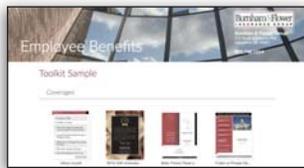
- **Legal Spouse**, as defined by Federal Law;
- **Children** (natural, adopted, step-children or legal guardianship) up to age 26 regardless of marital status, financial dependency, residency with the Eligible Employee, student status, employment status, or eligibility for other coverage. Note: Some carriers cover dependents through the end of the calendar year that they turn 26.

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://www.bftoolkit.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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COBRA Administration

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.

EXPLANATION OF BENEFITS (EOB)

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.





Confidence comes with every card.*



know. compare. choose.

How to activate your online Blue Cross member account

Enjoy the convenience — and freedom — you get with your account:

-  Check your balance and plan's benefits.
-  Track your claims and explanation of benefits statements.
-  Find care and look up costs.
-  Get answers fast to questions about your plan with MIBlue Virtual AssistantSM, an interactive, automated chat feature.
-  Show your member ID card, and order more for family members on your plan.

Plus, you can get member discounts, health and well-being resources and more.

ACTIVATE YOUR ACCOUNT IN ONE OF THREE WAYS:

Go online.

1. Go to bcbsm.com/register and select *Register Now*.
2. Once your account is activated, you can set up one for each of your dependents.

Use our app.

1. Download the app from the App Store[®] or Google Play[™] (search **BCBSM**).
2. Tap the  app and then *Register*.

Text us.

Text **REGISTER** to **222764** to start setting up your account.*

*Message and data rates may apply. Visit bcbsm.com for our *Terms and Conditions of Use* and *Privacy Practices*.

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Blue Cross Online Visits™



Virtual care that's always there

Convenient and affordable medical and behavioral health care you can trust

With Blue Cross Online VisitsSM, you and everyone on your health care plan can get virtual medical and behavioral health care on your smartphone, tablet or computer.

Blue Cross Online Visits are included with your Blue Cross health care plan.

MEDICAL

Have a virtual visit with a U.S. board-certified doctor or nurse practitioner for minor illnesses such as colds, sore throats, urinary tract infections and pink eye. And, it's easy to find providers who specialize in children with the *Children's Medical* feature.

Medical visits are available 24/7, anywhere in the U.S., when your primary care provider isn't available. You don't need an appointment and the average wait time to see a provider is five minutes. Prescriptions, if needed, can be sent to your preferred pharmacy.

BEHAVIORAL HEALTH

Through the *Therapy* and *Psychiatry* options, you can connect with a licensed therapist or U.S. board-certified psychiatrist when you're dealing with stressful situations or issues such as grief, anxiety or depression.

An appointment is needed for virtual behavioral health visits. Many providers offer extended hours, including nights and weekends.

Start a visit or sign up today
Download the BCBSM Online VisitsSM app
or visit bcbsmonlinevisits.com

Family members ages 18 and older will need to create their own accounts. When updating or creating your account, choose your plan name and enter your enrollee ID so your coverage is applied correctly. Call 1-844-606-1608 with any questions about your account.

Remember to follow up with your primary care provider. Your plan may have copayments, deductibles and out-of-pocket costs.



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REGISTER YOUR MEMBER ACCOUNT TODAY

To earn its benefits, you'll need a Blue Cross online member account.

Blue Cross RewardsSM is an innovative solution built right into your online member account. You can earn as much as \$550 per family member when you shop for non-emergency health services like a CT scan, mammogram, MRI or colonoscopy.

After you've completed your service at a cost-effective provider location and your claim is processed, you'll be eligible for an e-gift card for Amazon, Home Depot, Target, and many more stores ranging from \$25 to \$75 depending on the service rendered.

Sign up today.

IT'S TIME YOU WERE REWARDED.

An online account also allows you to:

- ✓ Access your health care information from your computer or mobile device.
- ✓ Check your coverage, out-of-pocket balance and claims.
- ✓ Find doctors, hospitals and specialists in your network.
- ✓ Get discounts on health-related products and services.

You'll need your Blue Cross member ID in hand to get started.

Getting started with Blue Cross Rewards is easy. If you don't have a registered online member account, go to bcbsm.com/get-rewards to get started.

Or, use our app.

1. Download the app on the App Store® or Google Play™ (search for BCBSM).



2. Tap the  app icon.

3. Tap *Register* and follow the instructions.

Blue Cross RewardsSM is available to the subscriber and dependents in households that have Blue Cross Blue Shield of Michigan as their primary health care provider.

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Google Play and the Google Play logo are trademarks of Google LLC.

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Save money and live healthier with Blue365[®]



Membership has its benefits

Blue Cross Blue Shield of Michigan and Blue Care Network members can score big savings on a variety of health-related products and services from businesses in Michigan and across the United States.

We've got plenty of deals to keep you and your family healthy.

Member discounts with Blue365 offers exclusive deals on things like:

- **Fitness and wellness:** Health magazines, fitness gear and gym memberships
- **Healthy eating:** Cookbooks, cooking classes and weight-loss programs
- **Lifestyle:** Travel and recreation
- **Personal care:** Lasik and eye care services, dental care and hearing aids

Cash in on discounts

Start saving today! Show your Blue Cross or Blue Care Network ID card at participating local retailers or use an offer code online to take advantage of these savings. For a full list of discount offers, log in or register at bcbsm.com and click *Member Discounts with Blue365[®]* on your home page. You can also conveniently access discounts on the go with the Blue Cross mobile app. Search **BCBSM** in Google Play™ or the App Store® to download our mobile app.

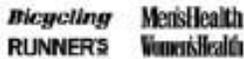


Blue365.

Because health is a big deal™

Member discounts with Blue365

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



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



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

Program information valid as of August 2018.

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
Blue Shield
Blue Care Network
of Michigan

Confidence comes with every card.®

Get access to top gyms, studios and well-being apps starting at only \$19.99 a month.



Blue Cross Blue Shield of Michigan and Blue Care Network members can receive exclusive pricing for **Gympass** through our member discount program, Blue365®.

Gympass offers multiple membership options, allowing you to choose a plan that fits your fitness needs. Memberships include access to:

- Up to 12,000 gyms and studios nationwide
- Live-streamed and on-demand classes
- One-on-one personal training sessions with certified trainers
- Online mental health support, nutrition guidance, meditation apps and more

One membership. Unlimited ways to achieve your health goals.

Gympass offers flexibility, allowing you to customize your well-being routine. Visit a different gym every day of the week or stick with your favorite. Try a therapy session in the afternoon or a meditation session before bed.

Gympass gives you more ways to enjoy the activities you love.

Ready to enroll?

1. Log in to your Blue Cross member account at bcbsm.com or the Blue Cross mobile app.
2. From bcbsm.com, click *Member Discounts with Blue365®* near the bottom of your homepage to link to the Blue365 deals site.
3. From the Blue Cross mobile app, tap the menu icon (=), then *Discounts* to link to the Blue365 deals site.
4. Search for the **Gympass** offer under *Fitness*.
5. Click *Verify Eligibility* to be directed to the **Gympass** home page.

Membership options ➔

Flexible membership options

We understand that everyone's fitness journey is unique and personal. Enroll in the membership option that meets your specific fitness needs.

Tier	Monthly fee	Benefits	Sample fitness network*
Starter	\$19.99	1,000-plus gyms, studios and live classes, plus 20 partner apps	Snap Fitness, Anytime Fitness, Strava and Calm
Basic	\$29.99	3,000-plus gyms, studios and live classes, plus 30 partner apps	Life Time, Curves, Powerhouse Gym – East Lansing and Powerhouse Gym – Kalamazoo
Bronze	\$59.99	3,600-plus gyms, studios and live classes, plus 35 partner apps	Life Time, Cascade Athletic Clubs, Chicago Athletic Club and Yogaworks
Silver	\$89.99	7,300-plus gyms, studios and live classes, plus 35 partner apps	Life Time, Crossfit in the D, D1 Training Grand Rapids, TITLE Boxing Club and Healing Clouds
Gold	\$169.99	10,000-plus gyms, studios and live classes, plus 35 partner apps	F45, Crossfit, CITYROW and iFeel
Platinum	\$249.99	12,000-plus gyms, studios and live classes, plus 35 partner apps	The Daily Method, SLT and JoyRide Studio
Diamond	\$349.99	12,400-plus gyms, studios and live classes, plus 35 partner apps	Barry's Bootcamp and solidcore
All plans include eight personal training sessions per month			

There are no enrollment or cancellation fees. You must be 18 years or older to enroll.

*Gym participation varies by location. To confirm gyms and resources available under each membership tier, click **VERIFY ELIGIBILITY** from the Gympass offer page on the Blue365 deals site. Once the form is completed, you'll be linked to the **Gympass** site for more information.



Visit the Blue365 deals site through your Blue Cross member account for complete terms and conditions for the Gympass offer. Blue365 is brought to you by the Blue Cross and Blue Shield Association, an association of independent, locally operated Blue Cross and Blue Shield plans. Gympass is an independent company that has partnered with the Blue Cross and Blue Shield Association to offer discounted gym memberships. Value-added items and services are not a part of your insurance benefits and are not covered under contracts with Medicare or any other applicable federal health care program. For complete terms and conditions see www.blue365deals.com/terms-use.

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A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Simply BlueSM HSA PPO Gold \$3000 0% with Rx Drug Simply Blue PPO HSASM SG with Rx 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. If your group is self-funded, please see any other plan documents your group uses. 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 diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

BV-PEDS;EA SG;SBD HSA-E SG

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association. 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. 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.
Simply BlueSM HSA PPO Gold \$3000 0% with Rx Drug, Rev Date 23 Q1 V1

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.

Benefits	In-network	Out-of-network
Deductibles Note: Your deductible combines deductible amounts paid under your Simply Blue HSA medical coverage and your Simply Blue prescription drug coverage.	\$3,000 per member, \$6,000 for the family (when two or more members are covered under your contract) (no 4th quarter carry-over)	\$6,000 per member, \$12,000 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.	<ul style="list-style-type: none"> 50% of approved amount for bariatric surgery 	<ul style="list-style-type: none"> 20% of approved amount for most other covered services 50% of approved amount for bariatric surgery
Annual out-of-pocket maximums - applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	\$6,000 per member, \$12,000 for the family (when two or more members are covered under your contract)	\$12,000 per member, \$24,000 for the family (when two or more members are covered under your contract)
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
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
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 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 the 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) <p>Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.</p>	80% after out-of-network deductible <p>Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.</p>
		One per member per calendar year
Routine screening colonoscopy	100% (no deductible or copay/coinsurance), for routine colonoscopy <p>Note: Medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.</p>	80% after out-of-network deductible
		One routine colonoscopy per member per calendar year

Physician office services		
Benefits	In-network	Out-of-network
Office visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Online visits - by physician must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Note: Online visits by a non-BCBSM selected vendor are not covered.		
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

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Benefits	In-network	Out-of-network
Office consultations - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
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

Benefits	In-network	Out-of-network
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

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	100% after in-network deductible	80% after out-of-network deductible

Unlimited days

Note: Nonemergency services must be rendered in a **participating** hospital.

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

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Simply BlueSM HSA PPO Gold \$3000 0% with Rx Drug, Rev Date 23 Q1 V1

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	100% after in-network deductible	100% after in-network deductible Limited to a maximum of 90 days per member per calendar year
Hospice care	100% after in-network deductible	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: <ul style="list-style-type: none"> must be medically necessary must be provided by a participating home health care agency 	100% after in-network deductible	80% after in-network deductible
Infusion therapy: <ul style="list-style-type: none"> 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	80% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
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	100% after in-network deductible	80% after out-of-network deductible
Note: For voluntary sterilizations for females, see " Preventive care services. "		
Elective abortions	100% after in-network deductible	80% after out-of-network deductible
Bariatric surgery	50% after in-network deductible	50% after out-of-network deductible

Limited to a **lifetime** maximum of one bariatric procedure per member

Human organ transplants

Benefits	In-network	Out-of-network
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
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	100% after in-network deductible	80% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

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Simply BlueSM HSA PPO Gold \$3000 0% with Rx Drug, Rev Date 23 Q1 V1

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance treatment	100% after in-network deductible	80% after out-of-network deductible
Unlimited days		
Residential psychiatric treatment facility: <ul style="list-style-type: none"> covered mental health services must be performed in a residential 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: <ul style="list-style-type: none"> Facility and clinic 	100% after in-network deductible	100% after in-network deductible in participating facilities only
<ul style="list-style-type: none"> Online visits <p>Note: Online visits by a non-BCBSM selected vendor are not covered</p>	100% after in-network deductible	80% after out-of-network deductible
<ul style="list-style-type: none"> 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

Benefits	In-network	Out-of-network
Applied behavior analysis (ABA) treatment - when rendered by an approved licensed behavior analyst - subject to preauthorization	100% after in-network deductible	100% after in-network deductible
<p>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.</p>		
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible	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

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)	100% after in-network deductible	80% after out-of-network deductible
<p>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 a network provider.</p>		
<p>Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p>		

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Benefits	In-network	Out-of-network
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.
• Chiropractic and osteopathic manipulation	100% after in-network deductible	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 <u>combined</u> 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	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	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 <u>combined</u> maximum for all outpatient visits for physical and occupational therapy
Outpatient speech therapy - when provided for habilitative care	100% after in-network deductible	80% after out-of-network deductible Limited to a 30-visit maximum per member per calendar year
Durable medical equipment Note: Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. 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	80% after out-of-network deductible
Prosthetic and orthotic appliances Note: Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	100% after in-network deductible	80% after out-of-network deductible
Private duty nursing care	Not covered	Not covered

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Simply BlueSM HSA PPO Gold \$3000 0% with Rx Drug 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 Pharmacy, 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 Pharmacy will handle mail order prescriptions only for specialty drugs. You may obtain specialty drugs through a Walgreens retail pharmacy as well as long as the drug is available at that location. You may want to call ahead to confirm availability at the location. **If you go to a non-AllianceRx Walgreens Pharmacy, you may be responsible for 100% of the cost of the specialty drug.** Other mail order prescription medications can continue to be sent to the OptumRx home delivery pharmacy. (OptumRx 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 Pharmacy 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
Generic drugs	1 to 30-day period	After deductible, you pay \$15 copay	After deductible, you pay \$15 copay	After deductible, you pay \$15 copay	After deductible, you pay \$15 copay plus an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible, you pay \$30 copay	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible, you pay \$35 copay	No coverage	No coverage
	84 to 90-day period	After deductible, you pay \$35 copay	After deductible, you pay \$35 copay	No coverage	No coverage

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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
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 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
Nonpreferred brand-name drugs	1 to 30-day period	After deductible, you pay \$100 copay	After deductible, you pay \$100 copay	After deductible, you pay \$100 copay	After deductible, you pay \$100 copay plus an additional 20% of BCBSM approved amount for the drug
	31 to 60-day period	No coverage	After deductible, you pay \$200 copay	No coverage	No coverage
	61 to 83-day period	No coverage	After deductible, you pay \$290 copay	No coverage	No coverage
	84 to 90-day period	After deductible, you pay \$290 copay	After deductible, you pay \$290 copay	No coverage	No coverage
Generic and preferred brand-name specialty drugs	1 to 30-day period	After deductible, you pay 20% of approved amount, but no more than \$200	After deductible, you pay 20% of approved amount, but no more than \$200	After deductible, you pay 20% of approved amount, but no more than \$200	After deductible, you pay 20% of approved amount, but no more than \$200 plus an additional 20% of 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
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

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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
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy .	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

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

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Features of your prescription drug plan

BCBSM Custom Select Drug List	<p>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.</p> <ul style="list-style-type: none"> ● Generic drug tier - This tier 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/coinsurance, making them the most cost-effective option for the treatment. ● Preferred brand-name drug tier - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive than generic and members pay more for them ● Nonpreferred brand-name drug tier - This tier includes non-specialty brand-name drugs for which there's either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs. ● Generic and preferred specialty drug tier - This tier includes generic and preferred brand-name specialty drugs that are used to treat difficult health conditions. These drugs are generally more cost-effective than nonpreferred specialty drugs. ● Nonpreferred specialty drug tier - This tier includes nonpreferred brand-name, specialty drugs that are used to treat difficult health conditions. Members pay more for nonpreferred specialty drugs because there are cost-effective generic or preferred drugs available.
Prior authorization/step therapy	<p>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.</p>
Quantity limits	<p>To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.</p>
Exclusions	<p>The following drugs are not covered:</p> <ul style="list-style-type: none"> ● 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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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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Blue DentalSM PPO 100/80/50 (80/50/50) \$1000(\$800) Dental 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. If your group is self-funded, please see any other plan documents your group uses. 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 18 years of age or younger on the group's renewal date. They will receive pediatric dental benefits up to the group's renewal date after they turn age 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 438,000 dentist locations² 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**.

¹Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.

²A 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.

Blue Par SelectSM 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, coinsurance 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 members, \$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 • Class II services • Class III services • Class IV services	None (covered at 100%) 20% 50% Not covered	20% 50% 50% Not covered
Dollar maximums • Annual maximum for Class I, II and III services • Lifetime maximum for Class IV services	Combined \$1,000 per non-pediatric member per calendar year (no more than \$800 of this amount can be used for services rendered by non-PPO dentists). The annual benefit maximum does not apply to pediatric members. Not applicable	Not applicable

Benefits	In-network	Out-of-network
Out-of-pocket maximum <ul style="list-style-type: none"> 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. 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	12 months for Class III 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 periods 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 periods.	

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
Diagnostic and preventive services: <ul style="list-style-type: none"> Routine oral examinations/evaluations - twice per calendar year 	100% of approved amount	80% of approved amount
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Fluoride treatments - twice per calendar year for pediatric members only 	100% of approved amount	80% of approved amount
<ul style="list-style-type: none"> Topical fluoride varnish for moderate- to high-risk caries patients - four times per calendar year for members age 3 and younger only and two times per calendar year for members age 4 to 14 only in combination with fluoride treatments <p>For example, two fluoride treatments or two topical fluoride varnishes, or one fluoride treatment and one topical fluoride varnish are payable in a calendar year for high-risk members between the ages of 4 and 14. However, two fluoride treatments and two topical fluoride varnishes are not payable for these members.</p>	100% of approved amount	80% of approved amount
<ul style="list-style-type: none"> Dental sealants - once per tooth per 36 months for first and second permanent molars for pediatric members only 	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
Diagnostic and preventive services: <ul style="list-style-type: none"> Diagnostic tests and laboratory examinations 	80% of approved amount after deductible	50% of approved amount after deductible
<ul style="list-style-type: none"> Space maintainers - once per quadrant per lifetime for missing posterior primary teeth for pediatric members only (recementation of a space maintainer is payable three times per quadrant per lifetime) 	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: <ul style="list-style-type: none"> 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

Benefits	In-network	Out-of-network
<ul style="list-style-type: none"> 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
Adjunctive general services:	80% of approved amount after deductible	50% of approved amount after deductible
<ul style="list-style-type: none"> General anesthesia or IV sedation 	80% of approved amount after deductible	50% of approved amount after deductible
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Office visits after regularly scheduled hours 	80% of approved amount after deductible	50% of approved amount after deductible
<ul style="list-style-type: none"> House and hospital calls for non-pediatric members only 	80% of approved amount after deductible	50% of approved amount after deductible
<ul style="list-style-type: none"> Antibiotic injections for non-pediatric members only 	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, 2017, the last date of the waiting period will be December 31, 2017, with benefits becoming active on January 1, 2018. 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	Coverage	Coverage
Major restorative services:	50% of approved amount after deductible	50% of approved amount after deductible
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> 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
Surgical exposure and facilitation of eruption of unerupted teeth	50% of approved amount after deductible	50% of approved amount after deductible
<ul style="list-style-type: none"> Extractions and surgical removal of non-impacted teeth 	50% of approved amount after deductible	50% of approved amount after deductible
<ul style="list-style-type: none"> Incision and drainage of cellulitis or fascial space abscesses of intraoral soft tissue 	50% of approved amount after deductible	50% of approved amount after deductible
<ul style="list-style-type: none"> Removal of exostoses (excess bony growths of the upper and lower jaw) 	50% of approved amount after deductible	50% of approved amount after deductible
<ul style="list-style-type: none"> Excision of hyperplastic tissue per arch 	50% of approved amount after deductible	50% of approved amount after deductible
<ul style="list-style-type: none"> Soft tissue biopsies for pediatric members only 	50% of approved amount after deductible	50% of approved amount after deductible
<ul style="list-style-type: none"> Frenulectomies 	50% of approved amount after deductible	50% of approved amount after deductible
Endodontic services:	50% of approved amount after deductible	50% of approved amount after deductible
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Therapeutic pulpotomies or pulpal debridement 	50% of approved amount after deductible	50% of approved amount after deductible
<ul style="list-style-type: none"> Vital pulpotomies on primary teeth 	50% of approved amount after deductible	50% of approved amount after deductible
<ul style="list-style-type: none"> 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

Benefits	Coverage	
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 andgingivoplasties	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
Prosthetic 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		
Benefits	In-network	Out-of-network
Orthodontics and related services	Not covered	Not covered



**Blue Cross
Blue Shield
of Michigan**

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Blue VisionSM 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		



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Vision Coverage (Pediatric) Benefits-at-a-glance Effective for groups on their plan year

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 members up to age 19. 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	None	None
Prescription glasses (lenses and/or frames)	None	None
Medically necessary contact lenses	None	None

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.	100% of approved amount	Reimbursement up to \$34 (member responsible for any difference)
One eye exam per 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	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
One pair of lenses, with or without frames, per calendar year		
Standard frames from a "select" collection	100% of approved amount	Reimbursement up to \$38.25 (member responsible for any difference)
One frame per calendar year		

BV-PEDS;EA SG;SBD HSA-E SG

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

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)	100% of approved amount	Reimbursement up to \$210 (member responsible for any difference)
	Covered - annual supply	
Standard (one pair annually) <ul style="list-style-type: none"> • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply) 	100% of approved amount	\$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Covered according to quantities outlined in your certificate, per calendar year	

BV-PEDS;EA SG;SBD HSA-E SG

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

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: <ul style="list-style-type: none"> • 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.



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.

Available Services When You Need Help the Most



Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done.

Learn more about the Employee Assistance Program services available to you.

— We are here for you —

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap

Enhanced EAP Services

Features	Value to Company and Employees
Employee Family Clinical Services	<ul style="list-style-type: none"> An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters Access to subject matter experts in the field of EAP service delivery
Counseling Options	<ul style="list-style-type: none"> Three sessions per year (per household) conducted by either face-to-face* counseling or video
Exclusive Provider Network	<ul style="list-style-type: none"> National network of more than 10,000 licensed clinical providers Network continually expanding to meet customer needs Flexibility to meet individual client/member needs

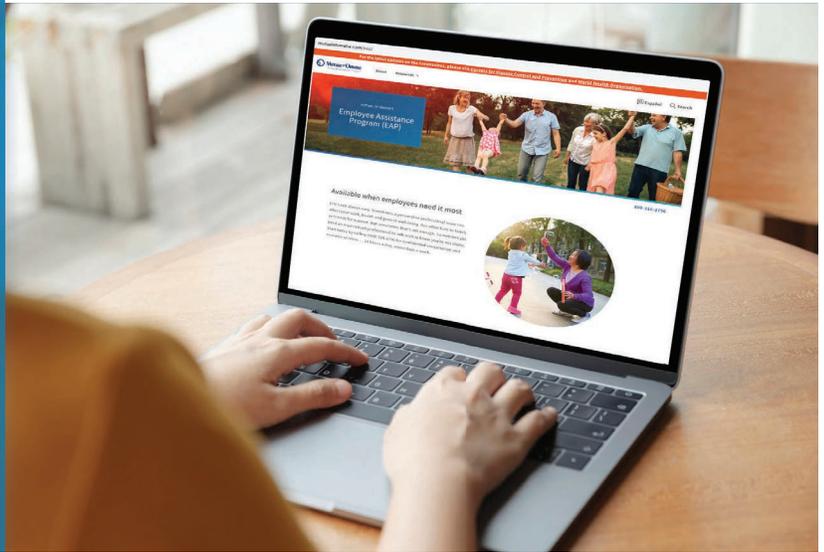
*California Residents: Knox-Keene Statute limits no more than three face-to-face sessions in a six-month period per person.

Continued on back.

Enhanced EAP Services *(continued)*

Features	Value to Company and Employees
Access	<ul style="list-style-type: none"> ▪ 1-800 hotline with direct access to a Master’s level EAP professional ▪ 24/7/365 services available ▪ Telephone support available in more than 120 languages ▪ Online submission form available for EAP service requests ▪ EAP professionals will help members develop a plan and identify resources to meet their individual needs
Employee Family Legal Services	<ul style="list-style-type: none"> ▪ Valuable resources – legal libraries, tools and forms – available on EAP website ▪ A counseling session may be substituted for one legal consultation (up to 30 minutes) with an attorney ▪ 25% discount for ongoing legal services for same issue
Employee Family Financial Services	<ul style="list-style-type: none"> ▪ Inclusive financial platform powered by Enrich that includes financial assessment tools, personalized courses, articles and resources, and ongoing progress reports to help members monitor their financial health ▪ A counseling session may be substituted for one financial consultation (up to 30 minutes) with an attorney ▪ 25% discount for ongoing financial services for same issue
Employee Family Work/Life Services	<ul style="list-style-type: none"> ▪ Child care resources and referrals ▪ Elder care resources and referrals
Online Services	<ul style="list-style-type: none"> ▪ An inclusive website with resources and links for additional assistance, including: <ul style="list-style-type: none"> ▪ Current events and resources ▪ Family and relationships ▪ Emotional well-being ▪ Financial wellness ▪ Substance abuse and addiction ▪ Legal assistance ▪ Physical well-being ▪ Work and career ▪ Bilingual article library
Employee Communication	<ul style="list-style-type: none"> ▪ All materials available in English and Spanish
Eligibility	<ul style="list-style-type: none"> ▪ Full-time employees and their immediate family members; including the employee, spouse and dependent children (unmarried and under 26) who reside with the employee
Coordination with Health Plan(s)	<ul style="list-style-type: none"> ▪ EAP professionals will coordinate services with treatment resources/providers within the employee’s health insurance network to provide counseling services covered by health insurance benefits, whenever possible

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.

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



This is not health insurance. Financial Wellness tools are offered through igrad. Although Mutual of Omaha Insurance Company (Mutual of Omaha) makes Enrich's services available to EAP customers, the use of Enrich's services is entirely voluntary. Mutual of Omaha does not provide, are not responsible for, do not assume an liability for and do not guarantee the accuracy, adequacy or results of any service, advice or documents provided by Enrich. Mutual of Omaha is not responsible and do not assume liability for any disclosure of personal data or information by Enrich. Services are only available to EAP customers of Mutual of Omaha.

Your Hearing Discount Program



Program Benefits - In addition to your hearing care benefit, you will have access to complimentary aftercare*, including:

- ✓ **Custom hearing solutions** — wide choice of products from the industry’s leading brands
- ✓ **Risk-free trial** — find your right fit by trying your hearing aids for 60 days
- ✓ **Follow-up care** — ensures a smooth transition to your new hearing aids
- ✓ **Battery support** — battery supply or charging station to keep your hearing aids powered
- ✓ **Warranty** — 3-year coverage for loss, repairs, or damage
- ✓ **Financing** — no interest for those who qualify
- ✓ **Savings for family and friends** — your parents, siblings, in-laws, and friends qualify, too

***Risk-free trial** - 100% money back guarantee if not completely satisfied, no return or restocking fees. Follow-up care - for one year following purchase. Batteries - two year supply of batteries (80 cells/ear/year) or one standard charger at no additional cost. Warranty - Exclusions and limitations may apply. Contact Client Services (1-844-267-5436) for details.

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.

	Level 1	Level 2	Level 3	Level 4	Level 5
Hearing Aid Features	Standard features	Additional, easy-to-use functions	Designed for work and play	Enhanced to keep you on the go	Leading technology keeps you connected
One Simple Price	\$995	\$1,495	\$1,795	\$2,195	\$2,645



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.

Worldwide Travel Assistance That Travels With You



Take comfort in knowing that Travel Assistance* travels with you worldwide, offering access to a network of professionals who can help you with local medical referrals or provide other emergency assistance services in foreign locations.

Enjoy Your Trip - We'll Be There If You Need Us - 24/7

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. For you, your spouse and dependent children on any single trip, up to 120 days in length, more than 100 miles from home.

Pre-trip Assistance**

Minimize travel hassles by calling us pre-departure for:

- Information regarding passport, visa or other required documentation for foreign travel
- Travel, health advisories and inoculation requirements for foreign countries
- Domestic and international weather forecasts
- Daily foreign currency exchange rates
- Consulate and embassy locations

*Brought to you by Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175. Services provided by AXA Assistance USA (AXA)

**Available at any time, not subject to 100 mile travel radius

452632

Emergency Travel Support Services

- Telephonic translation and interpreter services - 24/7 access to telephone translation services
- Locating legal services - referrals for local attorney or consular offices and help maintain business and family communications until legal counsel is retained (includes coordination of financial assistance for bonds/bail)
- Baggage - assistance with lost, stolen or delayed baggage while traveling on a common carrier
- Emergency payment and cash - assistance with advance of funds for medical expenses or other travel emergencies by coordinating with your credit card company, bank, employer, or other sources of credit; includes arrangements for emergency cash from a friend, family member, business or credit card
- Emergency messages - assistance with recording and retrieving messages between you, your family and/or business associates at any time
- Document replacement - coordination of credit card, airline ticket or other documentation replacement
- Vehicle return - if evacuation or repatriation is necessary, return your unattended vehicle to the car rental company



WORLDWIDE TRAVEL ASSISTANCE

Services available for business and personal travel.

For inquiries within the U.S. call toll free:

1-800-856-9947

Outside the U.S. call collect:

(312) 935-3658



WORLDWIDE TRAVEL ASSISTANCE

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Medical Assistance

- Locating medical providers and referrals
- Communication on your medical status with family, physicians, employer, travel company and consulate
- Emergency evacuation if adequate medical facilities are not available, including payment of covered expenses
- Transportation home for further treatment - in the event of death, assist in the return of mortal remains
- Transportation arrangements for the visit of a family member or friend if your hospitalization is more than seven calendar days
- Return home for dependent children if your hospitalization is more than seven calendar days
- Assistance with lodging arrangements if convalescence is needed prior to, or after, medical treatment
- Coordination with your health insurance carrier during a medical emergency
- Assistance obtaining prescription drugs or other necessary personal medical items

Identity Theft

Your Travel Assistance benefit automatically includes Identity Theft Assistance, coordinated at no additional cost. Whether at home or traveling, this benefit provides education, prevention and recovery information to help you protect your identity.

Education and Prevention

- Comprehensive ID theft assistance guide
- Tips to defend against ID theft

Recovery Information

- Information regarding the steps to recover from credit card and check fraud

- Guidelines if your Social Security number is compromised
- Instructions for lost or stolen passport
- Contact list for financial institutions, credit bureaus and check companies

Assistance

If you need help with an ID theft issue, case managers are available 24 hours a day, seven days a week and can be reached by calling the same toll-free number used to contact AXA: 800-856-9947.

Travel Assistance Plan Limitations

AXA will not pay emergency evacuation, medically necessary repatriation, repatriation of remains or other expenses incurred while traveling within 100 miles of participant's place of residence, or for any one of the following reasons:

- A single trip lasts more than 120 days in length
- Traveling against the advice of a physician
- Traveling for medical treatment
- Pregnancy and childbirth (exception: complications of pregnancy)

There is a maximum benefit amount per person associated with emergency evacuation, medical repatriation and/or return of mortal remains.

All additional costs would be the responsibility of the member. This includes medical costs which are the responsibility of the person receiving medical services. Services must be authorized and arranged by AXA Assistance USA, Inc. designated personnel to be eligible for this program. No reimbursement claims for out-of-pocket expenses will be accepted.

Travel assistance services are independently offered and administered by AXA Assistance USA, Inc. (AXA). Insurance benefits provided as part of Travel Assistance underwritten by a third party. AXA is not affiliated in any way with Mutual of Omaha companies. Each company is responsible for its own financial and contractual obligations. There may be times when circumstances beyond AXA Assistance USA's control hinder its endeavors to provide services. AXA Assistance USA will make all reasonable efforts to help you resolve the emergency situation. Both companies are responsible for their own contractual and financial obligations.



Carry this card with you
when you travel

Brought to you by Mutual of Omaha.
Services provided by AXA Assistance USA.



Carry this card with you
when you travel

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Services provided by AXA Assistance USA.



Will Preparation Services

Services provided by Epoq, Inc.



Create your will at
www.willprepservices.com
and use the code MUTUALWILLS
to register

Creating a will is an important investment in your future. It specifies how you want your possessions to be distributed after you die. Whether you're single, married, have children or are a grandparent, your will should be tailored for your life situation.

That's why it's good you have access to FREE online will preparation services provided by Epoq, Inc. (Epoq).

Easy, Free and Secure

Epoq offers a secure account space that allows you to prepare wills and other legal documents. Create a will that's tailored to your unique needs from the comforts of your own home.

Epoq provides the following FREE documents:

- Last Will and Testament
- Power of Attorney
- Healthcare Directive
- Living Trust

Here's how it works:

- Log on to www.willprepservices.com and use the code MUTUALWILLS to register
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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/nhhipp/>
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://dhcfnv.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](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 than 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.

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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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