This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.
Welcome To Open Enrollment

OPEN ENROLLMENT FOR BENEFIT PLAN YEAR 01/01/2020—12/31/2020

Each year, during the Open Enrollment Period, you will have the opportunity to enroll in or make changes to your benefit elections and dependents without a qualifying event. Please take the time to review all of the plan options carefully to determine which plan options meet the anticipated needs of you and your family. Once you have made your elections, you will not be able to change them until the next Open Enrollment Period, unless you experience a qualifying event.

Open Enrollment Dates: November 18th—December 6th

MAKING CHANGES TO YOUR BENEFITS DURING THE PLAN YEAR (QUALIFYING EVENT)

As a reminder, the Open Enrollment Period is your opportunity to make changes to your coverage. You cannot make changes to your coverage during the benefits plan year unless you experience a change in family status, such as:

- Loss or gain of coverage through your spouse.
- Loss of eligibility of a covered dependent.
- Death of your covered spouse or child.
- Birth or adoption of a child.
- Marriage, divorce, or legal separation.
- Switch from part-time employment to full-time employment.

If you do not make changes within 30 days of the ‘qualifying event,’ you must wait until the following Open Enrollment Period.

TABLE OF CONTENTS

Contact Information Page 2
Medical Benefit Summary Page 4
SBC Uniform Glossary Page 20
Health Bridge Information Page 26
BCBS Information Page 35
FSA/HSA Information Page 40
Notices Page 42
QUESTIONS?

Because the world of healthcare and insurance can be confusing and hard to navigate, we are pleased to introduce your Account Manager at Brown & Brown who will be able to assist you with all things related to your benefits. Your Account Manager will be working in conjunction with the Human Resources Department so that benefit needs are addressed in a timely fashion.

B&B Account Manager:  
Angela Garner  
(989) - 399 - 0457  
agarner@bbcmich.com

City of Grand Haven:  
Zac VanOsdol  
(616) 847-4887  
zvanosdol@grandhaven.org

Office Hours: Monday through Friday, 8:00 am to 5:00 pm EST

<table>
<thead>
<tr>
<th>Plan</th>
<th>Carrier</th>
<th>Phone</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Blue Cross Blue Shield of Michigan</td>
<td>313-225-9000</td>
<td><a href="http://www.bcbsm.com">www.bcbsm.com</a></td>
</tr>
<tr>
<td>Dental</td>
<td>Blue Cross Blue Shield of Michigan</td>
<td>800-524-0149</td>
<td><a href="http://www.deltadentalmi.com">www.deltadentalmi.com</a></td>
</tr>
</tbody>
</table>

Brown & Brown of Central Michigan Claim Advocacy Services

<table>
<thead>
<tr>
<th>Name</th>
<th>Direct Number</th>
<th>Email</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebecca Castillo</td>
<td>989-399-0460</td>
<td><a href="mailto:rcastillo@bbcmich.com">rcastillo@bbcmich.com</a></td>
<td>989-607-9997</td>
</tr>
<tr>
<td>Olga Roberson</td>
<td>989-399-0455</td>
<td><a href="mailto:oroberson@bbcmich.com">oroberson@bbcmich.com</a></td>
<td>989-607-2241</td>
</tr>
<tr>
<td>Farran Braman</td>
<td>989-399-0467</td>
<td><a href="mailto:fbraman@bbcmich.com">fbraman@bbcmich.com</a></td>
<td>989-607-2243</td>
</tr>
<tr>
<td>Judy Robinson</td>
<td>989-399-0465</td>
<td><a href="mailto:jrobinson@bbcmich.com">jrobinson@bbcmich.com</a></td>
<td>989-607-2240</td>
</tr>
<tr>
<td>Brandon Weslock</td>
<td>989-399-0459</td>
<td><a href="mailto:bweslock@bbcmich.com">bweslock@bbcmich.com</a></td>
<td>989-607-2239</td>
</tr>
</tbody>
</table>
ANNUAL OPEN ENROLLMENT

PLAN YEAR 01/01/2020 — 12/31/2020

Each year, during the Open Enrollment Period, you will have the opportunity to enroll in or make changes to your benefit elections and dependents without a qualifying event. Please take the time to review all of the plan options carefully to determine which plan options meet the anticipated needs of you and your family. Once you have made your elections, you will not be able to change them until the next Open Enrollment Period, unless you experience a qualifying event.

Open Enrollment for our benefit plans will be conducted November 18 through December 6. Elections you make during open enrollment will become effective January 1, 2020.

WHO IS ELIGIBLE?

Full time employees are eligible to participate in benefit plans on the first day of the month following/ coinciding with one month of continued service. Full time employment is defined as working a minimum of 30 hours per week. Your eligible dependents include your spouse, registered domestic partner, and dependent children. Dependent children are eligible to age 26.

MID-YEAR CHANGES?

Unless you have a qualifying event, you cannot make changes to the benefits you elect until the next open enrollment period. The Health Insurance Portability And Accountability Act of 1996 (HIPAA) provides employees additional opportunities to enroll in a group health plan if they experience a loss of other coverage or certain life events. If you are declining coverage at this time for either yourself or your eligible dependents, you may be able to enroll yourself and/or your eligible dependents in coverage at a later date if there is a loss of other coverage.

If you experience a qualified “change in status,” you must make any associated enrollment or benefit changes within 30 days of the event except for a Medicare or Medicaid entitlement event, in which case you must make changes within 60 days of the event. You have the right to elect coverage during the plan year if your or your dependent’s Medicaid/Children’s Health Insurance Program (CHIP) coverage terminates due to discontinuation of eligibility under the program or if you become eligible for a Medicaid/CHIP premium assistance subsidy (if available in your state) providing you request enrollment within 60 days of the loss of coverage or eligibility for premium subsidy. Qualified changes in status include: Change in legal marital status; Change in number of dependents; Change in employment status of employee, spouse, or dependent; A dependent newly satisfies or ceases to satisfy eligibility requirements; Change in place of residence; Loss of certain other health coverage; Court judgment, decree, or order; Medicare or Medicaid entitlement; Significant cost or other coverage changes; Family Medical Leave Act (FMLA) leave of absence; Reduction of hours; Exchange/Marketplace enrollment. Please note that there are several conditions and/or limitations that apply to the events listed above. Please contact Human Resources if you have any questions or believe that you may qualify for an election change.
# City of Grand Haven
Plan Options and Alternatives 2020

<table>
<thead>
<tr>
<th>Plan Network</th>
<th>Community Blue</th>
<th>HDHCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>$20</td>
<td>0%, after Deductible</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$20</td>
<td>0%, after Deductible</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>$20</td>
<td>0%, after Deductible</td>
</tr>
<tr>
<td># of Chiro</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$50</td>
<td>0%, after Deductible</td>
</tr>
<tr>
<td>Deductible</td>
<td>$250 / $500</td>
<td>$1400 / $2800 *</td>
</tr>
<tr>
<td>Percent Coinsurance</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1000 / $3000</td>
<td>N/A</td>
</tr>
<tr>
<td>Out of Pocket Maximum</td>
<td>$6350 / $12700</td>
<td>$2250 / $4500 *</td>
</tr>
<tr>
<td>Generic Rx</td>
<td>$10</td>
<td>$10 after Ded.</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$40</td>
<td>$40 after Ded.</td>
</tr>
<tr>
<td>Non preferred Brand</td>
<td>$80</td>
<td>$80 after Ded.</td>
</tr>
<tr>
<td>Preferred Specialty</td>
<td>15% ($150 Maximum)</td>
<td>15% ($150 Maximum) after Ded.</td>
</tr>
<tr>
<td>Non Preferred Specialty</td>
<td>25% ($300 Maximum)</td>
<td>25% ($300 Maximum) after Ded.</td>
</tr>
<tr>
<td>Mail Order</td>
<td>90 day x1</td>
<td>90 day x2</td>
</tr>
</tbody>
</table>

*In Network Benefits shown only. See benefit summaries for Out of Network details.*
<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$250 Individual/ $500 Family</td>
<td>$500 Individual/ $1,000 Family</td>
<td></td>
</tr>
<tr>
<td>Are these services covered before you meet your deductible?</td>
<td>Yes</td>
<td>Preventative care services are covered before you meet your deductible.</td>
<td></td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No</td>
<td>No.</td>
<td></td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$350 Individual/ $700 Family</td>
<td>$1,200 Individual/ $2,400 Family</td>
<td></td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit? (may include a co-insurance maximum)</td>
<td>Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn’t cover.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes</td>
<td>See <a href="http://www.bcbsh.com">website</a> or call the number on the back of your BCSM ID card for a list of network providers.</td>
<td></td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>No.</td>
<td></td>
</tr>
</tbody>
</table>

**SUMMARY OF BENEFITS AND COVERAGE - BCBSM**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the costs for covered health care services. Note: Information about the cost of the plan (called the premium) will be provided separately. The SBC covers some items and services even if you haven’t yet met the deductible amount. This plan covers certain preventative services at [website](http://www.bcbsh.com/preventive-care-benefits).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copay/office visit; deductible does not apply</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 copay/visit; deductible does not apply</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No Charge; deductible does not apply</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>May require preauthorization</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic or select prescribed over-the-counter drugs</td>
<td>$10 copay for retail 30-day supply; $20 copay for retail or mail order 90-day supply; deductible does not apply</td>
<td>In-Network copay plus an additional 25% of the approved amount; deductible does not apply</td>
<td>Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand-name drugs</td>
<td>$40 copay for retail 30-day supply; $80 copay for retail or mail order 90-day supply; deductible does not apply</td>
<td>In-Network copay plus an additional 25% of the approved amount; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non preferred brand-name drugs</td>
<td>$80 copay for retail 30-day supply; $160 copay for retail or mail order 90-day supply; deductible does not apply</td>
<td>In-Network copay plus an additional 25% of the approved amount; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

*copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.*
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$150 copay/visit; deductible does not apply</td>
<td>$150 copay/visit; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 copay/visit; deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>If you need behavioral health services (mental health and substance use disorder)</strong></td>
<td>Outpatient services</td>
<td>20% coinsurance</td>
<td>20% co-insurance for mental health; 40% coinsurance for substance use disorder</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No Charge; deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance for Applied Behavioral Analysis; 20% coinsurance for Physical, Speech and Occupational Therapy</td>
<td>20% coinsurance for Applied Behavioral Analysis; 40% coinsurance for Physical, Speech and Occupational Therapy</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No Charge; deductible does not apply</td>
<td>No Charge; deductible does not apply</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
# SUMMARY OF BENEFITS AND COVERAGE - BCBSM

## Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture treatment</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Long term care</td>
</tr>
<tr>
<td>• Routine eye care (Adult)</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Weight loss programs</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Coverage provided outside the United States. See <a href="http://provider.bcbs.com">http://provider.bcbs.com</a></td>
</tr>
<tr>
<td>• If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses - like the deductible, copayments, or co-insurance, or benefits not otherwise covered</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S</td>
</tr>
<tr>
<td>• Private duty nursing</td>
</tr>
</tbody>
</table>

[Image of the document page]
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor’s Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.cms.gov or by calling the number on the back of your BCBSM ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross and Blue Shield of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov

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

Does this plan meet Minimum Value Standards? Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
### About these Coverage Examples:

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

#### Peg is Having a Baby
- 9 months of in-network pre-natal care and a hospital delivery

<table>
<thead>
<tr>
<th>Coverage Item</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$250</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$20</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>20%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>20%</td>
</tr>
</tbody>
</table>

**Total Example Cost:** $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing Item</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$70</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $60
- The total Peg would pay is: $2,380

#### Managing Joe’s Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

<table>
<thead>
<tr>
<th>Coverage Item</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$250</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$20</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>20%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>20%</td>
</tr>
</tbody>
</table>

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

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing Item</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$900</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $60
- The total Joe would pay is: $1,510

#### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

<table>
<thead>
<tr>
<th>Coverage Item</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>$250</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$20</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>20%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>20%</td>
</tr>
</tbody>
</table>

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

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing Item</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$60</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $0
- The total Mia would pay is: $510
ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language
If you, or someone you’re helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

If you, or anyone you are assisting, needs help, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

Important disclosure
Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminate in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

Simply Blue HSA PPO Plan $1400/0% LG

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

**Coverage Period:** Beginning on or after 01/01/2020
**Coverage for:** Individual/Family  |  **Plan Type:** PPO

---

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call the number on the back of your BCBSM ID card. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call the number on the back of your BCBSM ID card to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
</table>
| **What is the overall deductible?** | In-Network: $1,400 Individual/ $2,800 Family  
Out-of-Network: $2,800 Individual/ $5,600 Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care services are covered before you meet your deductible. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at (https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| **Are there other deductibles for specific services?** | No. | You don’t have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** (May include a coinsurance maximum) | In-Network: $2,250 Individual/ $4,500 Family  
Out-of-Network: $4,500 Individual/ $9,000 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met. |
<p>| <strong>What is not included in the out-of-pocket limit?</strong> | Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit. |
| <strong>Will you pay less if you use a network provider?</strong> | Yes. See (<a href="http://www.bcbsm.com">http://www.bcbsm.com</a>) or call the number on the back of your BCBSM ID card for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| <strong>Do you need a referral to see a specialist?</strong> | No. | You can see the specialist you choose without a referral. |</p>
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>No Charge</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No Charge</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No Charge; deductible does not apply</td>
<td>Not covered</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No Charge</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No Charge</td>
<td>20% coinsurance</td>
<td>May require preauthorization</td>
</tr>
<tr>
<td>If you have a test</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic or select prescribed over-the-counter drugs</td>
<td>$10 copay/prescription for retail 30-day supply; $20 copay/prescription for retail or mail order 90-day supply</td>
<td>In-Network copay plus an additional 20% of the approved amount</td>
<td>Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand-name drugs</td>
<td>$40 copay/prescription for retail 30-day supply; $80 copay/prescription for retail or mail order 90-day supply</td>
<td>In-Network copay plus an additional 20% of the approved amount</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non preferred brand-name drugs</td>
<td>$80 copay/prescription for retail 30-day supply; $160 copay/prescription for retail or mail order 90-day supply</td>
<td>In-Network copay plus an additional 20% of the approved amount</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgical center)</td>
<td>No Charge</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>No Charge</td>
<td>No Charge</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Mileage limits apply</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>No Charge</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>
## SUMMARY OF BENEFITS AND COVERAGE - BCBSM

<table>
<thead>
<tr>
<th>What You Will Pay</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>No Charge</td>
<td>20% coinsurance to meet deductible</td>
<td>Preauthorization is required.</td>
</tr>
<tr>
<td>Physician/surgeon fee</td>
<td>No Charge</td>
<td>No Charge for mental health, 20% coinsurance for substance abuse disorder</td>
<td>Preauthorization is required.</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>No Charge</td>
<td>20% coinsurance to meet deductible</td>
<td>Preauthorization is required.</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>No Charge</td>
<td>20% coinsurance to meet deductible</td>
<td>Preauthorization is required.</td>
</tr>
<tr>
<td>Office visits</td>
<td>No Charge</td>
<td>Preauthorization is required.</td>
<td>Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.</td>
</tr>
<tr>
<td>Childbirthdelivery professional services</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.</td>
</tr>
<tr>
<td>Childbirthdelivery facility services</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.</td>
</tr>
<tr>
<td>Home health care</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No Charge</td>
<td>No Charge</td>
<td>Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.</td>
</tr>
</tbody>
</table>

**Services You May Need**

- **Facility fee (e.g., hospital room)**
- **Physician/surgeon fee**
- **Outpatient services**
- **Inpatient services**
- **Office visits**
- **Childbirth delivery professional and facility services**
- **Home health care**
- **Rehabilitation services**
- **Skilled nursing care**
- **Durable medical equipment**
- **Hospice services**

**Common Medical Events**

- If you have a hospital stay
- If you need behavioral health services (mental health and substance use disorder)
- If you are pregnant
- If you need help recovering or have other special health needs

**Limitations, Exceptions & Other Important Information**

- Maternity care may include services described elsewhere in the SBC (i.e., tests) and cost sharing does not apply to certain maternity services considered to be preventive.
- Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.
- Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
- Preauthorization is required. Visit limits apply.
### SUMMARY OF BENEFITS AND COVERAGE - BCBSM

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>For more information on pediatric vision or dental, contact your plan administrator</td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

#### Excluded Services & Other Covered Services:

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

- Acupuncture treatment
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services** (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care

  - Coverage provided outside the United States. See [http://provider.bcbs.com](http://provider.bcbs.com)

  - If you are also covered by an account-type plan such as an integrated health flexible spending arrangement (FSA), health reimbursement arrangement (HRA), and/or a health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses - like the deductible, co-payments, or co-insurance, or benefits not otherwise covered

- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor’s Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebia/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.cms.gov or by calling the number on the back of your BCBSM ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP) Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720 or http://www.michigan.gov/difs or difs-HICAP@michigan.gov

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

Does this plan meet Minimum Value Standards? Yes
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.
(IMPORTANT: Blue Cross Blue Shield of Michigan is assuming that your coverage provides for all Essential Health Benefit (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage of specific EHB categories, for example prescription drugs, through another carrier.)

Language Access Services: See Addendum

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
### About these Coverage Examples:

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

#### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan’s overall deductible: $1,400
- Specialist coinsurance: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

Total Example Cost: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,400</td>
<td>$1,400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$30</td>
<td>$70</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions: $60
- The total Peg would pay is: $1,490

#### Managing Joe’s Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $1,400
- Specialist coinsurance: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

Total Example Cost: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,400</td>
<td>$1,400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$70</td>
<td>$70</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions: $60
- The total Joe would pay is: $2,160

#### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $1,400
- Specialist coinsurance: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic tests (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,400</td>
<td>$1,400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered

- Limits or exclusions: $0
- The total Mia would pay is: $1,400
SUMMARY OF BENEFITS AND COVERAGE - BCBSM

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

If you, or someone you’re helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

Ese si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno: Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

If you, or someone you’re helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

If you, or someone you’re helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

If you, or someone you’re helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

If you, or someone you’re helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminate in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226-0001, phone: 888-605-6461, TTY: 711, fax: 666-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn’t a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount
This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal
A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing
When a provider bills you for the balance remaining on the bill that your plan doesn’t cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider’s charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Complications of Pregnancy
Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren’t complications of pregnancy.

Copayment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called “out-of-pocket costs”). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn’t cover usually aren’t considered cost sharing.

Cost-sharing Reductions
Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you’re a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Claim
A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)
Deductible
An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won’t pay anything until you’ve met your $1000 deductible for covered health care services subject to the deductible.)

Jane pays 100% Her plan pays 0%
(See page 6 for a detailed example.)

Excluded Services
Health care services that your plan doesn’t pay for or cover.

Formulary
A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a “policy” or “plan”.

Home Health Care
Health care services and supplies you get in your home under your doctor’s orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn’t include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn’t require an overnight stay.

Diagnostic Test
Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition
An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn’t get medical attention right away. If you didn’t get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation
Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services
Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital’s emergency room or other place that provides care for emergency medical conditions.
**Individual Responsibility Requirement**

Sometimes called the “individual mandate”, the duty you may have to be enrolled in health coverage that provides **minimum essential coverage**. If you don’t have **minimum essential coverage**, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

**In-network Coinsurance**

Your share (for example, 20%) of the **allowed amount** for covered healthcare services. Your share is usually lower for in-network covered services.

**In-network Copayment**

A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

**Marketplace**

A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an “Exchange”. The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

**Maximum Out-of-pocket Limit**

Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limit stated for your plan.

**Medically Necessary**

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

**Minimum Essential Coverage**

Health coverage that will meet the **individual responsibility requirement**. Minimum essential coverage generally includes plans, health insurance available through the **Marketplace** or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

**Minimum Value Standard**

A basic standard to measure the percent of permitted costs the **plan** covers. If you’re offered an employer **plan** that pays for at least 60% of the total allowed costs of benefits, the **plan** offers minimum value and you may not qualify for **premium tax credits** and **cost sharing reductions** to buy a **plan** from the **Marketplace**.

**Network**

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

**Network Provider (Preferred Provider)**

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called “preferred provider” or “participating provider.”

**Orthotics and Prosthetics**

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

**Out-of-network Coinsurance**

Your share (for example, 40%) of the **allowed amount** for covered health care services to providers who don’t contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

**Out-of-network Copayment**

A fixed amount (for example, $30) you pay for covered health care services from providers who do **not** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.
Out-of-network Provider (Non-Preferred Provider)
A provider who doesn’t have a contract with your plan to provide services. If your plan covers out-of-network services, you’ll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider”.

Out-of-pocket Limit
The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn’t cover. Some plans don’t count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan
Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits
Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage
Coverage under a plan that helps pay for prescription drugs. If the plan’s formulary uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount you’ll pay in cost sharing will be different for each “tier” of covered prescription drugs.

Prescription Drugs
Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)
Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider
A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider
An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.
Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don’t get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as “skilled care services”, which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.
How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500  
Coinsurance: 20%  
Out-of-Pocket Limit: $5,000

January 1st  
Beginning of Coverage Period

Jane pays 100%  
Her plan pays 0%

Jane hasn't reached her $1,500 deductible yet  
Her plan doesn't pay any of the costs.  
Office visit costs: $125  
Jane pays: $125  
Her plan pays: $0

Jane pays 20%  
Her plan pays 80%

Jane reaches her $1,500 deductible, coinsurance begins  
Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.  
Office visit costs: $125  
Jane pays: 20% of $125 = $25  
Her plan pays: 80% of $125 = $100

Jane pays 0%  
Her plan pays 100%

Jane reaches her $5,000 out-of-pocket limit  
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.  
Office visit costs: $125  
Jane pays: 0  
Her plan pays: $125
HEALTH BRIDGE

Benefits-at-a-Glance

Your employer sponsors a group health plan ("Companion Group Health Plan"). The Companion Group Health Plan provides benefits though a variety of component parts. The HealthBridge Program is one part of your Companion Group Health Plan and is offered to you by your employer. The HealthBridge Program is a new employee benefit offering - a Healthcare Expense Consolidation & Flexible Payment Plan. This is not a contract or insurance. In the event that this document conflicts with the terms of the agreement between your employer and HealthBridge, the terms of the agreement will control.

For additional assistance contact the HealthBridge Customer Care Center at 800-931-8890 or contact your Employer's Benefits Administration Office.

HealthBridge members receive a consolidated, monthly statement of charges that represent deductibles and co-insurance owed by members to HealthBridge network providers. Members have the option to either pay the statement in full at a Quick Pay discount, or over time at a low interest rate after an interest-free period.

HealthBridge automatically purchases all out-of-pocket medical expenses (deductibles and/or coinsurance) incurred under a Member’s Companion Group Health Plan from Providers in the HealthBridge network. Each month, HealthBridge totals all the eligible out-of-pocket expenses purchased on a Member’s behalf during the month and sends the Member one consolidated bill.

This means that even if a Member visits 15 different HealthBridge Providers in one month, the Member will only receive one bill from HealthBridge. This one bill will consolidate all 15 visits and their related charges after the Companion Group Health Plan adjudicates the claims.

Upon receipt of each monthly bill, a Member has three options: (1) pay the balance in full by the statement due date and receive a Quick Pay Discount on eligible provider charges, (2) pay the minimum payment required, and pay the balance in full during the Interest Free Period (3) elect the Extended Repayment Option. If the Member elects the Extended Repayment Option, Member is agreeing to pay an annual interest rate charge of 7%. More details about the HealthBridge Program are available at www.myhealthbridge.com.
<table>
<thead>
<tr>
<th>HealthBridge Program</th>
</tr>
</thead>
</table>
| **Program Administrator Information** | HealthBridge Financial, Inc.  
3200 Broadmoor Ave SE  
Grand Rapids, Michigan 49512  
(800) 931-8890  
http://www.myhealthbridge.com |
| **Eligibility** | Any Employee (and Employee’s dependents) who is covered by a City of Grand Haven or Board of Light and Power Companion Group Health Plan are eligible as Members under the HealthBridge Program. |
| **Effective Date of Coverage** | Plan coverage begins on the later of the day the Employer adopts the Plan or the day the Employee or Dependent becomes eligible under the Employer’s Companion Group Health Plan. |
| **Waiting Period** | There is no waiting period under the Plan. |
| **Coverage Termination** | Plan coverage will terminate on the earlier of the following dates: (1) the date the Member ceases to be covered under Employer’s Companion Group Health Plan or (2) the date the Plan is terminated. |
| **HealthBridge Member** | Any Employee, Former Employee or Dependent who is enrolled in and covered by the Employer’s Companion Group Health Plan. |
| **Interest Free Period** | 3 Months  
Interest Free Period is the period of time during which there will be no interest charged to Members on an outstanding balance. Minimum payments will still be due during any Interest Free Period. |
| **Interest Rate for Extended Repayment Option** | A 7% annual interest rate is charged on outstanding statement balances after the conclusion of the Interest Free Period, and until the balance is paid in full by the Member. |
| **Quick Pay Discount** | The discount available if the Member: (1) pays the full amount of the statement balance by the due date and (2) received health care from a participating HealthBridge network provider offering a Quick Pay Discount. |
| Minimum Payment Due | The minimum payment due on a monthly statement is either:  
|                     | • The calculated amount based on the statement balance. This varies depending on the date of each charge, length of time, and annual interest rate; **OR**  
|                     | • $25, if the calculated amount is less than $25. The minimum statement billed is $25; **OR**  
|                     | • $24 or less as a final payment. |
| Monthly Statement   | Member statements are generated on the twelfth day after the first claim is purchased. The due date will be set as the day before the next statement generation date. |
| Statement Charges   | Charges on a Member's monthly statement represent the patient liability after health plan payments on adjudicated claims, which are payable to HealthBridge. HealthBridge has already paid the providers for the patient responsibility portion of the charge. At this time, the only charges listed on a HealthBridge Statement are for deductibles and co-insurance expenses, which are outlined in your Employer's Health Plan. HealthBridge Statements do not include co-payments (copays), prescriptions, or other out-of-pocket expenses not listed as deductibles or co-insurance on adjudicated claims. |
| Adjudicated Claims  | Adjudicated Claims are those claims processed by your Employer's Health Plan after receipt from your provider. HealthBridge does not process your claims, but only receives the amount due based on your Health Plan’s adjudication. |
Frequently Asked Questions

General

Tell me more about the HealthBridge program.
When you (or any family member covered under your BCBSM policy) receives medical services at NOCHS, HealthBridge pays the remaining medical deductible or coinsurance on your behalf.

You then receive a monthly statement from HealthBridge that consolidates the claims paid on your behalf during the last month. You will then manage and pay your balance directly with HealthBridge.

Does this change my Blue Cross Blue Shield of Michigan Medical Plan benefits?
Nothing has changed in your medical plan.

Do I have to sign up for HealthBridge?
As a member of Blue Cross Blue Shield of Michigan through the City of Grand Haven or the Board of Light and Power, you are automatically enrolled in HealthBridge.

Is there a cost to be enrolled in HealthBridge?
No, there is not a membership fee.

How can I reach HealthBridge Customer Service?
Customer Service is available at (800) 931-8890. Customer Care Specialists are available Monday - Friday 8 a.m.- 8 p.m., or Saturday 9 a.m.-1 p.m. Times are Eastern. Se habla español.
HEALTH BRIDGE

Frequently Asked Questions

Account Management

How can I access the HealthBridge Member Portal to view my account?
Go to https://Member.myhealthbridge.com from your computer or smartphone.

The HealthBridge application requires JavaScript. If your browser (Chrome, Explorer, Firefox) has a security setting that prevents JavaScript from executing and you are using your own personal computer, you can enable JavaScript by going into your privacy and security in your Browser Settings to enable.

How do I activate my online account?
Employees covered by Blue Cross Blue Shield will be sent a letter with details to activate their online account. An email account is required.

Can I activate my online account if I don’t have my letter in front of me?
1) Go to https://Member.myhealthbridge.com from your computer or smartphone.
2) Select the link for Help below the Log In button.
3) Select the Sign Up link.
4) Complete the fields to verify that you are a HealthBridge member.
5) You will be prompted to create a new password.

How does my spouse, or covered dependent over 18, activate their online account?
He/she can follow the steps above to activate their account. Or, they can call our client service specialists to validate their account and provide their email address to receive an email with a temporary password. (800) 931-8690

What if I forget my password?
1) Go to https://Member.myhealthbridge.com from your computer or smartphone.
2) Select the link for Help below the Log In button.
3) Select the link for Forgot Password to reset your password.

Client service specialists can also help you reset your password. (800) 931-8890

Can I change my Username?
At this time, your username cannot be changed. HealthBridge is working to add this capability in the future.
Frequently Asked Questions

Can I change the email where I receive HealthBridge notifications?
Yes, you can enter a preferred email address to receive statements and other account notifications. Log in to your account and add your preferred communication email in your account profile.

How can I access a family member’s account?
If your family member is under 18, you will automatically have access to their account.

If your family member is 18 or over, you will need to follow the process for a HIPAA authorization to access their account.

1. You Request Account Access
   1) Log in to https://Member.myhealthbridge.com
   2) Select the family member from your home page.
   3) From the pop up – choose Request Access.
   4) Enter a 4-digit PIN and submit the request. (Note: PIN can only be used 1 time)
   5) Contact your family member and tell her/him the 4-digit PIN.

2. Family Member Accepts Your Request
   1) Log in to https://Member.myhealthbridge.com  (Note: If person has not yet activated their account, he/ she will need to do so prior to ability to use the PIN. Your PIN is not a password to log into their account.)
   2) Enter the 4-digit PIN on the pop-up screen to request for access to this account
   3) An email is sent to the requestor that access is complete.

Tip: If your family member has not yet activated his or her account, he or she will need to first follow the steps to log in for the first time. We recommend that your family member log in one time before you perform Request Account Access steps.
**Frequently Asked Questions**

**Payments**

**How will I be billed?**
When you seek services at NOCHS, or at one of the other providers within the HealthBridge network, you will receive a consolidated billing statement from HealthBridge rather than separate bills from each provider. The statement you receive will contain all the out-of-pocket claims that HealthBridge has paid on your behalf within that monthly billing cycle.

**How is my HealthBridge payment calculated?**
Your monthly payments are calculated over 24 months with an interest-free period of 3 months. After that period, if you need additional time to pay the balance, there is a low fixed annual interest rate of 7%. Whenever you pay off your balance – even if it’s your very last payment – you receive a 10% discount on the remaining balance.

**What payment methods can I use?**
You can make a payment by using your Visa, Mastercard, check, or funds from your Flexible Spending Account (FSA) or a Health Savings Account (HSA). You can make online payments, mail in a payment, or call in a payment (at no additional charge) to a HealthBridge Customer Care Specialist.

**What if I don’t need a repayment arrangement?**
If you do not need a repayment arrangement, you can pay your HealthBridge balance immediately and take the 10% discount. If your situation ever changes, you will always have a longer repayment period available with the HealthBridge program.

**Why don’t I pay HealthBridge providers directly?**
Because HealthBridge has paid the providers on your behalf. The only statement you should receive from HealthBridge network providers moving forward is from HealthBridge. You will receive an email or statement from HealthBridge informing you of a balance due. Payments will now be made directly to HealthBridge.

**What if I receive care at a provider that is not in the HealthBridge Provider Network?**
HealthBridge would not cover that expense. You will receive the same type of bill and pay for that separately – the same way you do today. We are continuing to expand the Provider Network, including reaching out to providers you visit, but are not yet in our Provider Network.
Frequently Asked Questions

Will I still receive an Explanation of Benefits?
Yes. BCBSM is still required to send you an Explanation of Benefits.

Can I use HealthBridge if I am covered by two or more health insurance plans (I have Coordination of Benefits)?
Yes. After all your health insurance plans have paid their respective portions, if you still have any remaining amounts due, and you would like the payment discounts and flexibility of HealthBridge, we can help. Simply contact HealthBridge to provide information with your remaining balance due.

Will I still make copays when I go to the doctor or hospital?
If a copay (copayment) is required by BCBSM, you’ll continue to pay it at the time you receive care, which is before any claims are created. After BCBSM processes a claim, if there is coinsurance or a deductible owed by you, that will appear on your HealthBridge statement. In the future, we are working on the ability to include copays in the HealthBridge program.

Privacy

Does my employer know how much my statements are or if I am paying in a timely manner?
HealthBridge does not share your individual payment, claim, or account information with your employer.

Does my HealthBridge statement contain details about my medical services?
The HealthBridge statement contains the BCBSM claim numbers, but it does not include any of the details about the type of visit, provider or diagnosis. If you have questions about a particular claim, contact Blue Cross Blue Shield of Michigan. Call the number on the back of your member ID card or 1-313-225-9000.

How does HealthBridge protect my private health information?
HealthBridge protects the privacy, confidentiality and security of your information online and in our databases. HealthBridge complies with HIPAA, the Health Insurance Portability and Accountability Act, for data privacy and security of medical data.
The dental plans are arranged through Blue Cross Blue Shield of Michigan.

Preferred Provider Organization (PPO) Plans provide you with the freedom to use a dentist of your choice or access the PPO network of dentists. If you use a dentist participating in the PPO network, your out-of-pocket expenses will be reduced, as fees are subject to a negotiated rate. If you use a non-network provider, you are responsible for paying the difference in cost between the non-network provider’s charges and the allowed amount.

Participating provider information can be found on the carrier’s website, www.mibluedentist.com.

<table>
<thead>
<tr>
<th>Benefit Comparison</th>
<th>In-Network</th>
<th>In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible/Individual</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Annual Deductible/Family</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Annual Plan Maximum</td>
<td>$1,000</td>
<td>$800</td>
</tr>
<tr>
<td>Lifetime Orthodontia Plan Maximum</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Diagnostic and Preventive Services</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Basic Services</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Major Services</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Orthodontia Services</td>
<td>75%</td>
<td>75%</td>
</tr>
</tbody>
</table>
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.
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.

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.
Tap in to your health care plan — anytime, anywhere

The Blue Cross mobile app helps you understand your health care plan and how it works. From deductible to claims to out-of-pocket costs, you’ll have the information you need to manage your plan and get the most from your coverage, wherever you go.

- View your claims and explanation of benefits statements to understand what providers charged and why. Sign up for email and push notifications.
- See what your plan covers, before you make an appointment to receive care.
- Know your deductible and how much you've paid toward your out-of-pocket balance.
- Find care in your network and compare the cost\(^2\). Check doctor and hospital quality.
- Show your health plan ID card to your doctor's office staff so they have the information they need to look up your coverage.

Get the app.
- Download on the App Store
- Get it on Google Play

Search BCBSM.
Or, text APP to 222764.\(^1\)

\(^1\)You’ll be sent a Blue Cross mobile app download link. Message and data rates may apply. Visit bcbsm.com for our Terms and Conditions of Use and Privacy Practices.

\(^2\)Cost estimates are available to most non-Medicare members.

Apple and the Apple logo are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc., registered in the U.S. and other countries.

Google Play and the Google Play logo are trademarks of Google LLC.
What’s included in online visits

Medical care
Use it when you’re traveling or at home with a sick child. Or when your primary care doctor isn’t available.
Visits last about 10 minutes although the doctor will spend as much time as needed. You can see a doctor on demand or by appointment 24 hours a day, seven days a week.

Behavioral health care
Online visits give you more choices for behavioral health care. Talk to therapists and psychiatrists about life’s challenges from the comfort of home.

Therapy visits
Therapists such as psychologists, licensed clinical social workers, marriage and family therapists and professional counselors use talk therapy.
Therapy is available to adults and children age 10 and older by appointment from 7 a.m. to 11 p.m. Visits typically last 45 minutes.

Psychiatry visits
Psychiatrists can make diagnoses and prescribe and manage medications.
Psychiatry is available to adults age 18 and over and visits are by appointment only. Extended hours during evenings and on weekends may be available. The initial visit usually lasts 45 minutes with 15 minute follow-up visits.

Prescriptions
Doctors may write prescriptions, if appropriate. They don’t write prescriptions for controlled substances.

How does it work?

Fast and convenient

Sign up now
Mobile – Download the BCBSM Online Visits™ app
Web – Visit bcbsmonlinevisits.com
Phone – Call 1-844-606-1608
Add your Blue Cross or Blue Care Network health care plan information.
See a doctor or therapist

1. Launch the online visits app or website, and log in to your account.
2. Choose a service: Medical, Therapy or Psychiatry.
3. Pick a doctor or begin a scheduled visit and enter your payment information.
4. Meet with the doctor or therapist online.
5. Get a prescription, if appropriate, sent to a local pharmacy.
6. Send a visit summary to your primary care doctor or other health care provider at the end of your online visit.

Choose a doctor or therapist who’s right for you

There are hundreds of doctors and therapists to choose from. They’re all specially trained in online visits. You can read their profiles to learn more about them such as languages they speak and other experience.

Doctors have an average of 15 years practicing medicine and are U.S. board-certified. They have experience in areas such as pediatrics, family medicine and emergency care. Psychiatrists are board-certified in psychiatry or neurology.

The masters- and doctoral-level therapists are licensed and credentialed in the state where you’re having a visit.

For questions about your online visits account or an online visit, call 1-844-606-1608, 24 hours a day, seven days a week.

Remember to coordinate all care through your primary care doctor. Blue Cross Online Visits uses the American Well technology platform and provider network, and is powered by American Well®. American Well is an independent company that provides online visits for Blue Cross and BCN members.

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.
FSA/HSA Eligible and Non-Eligible Expenses

HSA Eligible Health Care Expenses
Please note that we do not intend this list to be comprehensive tax advice.
For more detailed information, please consult IRS Publication 502 or see your tax advisor.

- Acupuncture
- Alcoholism treatment
- Allergy shots and testing
- Ambulance (ground or air)
- Artificial limbs
- Blind services and equipment
- Car controls for handicapped
- Chiropractor services
- Coinsurance and deductibles
- Contact lenses
- Crutches, wheelchairs, walkers
- Dentures
- Diagnostic tests
- Doctor's fees
- Drug addiction treatment & facilities
- Drugs (prescription)
- Eye examinations and eyeglasses
- Home health and/or hospice care
- Hospital services
- Insulin
- Laboratory fees
- LASIK eye surgery
- Medical alert (bracelet, necklace)
- Medical monitoring and testing devices
- Nursing services
- Obstetrical expenses
- Oculusal guards
- Operations and surgeries (legal)
- Optometrists
- Orthodontia
- Orthopedic services
- Osteopaths
- Oxygen/oxygen equipment
- Physical exams (except for employment-related physicals)
- Physical therapy
- Psychiatric care, psychologists, psychotherapists
- Radial keratotomy
- Schools (special, relief, or handicapped)
- Sexual dysfunction treatment
- Smoking cessation programs
- Surgical fees
- Television or telephone for the hearing impaired
- Therapy treatments
- Transportation (essentially and primarily for medical care; limits apply)
- Vaccinations
- Vitamins
- Weight loss programs
- X-rays
*if prescribed for a particular ailment or medical condition; provider letter required.

Important Notice About Over-the-Counter (OTC) Medications
OTC medications require a doctor’s prescription to be eligible for HSA reimbursement. For that reason, OTC medications cannot be purchased using the mySourceCard™ unless dispensed by a pharmacy the same as a standard prescription (with an Rx number). If a manual claim is submitted for purchase of an OTC medication, both a copy of the prescription and the purchase receipt must be included to receive reimbursement.

Non-medicated OTC products (diabetes test strips, saline solution, bandaids, etc.) do not require a prescription. You can use either the mySourceCard™ to purchase these items or submit the purchase receipt for reimbursement.

FSA/HSA Eligible OTC Medications and Products
COPY OF PRESCRIPTION AS WELL AS DETAILED RECEIPT REQUIRED FOR REIMBURSEMENT:
Acne medications
Allergy & sinus, cold, flu & cough remedies
Antacids & acid controllers
Antibiotic & antiseptic sprays, creams & ointments
Anti-diarrheals
Anti-fungals
Anti-gas & stomach remedies
Anti-itch & insect bite remedies
Anti-parasitics
Digestive aids
Baby care (diaper rash ointments, teething gel, rehydration fluids, etc.)
Contraceptives (condoms, gels, foams, suppositories, etc.)
Eczema & psoriasis remedies
Eye drops, ear drops, nasal sprays
First aid kits
Hemorrhoidal preparations
Hydrogen peroxide, rubbing alcohol
Laxatives
Medicated band aids & dressings
Motion sickness remedies
Nicotine patches and medications (smoking cessation aids)
Pain relievers (aspirin, ibuprofen, acetaminophen, naproxen, etc.)
Sleep aids & sedatives
Wart removal remedies, corn patches

ELIGIBLE FOR REIMBURSEMENT WITH DETAILED RECEIPT ONLY (NO PRESCRIPTION REQUIRED):
- Breast pumps for nursing mothers
- Braces & supports
- Contact lens solution
- CPAP equipment & supplies
- OTC varieties of Insulin
- Diabetic testing supplies/equipment
- Durable medical equipment (power chairs, walkers, wheel chairs, etc.)
- Home diagnostic (pregnancy tests, ovulation kits, thermometers, blood pressure monitors, etc.)
- Non-medicated band aids, rolled bandages & dressings
- Reading glasses

All OTC items listed are examples
FSA/HSA Non-Eligible Health Care Expenses

- Advance payment for services to be rendered
- Automobile insurance premium allocable to medical coverage
- Boarding school fees
- Body piercing
- Bottled water
- Chauffeur services
- Controlled substances
- Cosmetic surgery and procedures
- Cosmetic dental procedures
- Dancing lessons
- Diapers for Infants
- Diaper service
- Ear piercing
- Electrolysis
- Fees written off by provider
- Food supplements
- Funeral, cremation, or burial expenses
- Hair transplant
- Herbs & herbal supplements
- Household & domestic help
- Health programs, health clubs, and gyms
- Illegal operations and treatments
- Illegally procured drugs
- Insurance premiums (not reimbursable under FSA only PRA)
- Long-term care services
- Maternity clothes
- Medical savings accounts
- Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits
- Personal items
- Preferred provider discounts
- Social activities
- Special foods and beverages
- Swimming lessons
- Tattoos/tattoo removal
- Teeth whitening
- Transportation expenses to & from work
- Travel for general health improvement
- Uniforms
- Vitamins & supplements without prescription

FSA/HSA Non-Eligible OTC Products

The following are examples of Over-the-Counter (OTC) medications and products which are NOT ELIGIBLE for HSA reimbursement.

- Aromatherapy
- Baby bottles & cups
- Baby oil
- Baby wipes
- Breast enhancement system
- Cosmetics (including face cream & moisturizer)
- Cotton swabs
- Dental floss
- Deodorants & anti-perspirants
- Dietary supplements
- Feminine care items
- Fiber supplements
- Food
- Fragrances
- Hair regrowth preparations
- Herbs & herbal supplements
- Hygiene products & similar items
- Low-carb & low-fat foods
- Low calorie foods
- Lip balm
- Medicated shampoos & soaps
- Petroleum jelly
- Shampoo & conditioner
- Spa salts
- Suntan lotion
- Toiletries (including toothpaste)
- Vitamins & supplements without prescription
- Weight loss drugs for general well-being
REQUIRED NOTICES

PREVENTIVE CARE

Medical

Certain services, when billed as preventive, are covered at 100% due to the new Health Care Reform Law. Please note, the services must be billed as preventive, not diagnostic. You may also wish to contact your insurance carrier in advance of a medical procedure that you may undergo to determine what your benefit level is. In doing so, you will want to obtain the diagnosis and the billing code in advance that the Doctor’s office or Hospital will use for payment of the service you will be provided. With the diagnosis and billing code, customer service should be able to tell you exactly how the service will be covered.

Items on the Preventive Care Guidelines are covered with $0 copay:


Pharmaceutical

Certain preventive care prescription drugs are covered 100%.

*A complete list of covered preventive care services and prescription drugs can be found at http://www.bcbsm.com/content/dam/public/Consumer/Documents/help/faqs/preventive-care-brochure.pdf

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan’s legal duties and privacy practices with respect to your health information.

LIFETIME LIMIT NO LONGER APPLIES AND ENROLLMENT OPPORTUNITY

The lifetime limit on the dollar value of benefits under City of Grand Haven’s BCBSM plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact Zac VanOs dol at (616) 847-4887.

OPPORTUNITY TO ENROLL IN CONNECTION WITH EXTENSION OF DEPENDENT COVERAGE TO AGE 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in City of Grand Haven’s BCBSM plan. Enrollment will be effective January 1, 2020. For more information contact Zac VanOs dol at (616) 847-4887.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Zac VanOs dol at (616) 847-4887.

MICHELLE’S LAW

Michelle’s Law is an act that requires health plans to allow college students who take a leave of absence or reduce their class load because of illness to retain their dependent status under their parents’ health plan for up to one year. Students’ eligibility for dependent coverage will continue for one year (unless the student would otherwise lose eligibility within the year). To qualify for protection under Michelle’s Law, the following requirements must be met: the student must be enrolled as a full-time student immediately before the leave of absence or scheduled reduction, the student must have written certification from a treating physician that the leave of absence or reduced schedule is necessary due to a severe illness or injury, and the leave or reduced schedule must have triggered the loss of student status under the health plan. If the plan sponsor changes group health plans during a medically necessary leave and the new health plan offers coverage of dependent children, the new plan will be subject to the same rules.
REQUIRED NOTICES

Women’s Health and Cancer Rights Act of 1998 (Janet’s Law)

Your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). These benefits are subject to applicable terms and conditions under your health plan, including copayments, deductible, and coinsurance provisions. They are also subject to medical insurance limitations and exclusions. This notification is a requirement of the act. If you would like more information on WHCRA benefits, call Zac VanOsドル at (616) 847-4887.

Newborns’ and Mothers’ Health Protection Act

The Newborns’ Act is a federal law that prohibits group health plans and insurance companies (including HMOs) that cover hospitalization in connection with childbirth from restricting a mother’s or newborn’s benefits for such hospital stays to less than 48 hours following a natural delivery or 96 hours following delivery by cesarean section, unless the attending doctor, nurse midwife or other licensed health care provider, in consultation with the mother, discharges the mother or newborn child earlier.

Tell Us When You’re Medicare Eligible

Please notify Human Resources when you or your dependents become eligible for Medicare. You will need to provide Human Resources with a copy of your Medicare card. We are required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the health plan pays primary. You must also contact Medicare directly to notify them that you have health care coverage through an employer group. Privacy laws prohibit anyone other than the Medicare beneficiary, or their legal guardian, to update or change Medicare records. The toll free number to contact Medicare Coordination of Benefits Contractor is 1-800-999-1118.

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic Information’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Nondiscrimination Notice

City of Grand Haven complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. City of Grand Haven does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

City of Grand Haven:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  ○ Qualified sign language interpreters
  ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary Language is not English, such as:
  ○ Qualified interpreters
  ○ Information written in other languages

If you need these services, contact Zac VanOsドル at (616) 847-4887. If you believe that City of Grand Haven has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Zac VanOsドル at (616) 847-4887.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

PREMIUM ASSISTANCE 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 July 31, 2019. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a></td>
<td>Website: <a href="http://flmedicaidtplrecovery.com/hipp/">http://flmedicaidtplrecovery.com/hipp/</a></td>
</tr>
<tr>
<td>Phone: 1-855-692-5447</td>
<td>Phone: 1-877-357-3268</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ALASKA – Medicaid</th>
<th>GEORGIA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>The AK Health Insurance Premium Payment Program</td>
<td>Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a></td>
</tr>
<tr>
<td>Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a></td>
<td>Phone: 678-564-1162 ext 2131</td>
</tr>
<tr>
<td>Phone: 1-866-251-4861</td>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
</tr>
<tr>
<td>Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/">http://dhss.alaska.gov/dpa/Pages/</a></td>
<td>Medicaid Eligibility:</td>
</tr>
<tr>
<td>State</td>
<td>Program Description</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</td>
<td><a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a></td>
</tr>
<tr>
<td>IOWA – Medicaid</td>
<td></td>
</tr>
<tr>
<td>NEW HAMPSHIRE – Medicaid</td>
<td></td>
</tr>
<tr>
<td>KENTUCKY – Medicaid</td>
<td></td>
</tr>
<tr>
<td>NEW JERSEY – Medicaid and CHIP</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### PREMIUM ASSISTANCE MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid/CHIP Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOUISIANA – Medicaid</td>
<td><a href="http://dhh.louisiana.gov/index.cfm/subhome/1n/331">Website</a></td>
<td>1-888-695-2447</td>
</tr>
<tr>
<td>MAINE – Medicaid</td>
<td><a href="http://www.maine.gov/dhhs/offi/public-assistance/index.html">Website</a></td>
<td>1-800-442-6003</td>
</tr>
<tr>
<td>MASSACHUSETTS – Medicaid</td>
<td><a href="http://www.mass.gov/eohhs/assistance/index.html">Website</a></td>
<td>1-800-862-4840</td>
</tr>
<tr>
<td>MISSOURI – Medicaid</td>
<td><a href="https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp">Website</a></td>
<td>1-800-657-3739</td>
</tr>
<tr>
<td>MONTANA – Medicaid</td>
<td><a href="http://dphhs.mt.gov/MontanaHealthCarePrograms/HIPP">Website</a></td>
<td>1-800-694-3084</td>
</tr>
<tr>
<td>NEBRASKA – Medicaid</td>
<td><a href="http://www.ACCESSNebraska.ne.gov">Website</a></td>
<td>(855) 632-7633</td>
</tr>
<tr>
<td>NEW YORK – Medicaid</td>
<td><a href="https://www.health.ny.gov/health_care/medicaid/">Website</a></td>
<td>1-800-541-2831</td>
</tr>
<tr>
<td>NORTH CAROLINA – Medicaid</td>
<td><a href="https://medicaid.ncdhhs.gov">Website</a></td>
<td>919-855-4100</td>
</tr>
<tr>
<td>NORTH DAKOTA – Medicaid</td>
<td><a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">Website</a></td>
<td>1-844-854-4825</td>
</tr>
<tr>
<td>MINNESOTA – Medicaid</td>
<td><a href="http://www.insureoklahoma.org">Website</a></td>
<td>1-888-365-3742</td>
</tr>
<tr>
<td>MISSOURI – Medicaid</td>
<td><a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">Website</a></td>
<td>573-751-2005</td>
</tr>
<tr>
<td>OREGON – Medicaid</td>
<td><a href="http://healthcare.oregon.gov/Pages/index.aspx">Website</a></td>
<td>1-800-699-9075</td>
</tr>
<tr>
<td>PENNSYLVANIA – Medicaid</td>
<td><a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">Website</a></td>
<td>1-800-692-7462</td>
</tr>
<tr>
<td>RHODE ISLAND – Medicaid and CHIP</td>
<td><a href="http://eohhs.ri.gov/">Website</a></td>
<td>855-697-4347, or 401-462-0311 (Direct Rite Share Line)</td>
</tr>
<tr>
<td>State</td>
<td>Medicaid Website</td>
<td>Medicaid Phone</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------</td>
<td>-------------------------</td>
</tr>
</tbody>
</table>
PREMIUM ASSISTANCE MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

To see if any other states have added a premium assistance program since July 31, 2019, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.
CREDITABLE COVERAGE NOTICE

Important Notice from City of Grand Haven About
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Grand Haven and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

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.

City of Grand Haven has determined that the prescription drug coverage offered by the City of Grand Haven Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
CREDITABLE COVERAGE NOTICE

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 do decide to enroll in a Medicare drug plan, your current City of Grand Haven coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current City of Grand Haven coverage, be aware that you and your dependents will not be able to get this coverage back.

Please contact your Plan Administrator for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.
CREDITABLE COVERAGE NOTICE

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with City of Grand Haven and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information about Your Current Prescription Drug Coverage...
Contact your Benefits Administrator for City of Grand Haven at 616-847-4887. For a further explanation of the prescription drug coverage plan provisions/options under the City of Grand Haven Health Plan please consult the relevant plan document provisions.

For More Information about This Notice...
Contact call Zac VanOsdol at (616) 847-4887. NOTE: You will receive this notice each year. You will also get it before the next period you can enroll in a Medicare prescription drug coverage, and if this coverage through City of Grand Haven changes. You also may request a copy of this notice at any time.
CREDITABLE COVERAGE NOTICE

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

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

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 1/1/2020

Name of Entity/Sender: City of Grand Haven

Contact--Position/Office: Zac VanOsdol

Address: 519 Washington Avenue

Phone Number: 616-847-4887
GLOSSARY OF TERMS

**Balance Billing** — When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

**Coinsurance** — The portion of the cost for care received for which an individual is financially responsible, which is usually calculated as a percentage (such as 20%). Often coinsurance applies after a specific deductible has been met and may be subject to an individual out-of-pocket. For example, if the plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your coinsurance payment of 20% would be $20. The plan pays the rest of the allowed amount.

**Copayment** — A payment you make at the time that selected services are rendered and no additional payment is required. Copayments are typically flat amounts (for example, $15), covering such items as office visits, prescriptions, and emergency care.

**Covered Expenses** — Health Care expenses that are covered under your health plan.

**Deductible** — the amount of eligible expenses you must pay out of pocket each plan year, before the plan begins to pay. The deductible may not apply to all services.

  ⇒ **Embedded Deductible**: An embedded deductible is an individual deductible level within a family contract. For example, if there is a family deductible of $3,000 with an individual embedded deductible of $1,500, when any one individual family member reaches $1,500 in expenses, their benefit plan coverage takes effect.

  ⇒ **Non-embedded deductible**: A non-embedded deductible requires that the entire family deductible be met before benefit plan coverage takes effect by any one or combination of family members.

**Evidence of Insurability** — A medical questionnaire which is used to determine whether an applicant will be approved or declined coverage.

**Guarantee Issue** — The amount which is available without providing an Evidence of Insurability (EOI). An EOI will be required for any amounts above this for late enrollees or increases in insurance.

**In-Network** — Care received from physicians, facilities, or suppliers that are contracted with the insurer to provide services on a negotiated discount basis.

**Out-of-Network** — Care received from physicians, facilities, or suppliers that are not contracted with the insurer to provide services on a negotiated discount basis.

**Out-of-Pocket Expense** — Amount you must pay toward the cost of health care services. This may include deductibles, copayment, and/or coinsurance.

**Out-of-Pocket Maximum** — The maximum dollar amount a member is required to pay out of pocket during a benefit period. Plans may vary but deductibles and coinsurance may apply toward meeting the out-of-pocket maximum.

**Preferred Provider** — A provider who has a contract with your carrier/vendor to provide services to you at a discount.

**Pre-existing Condition** — Any Injury or Sickness for which you received medical treatment, advice, or consultation, care, or services including diagnostic measures, or had drugs or medicines prescribed or taken in the X months prior to the day you become insured.

**Provider** — A physician (medical, dental, or vision), health care professional or health care facility licensed, certified, or accredited as required by state law.

**Prior Authorization/Pre-Service Notification** — The decision by the plan or health insurer that a health care service, treatment plan, prescription drug, medical equipment, or other health care services defined in the certificate of coverage, is medically necessary. The plan may require preauthorization for certain services before receiving them, except in an emergency.

**UCR (Usual, Customary, & Reasonable)** — The amount paid for a service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount is sometimes used to determine the allowed amount.