Oakland County

EMPLOYEE BENEFITS

January 2022

Benefit Guide

Oakland County | Human Resources Benefits Unit

IMPORTANT CONTACT INFORMATION

Medical

(PPO)
ASR Health Benefits
(800) 968-2449
www.asrhealthbenefits.com

(PPO)
Blue Cross/Blue Shield of Michigan
(877) 790-2583
www.bcbsm.com

(HMO)
Health Alliance Plan (HAP)
(313) 872-8100
www.hap.org

Prescription

Navitus Health Solutions
(888) 240-2211
www.navitus.com

Novixus Mail Order
(877) 668-4987
www.novixus.com

Dental
Delta Dental of Michigan
(800) 524-0149
www.deltadentalmi.com

Vision
National Vision Administrators
(800) 672-7723
www.e-nva.com

Flexible Spending Accounts
WageWorks
(877) 924-3967
www.wageworks.com

Disability and Life Insurance (Oakland County Policy Number: 402334)

The Hartford – Disability
(800) 898-2458
www.thehartfordatwork.com

The Hartford – Life
(877) 320-0484

Employee Benefits
2100 Pontiac Lake Rd, 41W
Waterford, MI 48328
www.oakgov.com/benefits

Carmen Cargill
New Hires, Family Status Changes, Dental, Vision Flexible Spending Accounts (248) 452-9189
cargillc@oakgov.com

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Benefits Supervisor
(248) 858-5212
bedrickys@oakgov.com

Kate Saranas
Medical, RX, Unemployment
(248) 858-0545
saranask@oakgov.com

Paige Ritchie
Benefits Support
(248) 858-0465
ritchiep@oakgov.com

Carol Sawinski
Disability, Life COBRA
(248) 858-5205
sawinskic@oakgov.com

IF YOU HAVE MEDICARE OR WILL BECOME ELIGIBLE FOR MEDICARE IN THE NEXT 12 MONTHS, FEDERAL LAW GIVES YOU MORE CHOICES ABOUT YOUR PRESCRIPTION DRUG COVERAGE. PLEASE REFER TO THE PRESCRIPTION DRUG COVERAGE AND MEDICARE NOTICE IN THIS BENEFIT GUIDE FOR MORE DETAILS.

Revised date 01/20/2021

Oakland County Employee Benefit Guide
Introduction

The Benefit Guide describes the benefits available through the County's Cafeteria Plan. The County of Oakland established a Cafeteria Plan effective January 1, 1994 for its employees, for the purpose of providing eligible employees with the opportunity to choose from various benefit plan options available under the Plan. The Plan is intended to qualify as a Cafeteria Plan under the provisions of Internal Revenue Service Code § 125.

The benefits covered include Medical, Dental, Vision, Life Insurance, Accidental Death and Dismemberment Insurance, and voluntary participation in Health Care and Dependent Care Flexible Spending Accounts. Other benefits available to eligible employees (Disability, Retirement Savings, Paid Time Off, etc.), are not included in the Cafeteria Plan.

The Benefit Guide is a resource that employees will have available to them throughout their employment with Oakland County. Some uses include:

- **Electing benefits as a New Hire:** Provides new employees with the information they need to elect their Medical plan, their Standard Dental and Vision plans, and, if desired, their optional Health and/or Dependent Care Reimbursement Account. New employees are automatically provided with the Standard Life Insurance and Accidental Death and Dismemberment Insurance.

- **Life events (marriages, births, etc.) throughout the calendar year:** Provides employees with information needed to make appropriate changes to their benefits within 30 days of the event.

- **Open Enrollment:** Provides employees with information on when the annual Open Enrollment occurs for the next calendar year.

- **Required Notices:** Provides employees and their dependents with the notices required by State and Federal legislation.

THIS BENEFIT GUIDE IS INTENDED TO BE AN OVERVIEW OF OUR FLEXIBLE BENEFITS CAFETERIA PLAN PROGRAM. IT IS NOT INTENDED TO BE A COMPLETE AND THOROUGH RESTATEMENT OF THE INDIVIDUAL PLAN OPTIONS AND THE PROVISIONS, CONDITIONS, LIMITATIONS, AND EXCEPTIONS THAT MAY APPLY SPECIFICALLY TO A PARTICULAR BENEFIT. IF THERE IS ANY CONFLICT BETWEEN THIS BENEFIT GUIDE AND THE ACTUAL TERMS OF OUR PLAN(S), THE PROVISIONS OF THE PLAN(S) WILL CONTROL.

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Questions?

Contact:

Stephanie Bedricky, Benefits Supervisor	(248) 858-5212
Paige Ritchie, Benefits Support	(248) 858-0465
Kate Saranas, Medical, Prescription, & Unemployment	(248) 858-0545
Carmen Cargill, Dental, Vision, Flexible Spending Accounts	(248) 452-9189
Carol Sawinski, COBRA, Life & Short/Long Term Disability	(248) 858-5205

Email: **benefits@oakgov.com**

New Hire Employee Important Notice:

If Human Resources – Employee Benefits does not receive your Health Plan Enrollment in Workday, you will receive the following coverage for yourself only:

- **ASR Health Benefits (PPO3) Medical Health Coverage**
- **Dental – Standard**
- **Vision – Standard**

The cost for Single ASR Health Benefits (PPO3) Medical Coverage is $16.00 bi-weekly (pre-tax). You will not be able to make changes to your coverage until you have a qualifying Life Event (marriage, birth of child, etc.) or the next Employee Benefits Open Enrollment period, which may be one year from eligibility.

NOTE: Health Care and Dependent Care Reimbursement (Flexible Spending) Accounts are available to all employees at hire. Your reimbursement account allocation(s) will be divided among the remaining pay of the calendar year. Please note that all coverages are effective within 30 days after hire, depending on your hire date. Please see the next page for eligibility.

Human Resources – 2ND Floor
Employee Benefits Unit
L. Brooks Patterson Building
2100 Pontiac Lake Rd, Bldg 41 W
Waterford, MI 48328-0440

Website: www.oakgov.com/benefits

Or contact Human Resources – Employee Benefits.

New Hire Employee Health Plan Eligibility Schedule:

New employees become eligible for enrollment as shown in the following chart. If you do not submit your Health Plan Enrollment in Workday, you will receive a standard benefits package (ASR PPO3, Standard Vision, and Standard Dental for yourself only). The following chart shows the effective dates for Medical, Dental, and Vision coverages for yourself and any eligible dependents that you include on your enrollment form.

DATE OF HIRE		ELIGIBLE FOR
FROM	THROUGH	HEALTH COVERAGE
JANUARY 1	JANUARY 31	FEBRUARY 1
FEBRUARY 1	FEBRUARY 28 OR 29	MARCH 1
MARCH 1	MARCH 31	APRIL 1
APRIL 1	APRIL 30	MAY 1
MAY 1	MAY 31	JUNE 1
JUNE 1	JUNE 30	JULY 1
JULY 1	JULY 31	AUGUST 1
AUGUST 1	AUGUST 31	SEPTEMBER 1
SEPTEMBER 1	SEPTEMBER 30	OCTOBER 1
OCTOBER 1	OCTOBER 31	NOVEMBER 1
NOVEMBER1	NOVEMBER 30	DECEMBER 1
DECEMBER1	DECEMBER31	JANUARY 1

Medical Coverage and Bi-Weekly Contributions:

A bi-weekly deduction is required for all medical coverages with Oakland County. The chart below summarizes the cost associated with the coverage that you choose and the number of dependents you include on your enrollment form.

If you choose:*	*Your bi-weekly deduction* will be:*		
	Single	2-person	Family (3 or more)
ASR Health Benefits (PPO1)	$32	$65	$75
Blue Cross/Blue Shield (PPO2)	$42	$70	$85
ASR Health Benefits (PPO3)	$16	$35	$45
Health Alliance Plan (HAP) HMO	$32	$65	$75

Employees also have the option to "Opt-Out" of medical coverage and receive a credit in their bi-weekly paychecks according to the following chart:

No Coverage Option	$7.69	$15.38	$23.08	Earnings
No Coverage Option Spouse/Parent is County Employee/Retiree	$3.85	$3.85	$3.85	Earnings

*Union represented employees' medical plans and bi-weekly deductions may differ. Please talk with your supervisor if you have questions about whether your job classification and position are union represented regardless of whether or not you pay union dues.

All bi-weekly healthcare contributions will be deducted from your pay. If you have not earned enough wages or utilized leave during a pay period, the contributions owed will be accrued and deducted from the first paycheck(s) you begin earning wages or receive leave time. If there is a month in which you neither earn wages nor utilize leave time, you will be required to pay in cash to Oakland County the full monthly healthcare premium charges on or before the first of the month for which coverage is to be provided.

Visit www.oakgov.com/benefits for Oakland County Employee Benefits forms, important telephone numbers, and website links.

LIFE EVENTS (STATUS CHANGES)

In accordance with federal regulations, the benefits you choose will remain in effect until the next Plan Year. You will only be able to change your benefit elections during the Plan Year if you have a qualifying change in status, the election change is consistent with your status change, and you contact Human Resources – Employee Benefits within **30 days** of the status change.

Examples of qualifying status changes include the following events:

- Change in legal marital status, including marriage, divorce, legal separation, or annulment
- Change in number of dependents
- Termination or commencement of employment by the employee, spouse, parent, or dependent
- Changes in a spouse/parent's health care coverage, if you have opted out of Oakland County's medical, dental, and/or vision plans
- A reduction or increase in hours worked by the employee, spouse, parent, or dependent (including a switch between part-time and full-time) in accordance with IRS guidelines

Documents Required to Support Eligible Status Change:

Event Category	Required Document (Photocopies are acceptable)
Birth of Child	Birth Certificate
Add Children	Birth Certificate (and Marriage Certificate, if married dependent)
Marriage	Marriage Certificate
Add Step-Children	Birth Certificate and Marriage Certificate
Adoption	Legal Court Documentation
Legal Guardianship	Legal Court Documentation

The Internal Revenue Service requires that the change in benefits must be consistent with the change in status. The examples above are only illustrative. The IRS has issued detailed guidelines that must be applied to individual cases. All requests for changes in benefits as a result of a status change event must be reviewed and approved by Human Resources – Employee Benefits. If you have a change in status (such as a marriage or birth of a child) and wish to add a dependent or change a benefit, you must complete a "Membership and Record Change" and "Family Status Change" form and provide the required documents. These forms are available on our website at www.oakgov.com/benefits or at the Human Resources Department. Assistance is available should you have any questions. According to the Plan, the form must be completed and returned within **30 days*** of the change in status to be eligible. Requests for **changes made after 30 days will not be accepted.**

*** Forms must be completed within 60 days for changes in eligibility for Medicaid or CHIP (Child Health Insurance Program). Please contact Human Resources – Employee Benefits for additional details.**

DEPENDENT ELIGIBILITY

Criteria for Children:

Children of the employee by birth or legal adoption may be covered through the end of the year in which they have their 26th birthday.

If a child does not meet the above criteria, they may only be covered if the employee is directed to do so by a National Medical Support Order and Human Resources – Employee Benefits has been provided with the appropriate updated and current legal documentation.

Children by birth or legal adoption of the employee's spouse (step-children of the employee) may be covered through the end of the year in which they have their 26th birthday or until such time that the marriage to your spouse has ended due to divorce, annulment, legal separation, or death.

Permanently Disabled children of the employee may be covered to any age if:

- The child became totally and permanently disabled prior to age 19; **AND**
- They are incapable of self-sustaining employment; **AND**
- The employee provides over half their total support as defined by the Internal Revenue Code; **AND**
- Their disability has been certified by a physician and the health carrier is notified in writing by the end of the year in which the child turns age 26.

Legal Guardianship children of the employee may be covered through the end of the year in which they have their 26th birthday if:

- They are unmarried
- Their legal residence is with you
- You supply over half their total support as defined by the Internal Revenue Code
- You provide up-to-date legal guardianship papers

Children, of whom you are the legal guardian, may only remain on your healthcare coverage while the Legal Guardianship Order is in effect. If at any point the Legal Guardianship Order ends, the children can no longer be covered and must be removed.

Criteria for Spouses:

Oakland County allows for the legal spouse of an employee to be covered under your benefits. Spouses are NOT eligible if you are legally separated (separate maintenance agreement in Michigan) or divorced. If you are legally separated or divorced and have a legal judgment that requires you to maintain health insurance for your ex-spouse, this individual **CANNOT** remain on your healthcare coverage. They must be removed from your Oakland County coverage, and you must obtain separate coverage for them.

CANCELING COVERAGE

At such time that your spouse or child(ren) no longer meets the eligibility criteria, you must complete a Membership and Record Change form to remove him/her from coverage. The Membership and Record Change form can be found on the www.oakgov.com/benefits website and must be submitted, **within 30 days from the date of the event,** to Human Resources – Employee Benefits.

OPEN ENROLLMENT

Oakland County's Open Enrollment is conducted annually during October and November. As part of Open Enrollment, all full-time eligible employees will have the opportunity to change their current benefits.

Before Open Enrollment commences, you will receive a task in Workday, which will be sent directly to your Workday inbox.

There will be one (1) continuous time period available for you to log onto the Open Enrollment website and make changes. This time period will begin in September and end in October.

PLEASE NOTE: A simple dependent eligibility verification is required as part of the annual Open Enrollment process. Miscellaneous Resolution #14115 requires employees that have dependents (spouse and/or children) on their healthcare plans to confirm each year during Open Enrollment whether or not their dependents are still eligible for coverage. This proactive confirmation of dependents assists in delaying the need to conduct annual dependent audits that would require employees to provide photocopies of legal documentation.

Employees with dependents (spouse and/or children) **MUST TAKE ACTION** during the Open Enrollment period to confirm dependent eligibility. **Failure to confirm dependent eligibility will result in coverage being dropped for non-verified dependents at the end of the current Plan Year (Plan Years are January 1 through December 31)**. The next available opportunity to add dependents back onto employee healthcare plan(s) will be during next year's Open Enrollment (with a January 1 effective date).

For further information regarding Open Enrollment, please visit the HR Benefits' website at www.oakgov.com/benefits.

MEDICAL PLANS

Oakland County is very aware of the different needs that each of us has for comprehensive medical coverage. It is understood that the medical plan you prefer may be different from the plan that your co-worker feels would be best for his/her needs. Some employees have no need for medical benefits, as they may have coverage elsewhere.

This workbook covers several different groups of employees. Please carefully review the information below to determine which plans are available to you.

YOUR CHOICES*:

- ASR Health Benefits (PPO 1)
- Blue Cross/Blue Shield Community Blue (PPO 2)
- ASR Health Benefits (PPO 3)
- Health Alliance Plan (HAP) HMO
- Traditional Plan (closed plan for current enrollees only)
- No Coverage

****Union represented employees benefits may differ***.

Note: All **dependents** on your coverage, including dependent children between 18 and 26 years of age, must have the same health, dental, and vision coverage you elect if they have any coverage at all.

ASR - PPO 1 Plan

The PPO 1 plan is administered by ASR Health Benefits, the division of the Health Alliance Plan that administers self-funded PPO plans. More information can be found at www.asrhealthbenefits.com.

If you are electing this plan as a plan change during Open Enrollment, please complete this change with the online system.

The PPO 1 Plan being offered consists of two parts: Basic and Master Medical.

Basic coverage, the first and most comprehensive part of the PPO 1 Plan, provides benefits (generally, 100% in-network coverage with no deductible) for in-patient services, including hospital, physician, surgeries, as well as for various outpatient services, including medical exams (diagnostic or routine), and laboratory or x-ray services. A few basic coverage services may be subject to a copayment. For example, a $100 copayment applies to emergency room visits that do not result in admission to the hospital or are not the result of accidental injury. Preventive services covered under this plan include, but are not limited to, the following services when provided by a participating provider: Annual health maintenance exam (including select lab tests), routine pap, mammogram, Prostate Specific Antigen (PSA) testing, well-child care, colonoscopy and select immunizations. No deductible, coinsurance, or copayments apply to eligible in-network preventive services.

The second part of this plan, the Master Medical coverage, provides benefits for a select list of outpatient medical expenses (for example, durable medical equipment and ambulance services). Before the master medical component of this plan provides reimbursement for the certain services deemed to be master medical expenses, you must first satisfy a calendar year deductible of $200 per person or $400 per family, and then the plan will pay 90% of the covered expenses until the $1000 coinsurance maximum has been reached. Once this coinsurance amount has been reached, the plan will pay 100% of eligible expenses for the rest of the calendar year. However, any copayments applicable to some basic coverage services may apply. Keep in mind that to receive the best benefits at the previously stated benefit percentage with the PPO 1 Plan, you must use participating providers. Failure to do so can result in a 15% reduction in the approved amount the Plan will pay. **Unlike a HMO, however, you are free to see any of the participating doctors that you choose without a referral**.

In most instances, the PPO 1 Plan will result in less out-of-pocket expense for you while still allowing the freedom to choose from a large group of doctors.

Refer to the Medical Option Comparison chart for more detailed information about this PPO plan option.

How to Find a Participating Provider:

- Go to www.asrhealthbenefits.com
- Click on I'm a Member
- Select Find a Providers
- Enter provider name or type of provider
- Click Search
    - Note: Participating providers may be in the Physicians Care/HAP, Cigna, and MultiPlan networks, all of which are included in the PPO 1 Plan. To access the Cigna or MultiPlan Website to search for participating providers in their network, follow steps 1 and 2 above, locate the Related Links box, and click on either Cigna or MultiPlan. For additional provider search instructions, contact ASR.

BCBS - PPO 2 Plan
The PPO 2 plan is administered by Blue Cross/Blue Shield of Michigan. More information can be found at www.BCBSM.com.

If you are electing this plan as a plan change during Open Enrollment, please complete this change with the online system.

The PPO 2 Plan being offered consists of basic coverage which provides benefits for in-patient hospital, physician, and laboratory services, as well as for various outpatient surgical, medical, laboratory services and durable medical equipment.

Before the plan provides reimbursement for eligible services, you must first satisfy a calendar year deductible of $100 per person or $200 per family. The plan will then pay 90% of the covered and approved expense until you have reached the coinsurance maximum of $500 per person or $1000 per family. Once this coinsurance amount has been reached, the plan will pay 100% of eligible expenses for the rest of the calendar year.

Keep in mind that with the PPO 2 Plan in order to receive the best benefits, you must use participating providers. Failure to do so can result in a 20% reduction in the approved amount the Plan will pay. **Unlike an HMO, however, you are free to see any of the participating doctors you wish without a referral.**

Preventive services, when provided by a participating provider, include annual health maintenance exam (including select lab tests), routine pap, mammogram, Prostate Specific Antigen (PSA) testing, well child care, colonoscopy and select immunizations. No deductible, coinsurance, or copayment is required for these preventive services.

Refer to the Medical Option Comparison chart for more detailed information about this PPO plan option.

A $100 copayment applies to Emergency Room visits that do not result in admission to the hospital or are not the result of accidental injury.

How to Find a Provider:

- Go to www.bcbsm.com
- Click on Find a Doctor
- Click on Get Started
- Choose PPO Plans or Traditional
- Enter ZIP code
- Enter the Specialty you are looking for or the name of a specific doctor or hospital
- Click on Search

ASR - PPO 3 Plan

The PPO 3 plan is administered by ASR Health Benefits, the division of Health Alliance Plan that administers self-funded PPO plans. More information can be found at www.asrhealthbenefits.com.

If you are electing this plan as a plan change during Open Enrollment, please complete this change with the online system.

The PPO 3 Plan being offered consists of comprehensive basic coverage which provides benefits for most inpatient and outpatient medical expenses, including, but not limited to, hospital, physician, surgical, medical exams, ambulance transportation, laboratory and x-ray services as well as durable medical equipment. Some covered services may be subject to a copayment. For example, a $100 copayment applies to emergency room visits that do not result in admission to the hospital or are not the result of accidental injury. Preventive services covered under this plan include, but are not limited to, the following services when provided by a participating provider: Annual health maintenance exam (including select lab tests), routine pap, mammogram, Prostate Specific Antigen (PSA) testing, well-child care, colonoscopy and select immunizations. No deductible, coinsurance, or copayments apply for these eligible in-network preventive services.

Before the plan provides reimbursement for eligible services, you must first satisfy a calendar year deductible of $250 per person or $500 per family. The plan will then pay 80% of most in-network covered expenses until the coinsurance maximum of $1000 per person or $2000 per family has been reached. Once this coinsurance maximum has been reached, the Plan will pay 100% of eligible expenses for the rest of the calendar year. However, any copayments applicable to certain services may apply.

Keep in mind that to receive the best benefits at the previously stated benefit percentage with the PPO 3 Plan, you must use participating providers. Failure to do so can result in a 15% reduction in the approved amount the Plan will pay. **Unlike an HMO, however, you are free to see any of the participating doctors you choose without a referral.**

Refer to the Medical Option Comparison chart for more detailed information about this PPO plan option.

How to Find a Participating Provider:

- Go to www.asrhealthbenefits.com
- Click on I'm a Member
- Select Find a Provider
- Enter provider name or type of provider
- Click Search
    - Note: Participating providers may be in the Physicians Care/HAP, Cigna, and MultiPlan networks, all of which are included in the PPO 3 Plan. To access the Cigna or MultiPlan Website to search for participating providers in their network, follow steps 1 and 2 above, locate the Related Links box, and click on either Cigna or MultiPlan. For additional provider search instructions, contact ASR.

HMO Plan
The HMO plan is offered through Health Alliance Plan. More information can be found at www.hap.org.

If you are electing this plan as a plan change during Open Enrollment, please complete this change with the online system. Also, be sure to add your Primary Care Physician or Facility information during enrollment.

Health Alliance Plan (HAP) is a Health Maintenance Organization (HMO) with Primary Care Physicians and Specialists in 18 counties and, as such, there are little or no out-of-pocket costs for hospital and physician care or diagnostic testing. In addition, well check-ups, immunizations, office visits (whether for illness or routine), and many other services are covered with a $20 copayment for every office visit.

Emergency care is covered world-wide. A $100 copayment applies to Emergency Room visits that do not result in admission to the hospital. Urgent care for non-life threatening events has a $20 copay charge.

Preventive services include routine physicals, well baby care, pap, mammogram, routine hearing exam, routine eye exam, select immunizations and related laboratory and radiology services. No copayment applies for these services.

Refer to the Medical Option Comparison chart for more detailed information about this HMO plan option.

It is important to recognize that an HMO operates quite differently from the PPO 1, PPO 2 or PPO 3 plans, in that **a primary care physician (PCP) directs all of your care in an HMO**. When you choose your PCP you're also choosing your network of doctors for any specialty care you may need. For example, if you choose a PCP in the Henry Ford Medical Group (HFMG), ACESS or the Genesys network, you will receive any specialty care from doctors within that network. If you choose a PCP in any of our other networks, you may be able to see specialists in any HAP network. This is sometimes referred to as an Open Delivery System. Emergency coverage is world-wide. There is no PCP or specialty coverage for out-of-network benefits.

Additional information and a list of participating providers are available at the Website noted above. Fertility treatments have limited coverage.

How to Find a Participating Provider:

- Go to www.hap.org
- Click on Find a Doctor/Facility
- Enter provider name
- Click Search
    - Note: Searches by Providers, Facility, and Services can also be done at the bottom of the Search page.

BCBS - Traditional Plan
The Traditional plan is administered by Blue Cross/Blue Shield of Michigan. More information can be found at www.bcbsm.com.

No new enrollments are allowed in the Traditional Plan. *Once an employee leaves Traditional Plan, it cannot be elected again until retirement.*

The Blue Cross/Blue Shield Traditional Plan is made up of two parts: Basic and Major Medical.

The Basic coverage provides benefits for inpatient hospital, physician, and laboratory services, as well as various outpatient surgical, medical, and laboratory services. Outpatient x-ray and laboratory services are covered with a 10% coinsurance.

The Major Medical plan covers such items as office visits, durable medical equipment, and ambulance services, as well as extending coverage in certain circumstances when benefits under the basic portion are exhausted. Before the master medical plan provides reimbursement for eligible services, you must first satisfy a calendar year deductible of $200 per person or $400 per family. The plan will pay 75% to 90% of the covered and approved expense. You will pay the remaining percentage as a coinsurance. The plan has a $1000 coinsurance maximum per family per calendar year. Once this coinsurance amount has been reached, the plan will pay 100% of eligible expenses for the rest of the calendar year.

Preventive services, when provided by a participating provider, include annual health maintenance exam (including select lab tests), routine pap, mammogram, Prostate Specific Antigen (PSA) testing, well child care, colonoscopy and select immunizations. No deductible, coinsurance, or copayment is required for these preventive services.

Refer to the Medical Option Comparison chart for more detailed information about this Traditional plan option.

A $100 copayment applies to Emergency Room visits that do not result in admission to the hospital or are not the result of accidental injury.

No Coverage Option
If you are covered under another medical benefit plan, you may choose not to participate in any of the medical benefit plans available.

You must provide evidence on an annual basis that you are enrolled in another medical plan by completing Form A - Other Medical Verification, which can be found in the front of this Benefit Guide or at www.oakgov.com/benefits.

Please Note: If your spouse/parent is providing your medical coverage **and** your spouse/parent is also an employee of Oakland County, **your earnings** for the "No Coverage" medical option will be less. Refer to your Benefit Statement.

A Note About Health Care Reimbursement Accounts (HCRA)
Remember your medical plan is just one part of your healthcare package. Your Health Care Reimbursement Account can play a significant role in limiting the cost for your healthcare needs. You can use your deposits to the HCRA to pay for medical copayments, deductibles, coinsurance, and other items not covered or not paid in full by your selected medical coverage. You can learn more about how to use the HCRA to your advantage by referring to the section on Health Care Reimbursement Accounts in this Benefit Guide.

PRESCRIPTION DRUG PLANS

Navitus Drug Plan

For non-HMO Medical Plans. More information can be found at www.navitus.com.

This section applies to employees that select the following medical plans:

- BCBS - Traditional Plan
- ASR - PPO 1 Plan
- BCBS - PPO 2 Plan
- ASR - PPO 3 Plan

Here are a few definitions that may help you understand your prescription drug program:

- **Formulary:** A list of preferred brand name prescription drugs as determined bya medical plan.
- **Non-Formulary**: Brand name prescription drugs not on the preferred list as determined by a medical plan.
- **Generics:** These are drugs whose patent has ended and can be manufactured by anyone. The Plan will consider as a Generic Drug, any Federal Food and Drug Administration approved generic pharmaceutical which is dispensed according to the professional standards of a licensed pharmacist, is clearly designated by the pharmacist as being generic and has a physician's prescription**.**

The Navitus formulary, or preferred drug list, includes prescription drugs established to be clinically sound and cost effective by a committee of physicians and pharmacists. The Pharmacy and Therapeutics (P&T) Committee at Navitus evaluates which drugs to include and exclude from the formulary list. Experts evaluate prescription drugs based on the following criteria:

- Effectiveness
- Side-effects
- Drug interactions
- Cost

Formulary (preferred drug list) additions, exclusions and coverage changes are made at the discretion of physicians and pharmacists on the Navitus P&T Committee. On-going evaluation of new and existing prescription drugs ensures the formulary is up-to-date, and meets patient health needs.

Therapeutic class reviews, are a group of drugs that are chemically similar, and have the same effect in the body. At least once a year the Navitus P&T Committee reviews the entire formulary (preferred drug list).

A three-tier prescription drug program is in effect for Oakland County employees. Under the three-tier program, the amount of the copayment varies as shown below:

- Tier 1 – This is your lowest cost option, including many generic medications and a few brand name drugs. Your copayment for Tier 1 prescriptions is $5.00.
- Tier 2 – This offers more brand name options, including preferred brands and some generics. Your copayment for Tier 2 prescriptions is $20.00.
- Tier 3 – This is your most costly option with Non-Preferred products (could include both brand and generic products). If your drug falls in Tier 3, discuss this and other options with your pharmacist or physician to determine if an alternative, less expensive medication in Tier 1 or 2 is appropriate for you. Your copayment for Tier 3 prescriptions is $40.00.

If you request a prescription to be filled with a brand name drug and there is a generic available, you will be responsible for the Tier 3 copay plus the difference between the cost of the brand and the generic drug. If your doctor makes the request, you will be responsible for the tier 3 copayment.

More information about Navitus, including participating pharmacies and formulary information, can be found at www.navitus.com or by calling (866) 333-2757.

You can obtain a three (3) month supply of medication by mail order or through your local pharmacy with one (1) copayment. This works especially well with maintenance drugs that are prescribed to you. To enroll or obtain the necessary forms regarding the mail order prescription service, contact NoviXus at www.novixus.com and www.oakgov.com/benefits or by calling (888) 240-2211.

For specialty medications, the Navitus SpecialtyRx Program works with Lumicera Specialty Pharmacy to offer services with the highest standard of care. In the event your physician prescribes a specialty drug, you may contact Lumicera Specialty Pharmacy directly at (855) 847-3553.

HAP Drug Plan

This section applies to employees that select the HMO Medical Plan. More information can be found at www.hap.org.

HAPs Ambulatory Pharmacy & Therapeutics (P&T) Committee reviews and approves the drugs listed based on how well they work and how safe they are. If more than one drug is safe and works well in treating a disease in question, the committee will look at the cost of the drugs. The less expensive drug may be placed in a lower tier. Drugs may switch tiers without notice.

A three-tier prescription drug program is in effect for Oakland County employees. Under the three-tier program, the amount of the copayment varies as shown below:

- Tier 1 – Most generic prescription covered drugs. Your copayment for Tier 1 prescriptions is $5.00.
- Tier 2 – Select brand prescription drugs. Your copayment for Tier 2 prescriptions is $20.00.
- Tier 3 –Brand prescription covered drugs with lower cost alternatives. This would include lifestyle prescription covered drugs (e.g., drugs for infertility, weight loss, erectile dysfunction, and injectable drugs). Your copayment for Tier 3 prescriptions is $40.00.

Members will pay the Brand Drug Copayment when a physician requests a Brand Drug as Dispensed as Written and a generic equivalent is available. Members, who request a Brand Drug when a generic drug is available, will be responsible to pay the Generic Copayment plus the difference between the cost of the Generic equivalent and the Brand Drug.

More information about HAP, including participating pharmacies and formulary information, can be found at www.hap.org or by calling (313) 872-8100.

With mail order you can obtain a standard three (3) month supply of medication with one (1) copayment. Mail order works especially well with maintenance drugs that are prescribed to you. At the local retail pharmacy, you may obtain a 30 or 90-day supply (whichever is greater) with one copayment. Information regarding the mail order prescription service through Pharmacy Advantage is available at www.PharmacyAdvantageRX.com or by calling (800) 456-2112.

IMPORTANT NOTE: **The information contained on this comparison is intended to be an easy to read summary to help you and your family make choices among the different options available to you. Be sure to carefully study each option before making your choice. This comparison summarizes some of the provisions and certain features of each plan. It cannot modify or affect the coverage or benefits provided in any way. No right will accrue to you and/or your eligible dependents because of any statement, error or omission from this comparison. Its provisions do not constitute amendments, modifications or changes in any existing contract.**

*** In order to be eligible for benefits as specified in the SPD, services received by a Covered Person must be administered or ordered by a Physician, be Medically Necessary for the diagnosis and treatment of an illness or injury and allowable/covered charges, unless otherwise specifically noted in the SPD.**

Medical Plan Options Comparison

BENEFITS	AVAILABLE TO ALL EMPLOYEES **PPO1** **ASR Health Benefits** www.asrhealthbenefits.com	AVAILABLE TO ALL EMPLOYEES **PPO2** **Blue Cross/Blue Shield PPO Community Blue Plan** www.BCBSM.com	AVAILABLE TO ALL EMPLOYEES **PPO3** **ASR Health Benefits** www.asrhealthbenefits.com	AVAILABLE TO ALL EMPLOYEES **HMO** **Health Alliance Plan (HAP)** www.HAP.org	ONLY AVAILABLE TO EMPLOYEES CURRENTLY ENROLLED **TRADITIONAL** **Blue Cross/Blue Shield Traditional Plan (BC/BS)** www.BCBSM.com
Employee Bi-Weekly Contributions	**$32 / $65 / $75**	**$42 / $70 / $85**	**$16 / $35 / $45**	**$32 / $65 / $75**	**$52 / $89 / $94**
NO COVERAGE Option	**Refer to Your Total Compensation Statement for (Earnings) amount.**				
Network(s)	HAP Alliance Health & Life PPO / Physicians Care / CIGNA / Multiplan	Blue Cross/Blue Shield	HAP Alliance Health & Life PPO / Physicians Care / CIGNA / Multiplan	Health Alliance Plan HMO	Blue Cross/Blue Shield
Deductible(s)	$200 per person/$400 per family per calendar year	$100 per person/$200 per family per calendar year	$250 per person/$500 per family per calendar year	No Deductible	$200 per person/$400 per family per calendar year
Coinsurance	0% for most services; l0% after deductible as noted.	l0% after deductible as noted. 50% for private duty nursing.	20% after deductible as noted. 50% after deductible for private duty nursing.	No Coinsurance	10% after deductible as noted. 25% for private duty nursing.
Coinsurance Maximum	$1,000 per person/family per calendar year.	$500 per person/$1,000 per family per calendar year.	$1,000 per person/$2,000 per family per calendar year.	Not Applicable	$1,000 per person/family per calendar year.
INPATIENT HOSPITAL CARE					
General Conditions Semi-Private Drugs Intensive Care Unit Meals Hospital Equipment Special Diets Nursing Care	100%	90% after deductible	80% after deductible	100% Bariatric Copay: $1,000	100%
OUTPATIENT HOSPITAL CARE					
Emergency Room Care Accidental Injuries Medical Emergencies	$100 copay Copay waived for accidental injury or if admitted.	$100 copay Copay waived for accidental injury or if admitted.	$100 copay, deductible and coinsurance may also apply for some services. Copay waived for accidental injury or if	$100 copay Copay waived if admitted.	$100 copay Copay waived for accidental injury or if admitted.

Medical Plan Options Comparison					
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			admitted.		
Physical Therapy	100%	90% after deductible 60 combined visits per calendar year.	80% after deductible	100% Includes Speech Therapy and Occupational Therapy Up to 60 consecutive visits per benefit period. May be rendered at home.	90% after deductible 60 combined or consecutive visits per calendar year.
URGENT CARE					
Urgent Care Visits	$20 copay	$20 copay	$20 copay	$20 copay	90% after deductible
PREVENTATIVE CARE SERVICES					
Routine Health Maintenance Exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100%	100%	100%	100%	100%
Routine Physical	100%	100%	100%	100%	100%
Routine Gynecological Exam	100%	100%	100%	100%	100%
Routine Pap Smear Screening – laboratory and pathology services	100%	100%	100%	100%	100%
Well-Baby Child Care Visits • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	100%	100% Plan covers 8 visits (birth through 12 months).	100%	100% No limits on number of visits.	100% Plan covers 8 visits (birth through 12 months).

Medical Plan Options Comparison					
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Adult and Childhood Preventive Services and Immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM, ASR and HAP that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100%	100%	100%	100%	100%
Routine Fecal Occult Blood Screening	100%	100%	100%	100%	100%
Routine Flexible Sigmoidoscopy Exam	100%	100%	100%	100%	100%
Routine Prostate Specific Antigen (PSA) Screening	100%	100%	100%	100%	100%
Routine Mammogram and Related Reading	100%	100% **NOTE:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent coinsurance.	100% **NOTE:** Medically necessary mammograms are subject to your deductible and percent coinsurance.	100%	100% **NOTE:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent coinsurance
Colonoscopy – Routine or Medically Necessary	100%	100% **NOTE:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent coinsurance.	100% **NOTE:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent coinsurance.	100%	100% **NOTE:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent coinsurance.
MENTAL HEALTH CARE					
Inpatient Mental Health	100%	90% after deductible	80% after deductible	100%	100%
Outpatient Mental Health Visits	$20 copay	$20 copay	$20 copay	$20 copay	100%
Inpatient Substance Abuse Care Chemical Dependency	100%	90% after deductible	80% after deductible	100%	100%
Outpatient Substance Abuse Care Chemical Dependency	$20 copay	90% after deductible Office Visit $20 copay	$20 copay	$20 copay	100% In approved facilities only

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SPECIAL HOSPITAL PROGRAMS					
Hospice Care	100%	100%	80% after deductible	Covered up to 210 days per lifetime.	100% of approved amount
Specified Human Organ Transplants	100%	90% to 100% Covered according to plan guidelines.	80% after deductible	Covered according to plan guidelines.	100% in approved facilities
MEDICAL AND SURGICAL CARE					
Surgery	100%	90% after deductible	80% after deductible	100% Voluntary second surgical opinion; $20 copay.	100% Voluntary second surgical opinion on certain surgeries.
Technical Surgical Assist.	100%	90% after deductible	80% after deductible	100%	100%
Anesthesia	100%	90% after deductible	80% after deductible	100%	100%
Maternity Care					
Delivery	100%	90% after deductible	80% after deductible	100%	100%
Pre- and Post-Natal Care	100%	100%	100% for some pre-natal visits; otherwise 80% after deductible	100% pre-natal visits $20 copay post-natal visits	100% pre-natal visits 90% after deductible post-natal visits
Inpatient Medical Care	100%	90% after deductible	80% after deductible	100%	100%
Inpatient Consultations	100%	90% after deductible	80% after deductible	100%	100%
Laboratory & Pathology	100%	90% after deductible	80% after deductible	100%	90% after deductible
Diagnostic Services	100%	90% after deductible	80% after deductible	100%	90% after deductible
Diagnostic and Therapeutic Radiology	100%	90% after deductible	80% after deductible	Covered	90% after deductible
ADDITIONAL BENEFITS					
Office Visits	$20 copay	$20 copay	$20 copay	$20 copay	90% after deductible
Chiropractic Care	$20 copay Limited to 38 visits per calendar year.	$20 copay Limited to 24 visits per calendar year.	$20 copay Limited to 38 visits per calendar year.	Not Covered	90% after deductible Limited to 38 visits per calendar year.
Allergy Testing	100%	100%	80% after deductible	$20 copay	90% after deductible
Allergy Therapy	100%	100%	80% after deductible	100%	90% after deductible
Ambulance Services	90% after deductible	90% after deductible	80% after deductible	100%	90% after deductible
Durable Medical Equipment	90% after deductible	90% after deductible	80% after deductible	100%	90% after deductible
Diabetic Supplies	90% No Annual Deductible	90% after deductible	80% after deductible	100%	90% after deductible
Private Duty Nursing	90% after deductible	50% after deductible	50% after deductible	Not Covered	75% after deductible
Skilled Nursing	100%	90% after deductible	80% after deductible	100% Up to 730 days renewable after 60 days.	100%

Medical Plan Options Comparison

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Assisted Reproductive Treatment	Not Covered	Not Covered	Not Covered	One attempt of artificial insemination per lifetime.	Not Covered
Voluntary Sterilization and FDA Approved Contraceptive Methods	100%	100%	100%	100%	100%
PROGRAM PROVISIONS					
Out of Network Services	In general, Plan pays 85% of approved amount less applicable copays. For diabetic supplies, durable medical equipment, and private duty nursing, Plan pays 75% of approved amount after deductible (if applicable).	Plan pays 70% of approved amount, after out-of-network deductible, less applicable copays.	In general, Plan pays 65% of approved amount after deductible less applicable copays. For private duty nursing, Plan pays 50% of approved amount after deductible.	Not covered except for emergencies	
Copays, Deductibles, Coinsurance, Annual Out-of-Pocket Coinsurance Maximums, and Lifetime Maximum Dollar Limitations	Copays: $20 / $100 as noted. Deductibles: $200 per person OR $400 per family per calendar year where noted (applies to limited benefits). Coinsurance: In general, 0% for most services, 10% after deductible as noted. Out-of-Pocket Coinsurance Maximum: $1,000 per person/family per calendar year. Lifetime/Annual Maximum: None.	Copays: $20 / $100 as noted. Deductibles: $100 per person OR $200 per family per calendar year where noted. Coinsurance: 10% after deductible as noted. 50% for private duty nursing. Out-of-Pocket Coinsurance Maximum: $500 per person OR $1,000 per family per calendar year. Lifetime/Annual Maximum: None.	Copays: $20 / $100 as noted. Deductibles: $250 per person OR $500 per family per calendar year where noted. Coinsurance: 20% after deductible as noted. 50% for private duty nursing. Out-of-Pocket Coinsurance Maximum: $1,000 per person OR $2,000 per family per calendar year. Lifetime/Annual Maximum: None.	Copays: $20 as noted. ER Copays: $100 Bariatric Copays: $1,000	Copays: $100 as noted. Deductibles: $200 per person OR $400 per family per calendar year where noted (applies to limited benefits). Coinsurance: 10% after deductible as noted. 25% for private duty nursing. Out-of-Pocket Coinsurance Maximum: $1,000 per person/family per calendar year. Lifetime/Annual Maximum: None.

Medical Plan Options Comparison

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Payment of Covered Services	Preferred (Network) Hospitals: 100% of covered benefits. Non-Network Hospitals: 85% of approved payment amount Preferred (Network) Physicians - Outpatient: 100% after $20 copay. Non-network Physicians - Outpatient: 85% of approved payment amount after $20 copay.	Preferred (Network) Hospitals: 90% of covered benefits, after deductible. Non-Network Hospitals: 70% of approved payment amount after out-of-network deductible. Preferred (Network) Physicians: 100% after $20 copay. Non-network Physicians: 70% of approved payment amount after out-of-network deductible and $20 copay.	Preferred (Network) Hospitals: 80% of covered benefits, less applicable deductible. Non-Network Hospitals: 65% of approved payment amount, after deductible. Preferred (Network) Physicians - Outpatient: 100% after $20 copay. Non-network Physicians - Outpatient: 85% of approved payment amount after $20 copay.	Copays as noted.	Participating Hospitals: 100% of covered benefits Non-participating Hospitals: Inpatient care in acute-care hospital - $70 a day. Inpatient care in other hospitals - $15 a day. Medicare Surgical: 100% of BCBSM's approved amount.
PRESCRIPTION DRUG PROGRAM					
Retail Prescription Carrier	**Navitus** www.navitus.com	**Navitus** www.navitus.com	**Navitus** www.navitus.com	**Health Alliance Plan** www.HAP.org	**Navitus** www.navitus.com
Mail Order Prescription Carrier	**NoviXus** www.novixus.com	**NoviXus** www.novixus.com	**NoviXus** www.novixus.com	**Pharmacy Advantage** www.PharmacyAdvantageRx.com	**NoviXus** www.novixus.com
Participating/Network Pharmacies	*Covered / Copays: Tier 1: $5 Most Generics/Some Brands; Tier 2: $20 Preferred Brands/Some Generics; Tier 3: $40 Non-Preferred products (could include both brand and generic) Select Birth Control pills covered $0 copay.	*Covered / Copays: Tier 1: $5 Most Generics/Some Brands; Tier 2: $20 Preferred Brands/Some Generics; Tier 3: $40 Non-Preferred products (could include both brand and generic) Select Birth Control pills covered $0 copay.	*Covered / Copays: Tier 1: $5 Most Generics/Some Brands; Tier 2: $20 Preferred Brands/Some Generics; Tier 3: $40 Non-Preferred products (could include both brand and generic products) Select Birth Control pills covered $0 copay.	*Covered / Copays: Tier 1: $5 Most Generic; Tier 2: $20 Select Brand name; Tier 3: $40 Non-Preferred. Select Birth Control pills covered $0 copay.	*Covered / Copays: Tier 1: $5 Most Generics/Some Brands; Tier 2: $20 Preferred Brands/Some Generics; Tier 3: $40 Non-Preferred products (could include brand and generic) Select Birth Control pills covered $0 copay.
Non-Participating/Non-Network Pharmacies	Paid at the in-network cost, less $5, $20 or $40 copay.	Paid at the in-network cost, less $5, $20 or $40 copay.	Paid at the in-network cost, less $5, $20 or $40 copay.	Not Covered.	Paid at the in-network cost, less $5, $20 or $40 copay.

Medical Plan Options Comparison					
BENEFITS	**AVAILABLE TO ALL EMPLOYEES** **PPO1** **ASR Health Benefits** www.asrhealthbenefits.com	**AVAILABLE TO ALL EMPLOYEES** **PPO2** **Blue Cross/Blue Shield PPO Community Blue Plan** www.BCBSM.com	**AVAILABLE TO ALL EMPLOYEES** **PPO3** **ASR Health Benefits** www.asrhealthbenefits.com	**AVAILABLE TO ALL EMPLOYEES** **HMO** **Health Alliance Plan (HAP)** www.HAP.org	**ONLY AVAILABLE TO EMPLOYEES CURRENTLY ENROLLED** **TRADITIONAL** **Blue Cross/Blue Shield Traditional Plan (BC/BS)** www.BCBSM.com
Maintenance Drugs	Maintenance drugs taken on a long-term basis can be filled as a three month supply for a one month copay through either the Mail Order Drug carrier or at a retail pharmacy.	Maintenance drugs taken on a long-term basis can be filled as a three month supply for a one month copay through either the Mail Order Drug carrier or at a retail pharmacy.	Maintenance drugs taken on a long-term basis can be filled as a three month supply for a one month copay through either the Mail Order Drug carrier or at a retail pharmacy.	Maintenance drugs taken on a long-term basis – a 30 or 90-day supply, whichever is greater, can be obtained for a one month copay at your local pharmacy. A 90-day supply of maintenance drugs may be obtained through mail order.	Maintenance drugs taken on a long-term basis can be filled as a three month supply for a one month copay through either the Mail Order Drug carrier or at a retail pharmacy.
***Note**: While in the hospital, drugs are covered under your medical plan.*	*If you request a prescription be filled with a brand name drug and there is a generic equivalent available, you will be responsible for the Tier 3 copay plus the differential between the cost of the brand and the generic drug. If your doctor makes the request, you will be responsible for the Tier 3 copay.	*If you request a prescription be filled with a brand name drug and there is a generic equivalent available, you will be responsible for the Tier 3 copay plus the differential between the cost of the brand and the generic drug. If your doctor makes the request, you will be responsible for the Tier 3 copay.	*If you request a prescription be filled with a brand name drug and there is a generic equivalent available, you will be responsible for the Tier 3 copay plus the differential between the cost of the brand and the generic drug. If your doctor makes the request, you will be responsible for the Tier 3 copay.	*If you request a prescription be filled with a brand name drug and there is a generic available, you will be responsible for the full cost differential between the cost of the brand and the copay of the generic drug. If your doctor makes the request, you will be responsible for the Tier 3 copayment.	*If you request a prescription be filled with a brand name drug and there is a generic equivalent available, you will be responsible for the Tier 3 copay plus the differential between the cost of the brand and the generic drug. If your doctor makes the request, you will be responsible for the Tier 3 copay.

DENTAL PLANS

More information can be found at www.deltadentalmi.com.

Delta Dental PPO (Point-of-Service) is a national point-of-service program that, in most cases, offers you reduced costs for dental services if you receive care from any dentist who participates with Delta Dental PPO. However, if your dentist does not participate with Delta Dental PPO, you can also save by visiting a dentist who participates in another Delta Dental Program, Delta Dental Premier.

You may want to ask your dentist at your next visit whether they participate with Delta Dental PPO. You can find a list of participating dentists by going to www.deltadentalmi.com and selecting "Find a Dentist".

Since Delta Dental PPO is part of the existing Delta Dental plan, it is essentially invisible to you in its operation and there are no choices to make during Open Enrollment.

Through the Delta Dental website, you will be able to find the "Consumer Toolkit" where you have 24/7 secure access to your benefit information. You can review benefits, eligibility, claims and payments, print ID cards and sign up for paperless Explanation of Benefits statements (EOB's).

Your Dental Options*

You have four dental options to choose from to allow you to tailor your benefit plan to best suit your needs:

- High Option Plan (Not available to New Hires)
- **Standard Plan – No cost to you.**
- Modified Plan (Not available to New Hires)
- No Coverage

Union represented employees' benefits may differ.

Dental Benefits

Your dental plan provides the following choices:

Service	*High Plan*	*Standard Plan*	*Modified Plan*
Deductible			
Single	$25	$25	$25
Family	$50	$50	$50
Plan Pays			
Preventive	100%	100%	100%
Basic[4]	85%	85%	50%
Major	50%	50%	50%
Orthodontia	50%	50%	50%
Maximum Benefit[1]	$1,500[2]	$1,000‡	$750‡
Orthodontia Limit[3]	$1,000	$1,000	$750

[1] Per individual per calendar year
[2] All benefits based on maximum approved fees
[3] Per eligible member per lifetime
[4] There is no copayment for periodontal maintenance (cleaning)

Endosteal implants are covered at the same level as other prosthodontic services and apply to the annual plan maximum. Oakland County's plan provides for two routine cleanings or two periodontal cleanings covered at 100% per calendar year. There is also enhanced coverage for enrollees with certain high-risk medical conditions. For those with a condition, you may be eligible to receive up to four teeth cleanings in a calendar year instead of the typical two. Composite (white) fillings are covered by Standard and High Dental at 85%, Modified at 50%. Brush biopsies are covered by Modified, Standard and High Dental at 100%. Dental sealants for children up to age 14 covered by Modified, Standard and High Dental at 100%. In addition, for people undergoing head and neck radiation, fluoride applications by your dentist are covered twice per benefit year.

Dental Plan Definitions

- **Preventive Services:** This category includes routine oral exams, cleanings and emergency treatment.
- **Basic Services:** This category includes fillings, x-rays, extractions, treatment of gum diseases, root canal therapy, oral surgery, periodontics, crowns and relines, and repairs to bridges and dentures.
- **Major Services:** This category includes endosteal implants and installation of full or partial dentures and bridgework.
- **Orthodontic Services:** Minor treatment for tooth guidance, full banding treatment, and monthly active treatment visits.

Dental Plans

If you currently have "No Coverage" and you are electing a dental plan for the upcoming Plan Year, please complete this change online during Open Enrollment.

For all dental plans listed, a $25 single or a $50 family deductible applies to Basic and Major services. The deductible does not apply to Preventive or Orthodontic services. There is no coinsurance on Preventive services and 50% coinsurance applies to Major and Orthodontic services. Orthodontic services are for eligible members to age 19. Non-Orthodontic maximums are per person per calendar year; orthodontic maximums are per eligible member per lifetime.

	Non-orthodontic Benefit maximum	Orthodontic Benefit maximum	Coinsurance for Basic services[4]
• High Option Plan	$1,500	$1,000	85%
• Standard Plan	$1,000	$1,000	85%
• Modified Plan	$750	$750	50%

- No Coverage Option --- If you are covered under another dental plan, you may choose not to participate in an Oakland County dental plan.

Please Note: If your spouse/parent is providing your dental coverage **and** your spouse/parent is also an employee of the County, **your** earnings for the "No Coverage" Dental option will be less.

Your Contributions
The High Option Plan requires a bi-weekly contribution and the Standard Plan does not. If you choose the Modified Plan or the No Coverage Option, these amounts will show as earnings on your paycheck.

All dependents on your coverage, including eligible dependent children between their 18th and 26th birthdays, must have the same health, dental, and vision coverage as you have selected, if they have any coverage at all. Contact Human Resources – Employee Benefits for details.

How to Find a Participating Provider:

- Go to www.deltadentalmi.com
- Click on Find a Dentist
- Select Delta Dental PPO and Delta Dental Premier
- Enter Zip Code
- Click on Search for a Dentist

Note: For additional information refer to the Delta Dental Certificates and Benefit Summaries found on www.oakgov.com/benefits under Healthcare/Dental.

A Note About Health Care Reimbursement Accounts (HCRA)
Your Health Care Reimbursement Account (HCRA) is an important portion of your total health care program. As you review the dental plan options, remember that you can set aside money in the HCRA to pay for some of your dental care expenses not covered or not paid in full by your selected dental option such as employee coinsurance, deductibles and the cost for orthodontic services. With your HCRA, these expenses can be paid for on a pre-tax basis.

Because of the variety of provider payment plans available for orthodontic expenses, you are encouraged to contact our Health Care Reimbursement account administrator, WageWorks at (877) 924-3967 prior to committing money to your Health Care Reimbursement Account (HCRA) to be sure that you will be reimbursed in the manner you requested.

VISION PLANS

More information can be found at www.e-nva.com.

Your Vision Options*

You can choose one of three vision options under the plan program. Plans are offered through National Vision Administrators (NVA) and services must be through a participating provider to receive the benefits shown.

- The **Standard Plan** which is no cost to you offers you a vision examination for a $5 copayment and lenses and frames for a $7.50 copayment. These benefits are payable every two (2) calendar years beginning January 1 of the new year.
- The **High Plan** also offers you a vision examination for a $5 copayment and lenses and frames for a $7.50 copayment. However, these benefits are payable every one (1) calendar year beginning January 1 of the new year (Not available to New Hires).
- No Coverage

To maximize your benefits under the plans and limit your out-of-pocket expenses, lenses and frames must be from an approved NVA participating provider.

All dependents on your coverage, including eligible dependent children between their 19th and 26th birthdays, must have the same health, dental and vision coverage you have selected, if they have any coverage at all. Contact Human Resources – Employee Benefits for details.

You may select one of the vision options, including the (No Coverage) option for vision.

Additional information and a list of participating providers are available at the NVA website noted above.

Please Note: Going to an eye care provider that is not an NVA participating provider will result in reduced payment of benefits and higher out-of-pocket expenses.

Your Contributions

The High Option Plan requires a contribution and the Standard Plan does not. You receive no additional earnings if you choose the "No Coverage" option.

How to Find a Participating Provider:

- Go to www.e-nva.com
- Click on Find a Provider
- Enter Group Number: 13061000
- Enter Zip Code
- Click on Find Provider

Note: For additional information refer to the NVA Benefit Summaries found on www.oakgov.com/benefits under Healthcare/Vision.

A Note About Health Care Reimbursement Accounts (HCRA)

Your Health Care Reimbursement Account (HCRA) is an important portion of your total health care program. As you review the vision plan options, remember that you can set aside money in the HCRA to pay for your vision care expenses not covered or not paid in full by your selected vision option such as employee copayments, expenses for uncovered services, and the cost for an extra pair of glasses. With your HCRA, these expenses can be paid for on a pre-tax basis.

EMPLOYEE LIFE INSURANCE

More Information can be found at www.TheHartfordatWork.com.

Life insurance through Oakland County is a Term Insurance plan administered by The Hartford. Loans are not available from the plan. Coverage for your spouse or dependent children is not available. There is no cash value.

Your Employee Life Insurance Options

You can select one of the four following levels of group term life insurance, to a maximum of $400,000. New hires will automatically receive Standard coverage (1.5x) and may increase that coverage, if desired, during Open Enrollment. **Each year you may increase your current life insurance coverage by one level without providing Evidence of Insurability (EOI).** Any increase of **more** than one level will require you to complete EOI. The Hartford will notify you by mail or e-mail with instructions on how to submit EOI online after the enrollment period has ended. Increases of more than one level will be subject to approval by The Hartford. You must complete the EOI and be approved by The Hartford; otherwise your coverage will be returned to one level above your previous election. For example; if you are currently covered at One and one-half times (1.5x) your Annual Benefit Salary and elect Three times (3x) your Annual Benefit Salary, coverage will increase to Two times (2x) your Annual Benefit Salary if you do not submit EOI to The Hartford or if you are not approved by The Hartford. **You will not receive another reminder**.

- One times Annual Benefit Salary (Not available to New Hires)
- **One and one-half times Annual Benefit Salary – Standard Plan is no cost to you.**
- Two times Annual Benefit Salary (Not available to New Hires)
- Three times Annual Benefit Salary (Not available to New Hires)

At age 70, your coverage amount is reduced to 60% of your pre-age 70 amount; at age 75, it is reduced to 40% and at age 80 to 30% of your pre-age 70 amount. The amount of insurance is determined by your Annual Benefit Salary as noted on the Benefit Statement found in your annual Open Enrollment Packet.

The Hartford life insurance rates that are used to calculate your benefit costs for Open Enrollment are subject to change each Plan Year.

You must select one of the life insurance options, as there is not a No Coverage option for life insurance.

Accelerated Death Benefit

In the event you are diagnosed with a terminal illness with a life expectancy of less than 1 year, you may be able to receive up to 80% of your life insurance benefit to assist you with current expenses. Your beneficiary would then receive the remaining balance at your death.

Conversion and Portability of Your Life Insurance

If your life insurance ceases because your employment ceases or you are no longer in a class eligible for such insurance, the amount of insurance which ceases (or a lesser amount if desired) may be converted or ported to an individual life insurance policy. Written application must be made for an individual policy and the first premium must be paid on it within 31 days after your life insurance ceases.

In order to convert or port to an individual life insurance policy, please complete the Portability and Conversion Form, which can be found at www.oakgov.com/benefits, and fax the completed form to The Hartford at (440) 646-9339. You may also call The Hartford at (877) 320-0484.

Tax Considerations

Federal tax laws state that the first $50,000 of group life insurance protection is not subject to taxes. Amounts in excess of $50,000 are taxable. The government assigns a value to these amounts and this value is added to your W-2 earnings based on your age as of the end of a calendar year. These amounts are called Imputed Income and are calculated based on the following rate table:

Imputed Income Table	
Age Category	Monthly rate per $1,000 of Employee Life Insurance
<25	$0.05
25-29	$0.06
30-34	$0.08
35-39	$0.09
40-44	$0.10
45-49	$0.15
50-54	$0.23
55-59	$0.43
60-64	$0.66
65-69	$ 1.27
70+	$ 2.06

Example:
If your base salary is $40,000, you are or will be 43 years old at the end of the current calendar year, your coverage amount would be $60,000.

Imputed income applies to any amount over $50,000 of life insurance. To calculate your imputed income for the year, follow these steps:

SAMPLE IMPUTED INCOME CALCULATION

1. Find the amount of Employee Life Insurance over $50,000
   Example: $60,000-$50,000 = $10,000
2. Divide the difference in Step 1 by 1,000 (because the rate table is on a per $1,000 of life insurance coverage basis).
   Example: $10,000/1,000=10
3. Take the product of Step 2 and multiply it by the Imputed Income Rate. This rate is found by taking your age, at the end of the calendar year for the plan year you are doing the calculation for, finding which category it falls into within the Imputed Income Rate Table, and using that category's Imputed Income Rate found in the column next to the age category.
   Example: $0.10 x 10 = $1
4. Finally, multiply the amount calculated in Step 3 by 12 (twelve months in a year), and this will be your Imputed Income (the amount that will be taxed) for the upcoming Plan Year.
   Example: $1.00 x 12 = $12

Federal tax law currently states that benefits received in the event of your death are not taxable to your beneficiaries.

Selecting the Right Amount

Only you can decide how much life insurance is right for your circumstances. The box below gives you some questions to think about which may help you decide how much life insurance you need.

Thoughts To Consider

- What would happen to your family without your pay? Would they have to alter their lifestyle?
- Is your income primary or secondary?
- Are there major payments to continue, such as a mortgage or car payment?
- Are you planning to pay for college for your child(ren)?
- Are your parent(s) depending on your support in their retirement years?

You should consider other resources that might be available when thinking about the above scenarios, including the following:

- Oakland County 401 (a) Plan.
- Oakland County 457 Deferred Compensation Plan.
- Oakland County Defined Benefits Retirement Plan.
- Social Security benefits.
- Life insurance policies you or your family may have purchased individually.
- Mortgage insurance.
- Personal savings you may have accumulated.
- Group term life insurance on your life provided through your spouse's employer.

**Remember*: Your County provided Life and AD&D ceases when your employment ends. You will have the option to convert or port the life insurance to an individual policy.*

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

You can choose a different level of Accidental Death and Dismemberment (AD&D) Insurance coverage than you selected for your life insurance protection. You may wish to obtain extra coverage in the event of your death or bodily impairment as a result of an accident.

AD&D insurance through Oakland County is a Term Insurance plan administered by The Hartford. Loans from the plan are not available. Coverage for your spouse or dependent children is not available.

Your AD&D Options

You can choose one of the four coverage options listed below to a maximum of $400,000.

- **One times Annual Benefit Salary – Standard Plan is no cost to you.**
- One and one-half times Annual Benefit Salary (Not available to New Hires)
- Two times Annual Benefit Salary (Not available to New Hires)
- Three times Annual Benefit Salary (Not available to New Hires)

At age 70, 75, and 80, benefits reduce in accordance with the same schedule as your Life Insurance. The amount of insurance is determined based on your Annual Benefit Salary as noted on the Benefit Statement found in your annual Open Enrollment Packet.

You must elect one of the AD&D options as there is not a No Coverage option for Accidental Death & Dismemberment Insurance.

AD&D Benefits

If you suffer bodily injury caused by an accident that results in loss of life or bodily impairment, you may be eligible for this benefit. Refer to the Schedule of Insurance found on the www.oakgov.com/benefits website or by calling The Hartford.

Loss means with regard to:

1) Life;
2) hands and feet, actual severance through or above wrist or ankle joints;
3) sight, speech and hearing, entire and irrecoverable loss thereof;
4) thumb and index finger, actual severance through or above the metacarpophalangeal joints; or
5) movement, complete and irreversible paralysis of such limbs.

If your accident causes you to lose your life, your beneficiary will receive the AD&D amount you selected. This AD&D amount will be in addition to your Employee Life Insurance amount. Payment for all other loses are payable to the participant. The amount payable is determined by the loss incurred. The amount payable, other payable losses due to injury as well as exclusions that apply can be found in the Plan Description.

Your Contributions

The County provides you with AD&D insurance in the amount of one times your Annual Benefit Salary which requires no employee contribution. Selecting levels above that will require an employee contribution.

The employee contributions listed on your Benefit Statement represent the total cost for providing each option for a Plan Year.

The Hartford AD&D insurance rates that are used to calculate your benefit costs for Open Enrollment are subject to change each Plan Year.

REIMBURSEMENT (FLEXIBLE SPENDING) ACCOUNTS

Tax Advantages

Oakland County offers a Health Care Reimbursement Account (HCRA) and a Dependent Care Reimbursement Account (DCRA) administered by WageWorks. A Reimbursement Account allows you to pay for eligible medical, dental, and vision care or dependent care expenses before Social Security, federal, state, and local income taxes are calculated and withheld from your pay. Contributing to a Reimbursement Account reduces your taxable income, lowers your taxes, and may also lower future Social Security benefits you may become eligible for. Oakland County's Reimbursement Accounts are the same as Flexible Spending Accounts (FSA).

How A Reimbursement Account Works

First you determine how much money you would like to contribute to the account(s). You elect the amount you want deducted from your pay each pay period. This election will begin January 1 and remain in effect for the entire Plan Year (through December 31).

Participants can be reimbursed for eligible expenses by using their provided Health Care Card or completing a Pay Me Back Claim Form. Pay Me Back Claim Forms can be submitted online through the WageWorks website located at **www.wageworks.com**. A hard copy of the form can also be obtained via **www.oakgov.com/benefits**. For further information regarding Health Care Cards, please see the "Using Your WageWorks Health Care Card" section below.

Beginning January 1, you will access to and can be reimbursed for the full (annual) amount you elected for your HCRA. However, the rules for DCRA differ. You can only be reimbursed up to the amount that is currently in your account at the time a claim is submitted. Depending on your specified preference, you will receive direct deposit or a check once any claims have been processed.

As long as you are an active employee, you can request reimbursement for health care expenses incurred until March 15 of the year following your original election. Dependent claims must be incurred in the original Plan Year. You have until April 30 of the following year to submit a claim for either account. **Reimbursement Accounts are "use it or lose it", and any monies not used are forfeited.** You may keep track of your account(s) and/or submit claims online at **www.wageworks.com.**

Reimbursement Account elections are for the entire Plan Year. However, you may be able to change your payroll deduction amount during the Plan Year if you have a qualified Change in Status (CIS). IRS-approved changes include: a change in marital status, a change in number of dependents, the termination or commencement of employment by the employee, spouse, or dependent, a reduction or increase in hours worked by the employee, spouse, or dependent, a dependent satisfying or ceasing to satisfy the plan eligibility requirements, and a change in place of residence or work of the employee, spouse, or dependent. In addition, the IRS defines a CIS for the Dependent Care Reimbursement Account as the death of a dependent parent or a change in your spouse's student status. The IRS requires that the change in benefits must be consistent with the CIS. All requests for changes in benefits as a result of a CIS must be reviewed and approved by Human Resources – Employee Benefits. **You only have 30 days from the date of the CIS to notify Human Resources – Employee Benefits of your status change event.** If you do not notify them within this time frame, you cannot change your Plan Year elections. Current elections will remain in effect until the end of the Plan Year or until another CIS occurs (whichever comes first).

Using Your FSA Dollars

When you pay for an eligible health care or dependent care expense, you want to put your FSA account to work right away. WageWorks gives you several options to use your money the way you choose.

Using Your WageWorks Health Care Card
Use your WageWorks Health Care Card instead of cash or credit at health care providers and pharmacies for eligible services, goods, and prescriptions.

You can also use the Card at general merchants and drug stores that have an industry standard (IIAS) checkout system that can automatically verify if the item is eligible for purchase with your account.

- Go to www.sigis.com to review a list of qualified merchants, like drug stores, supermarkets and warehouse stores that accept the Card.
- When you swipe your Card at the checkout, choose "credit" (even though it isn't a credit card).
- Pay for services or purchases on the same day you receive them. If your health plan covers a portion of the cost, make sure you know what amount you need to pay before using the Card, by presenting your health plan member ID card first, so the merchant can identify your copay or coinsurance amount and ensure the service is claimed to your health care, dental, or vision insurance plan.
- **Save your receipts or digital copies.** You will need them for tax purposes. Plus, even when your Card is approved, a detailed receipt may still be requested.
- If you've lost or can't produce a receipt for an expense, your options may range from submitting a substitute receipt to paying back the plan for the amount of the transaction.
- If you use your Card at an eye doctor's or dentist's office, we will most likely ask you to submit an Explanation of Benefits (EOB) or other documentation for verification. Failure to do so will result in your Card being suspended.
- If you lose your Card, please call WageWorks Customer Service immediately at 1-877-924-3967 and order a new one. You will be responsible for any charges until you report the lost Card.
- Replacement cards can also be ordered at www.wageworks.com through "Employee Log in" and selecting the Card Center.
- Do not discard your WageWorks Health Care Card if you will be participating in the next Plan Year. You will continue to use the same card issued previously.

Using Your Smartphone
With the EZ Receipts mobile app from WageWorks, you can file and manage your reimbursement claims on the spot, with a click of your smartphone camera, from anywhere.

To use EZ Receipts:

- Download the app from www.wageworks.com or the Apple or Google Play Stores.
- Log into your account.
- Choose the type of receipt from the simple menu.
- Enter some basic information about the claim or Card transaction.
- Use your smartphone camera or device to capture the documentation.
- Submit the image and details to WageWorks.

Health Care Reimbursement Account (HCRA)
A Health Care Reimbursement Account (HCRA) enables you to take control of your out-of-pocket health expenses by setting aside pretax dollars to pay for everyday eligible expenses. The result can be savings of up to 40 percent on products and services like eyeglasses, prescriptions, dental care, and over-the-counter items, like band-aids. HCRAs also cover copayments, coinsurance, and deductibles.

To determine if a HRCA may be right for you, consider the medical, dental, and vision expenses you, your spouse, and any eligible dependents pay throughout a calendar year (copays, deductibles, and coinsurance).

The Health Care Reform law passed on March 23, 2010 and limits the annual amount that can be contributed to an HCRA to $2,500.

You can contribute between $4 and $96 per pay period to the HCRA for eligible expenses. Eligible health care expenses are out-of-pocket health care expenses incurred by you, your spouse and any eligible dependents within the IRS guidelines and not reimbursed by your medical, prescription drug, dental or vision coverage. IRS Publication 502 provides the most current requirements regarding who is an eligible dependent.

If you are an active employee, keep in mind that you can only submit expenses for those periods during which you were an active participant in the account. This means if you request to stop all contributions, you cannot submit claims for expenses incurred after the period of time in which contributions were stopped.

If you separate from County employment, you have until April 30th following the end of the Plan Year to submit your requests for Health Care and Dependent Care reimbursements. Only covered health care expenses incurred prior to your date of separation of your County employment are eligible for reimbursement consideration.

Eligible Health Care Expenses
Below are some expenses **generally eligible** for reimbursement under an HCRA. Please refer to Section 213(d) of the Internal Revenue code for the IRS definition of deductible medical expenses that are eligible for reimbursement or contact Customer Service at (877) 924-3967 for more details.

Eligible Health Expenses

Acupuncture	Osteopathic services
Ambulance	Oxygen equipment
Artificial limbs	Physical examination
Bandages	Physician
Braille books & magazines	Physiotherapist
Breast pumps	Podiatrist
Birth control pills	Prescription drug(s)
Chiropractor	Psychiatric care
Crutches	Psychologist
Drugs and medicines (with a doctor's prescription)	Psychoanalysis
Fertility treatment	Surgery
Guide dog or other animal	Telephone/television for hearing impaired
Hearing devices	Therapy/counseling
Hospital services	Transplants
Laboratory fees	Vasectomy
Medical services	Weight-loss programs (prescribed by a physician to treat a specific illness)
Medical supplies	Wig to replace hair lost to disease
Nursing services	X-ray
Operations	

Eligible Dental Expenses

Artificial teeth: caps	Orthodontia *
Dentures	Root canals

* **Orthodontia Note**: Due to the variety of provider payment plans available for orthodontic expenses, you are encouraged to contact Customer Service at (877) 924-3967 for specific reimbursement requirements. Because most orthodontia expenses are considered recurring, an initial request will be made for an Orthodontia contract. Once submitted, no additional documentation will be required unless

your payment does not correspond exactly with your payment plan.

Eligible Vision Expenses

Contact lenses	Eye surgery: Lasik
Eyeglasses/reading glasses	Optometrist
Eye examinations	Prescription sunglasses

Ineligible Health Care Expenses

Automobile insurance premiums	Health club membership or exercise class (unless prescribed by a doctor to treat a specific medical condition)
Contact lens service contracts	Insurance premiums for other medical, dental or supplemental coverage
Cosmetic surgery or similar procedures	Long-term care services or premiums
Cosmetics, toiletries, toothpaste, mouthwash feminine products	Over the counter drugs and medicine without a prescription
Electrolysis or hair removal	Teeth whitening/bleaching
Hair transplants, hair re-growth treatments	Sunglasses
Herbal supplements	Weight loss programs or medication to promote general health

Over-the-Counter Medication

The Health Care Reform law passed on March 23, 2010 requires any Over-the-Counter drug and/or medicine be prescribed by your physician to be eligible for reimbursement. Over-the-Counter items that are not drugs or medicines, such as bandages, breast pumps, blood pressure cuffs and contact solution can be purchased without a prescription. Examples of items typically covered through your flexible spending accounts can be found at **www.wageworks.com/employee/health-care/expenses/fsa.htm** or you can contact Customer Service directly at (877) 924-3967 for more information.

Planning Your Account

To plan the right amount in your Health Care Reimbursement Account for you during the Plan Year, consider the following possible expenses and complete the guide below.

Medical deductible(s) and coinsurance	$_____
Dental expenses	$_____
Vision care expenses	$_____
Prescription drug copayments	$_____
Other expenses	$_____
TOTAL (See note below)	$_____

Make sure that your TOTAL amount is not more money than you expect to use in a Plan Year or you will lose whatever is left over*.

Divide by number of pay periods	÷ 26
Round to nearest whole dollar (to a maximum of $96) for your per pay period deduction.	$_____

In accordance with IRS regulations, any expenses incurred from January 1 through March 15 of the following year can be reimbursed with any unused prior Plan Year money; in this case, unused money from the current Plan Year. Please refer to the Reimbursement Account Claim Procedure section of this workbook for information on submitting claims for reimbursement.

* Except for distributions after June 18, 2008 as provided under IRS Notice 2008-82 (Distribution to Reservists).

Thoughts to Consider

To assist you in deciding whether or not to participate in the Health Care Reimbursement Account, consider the following:

- Do you typically incur and pay your medical plan deductible each year for yourself or an enrolled dependent?
- Do you have dental expenses not covered under a dental plan?
- Are you or one of your dependents planning to get new glasses or contact lenses?
- Do you have any other medical, dental, vision or hearing expenses not covered under any insurance plan such as copayments and coinsurance?

Your Choices

- You may select any qualifying dollar amount from a minimum of $4 per pay to a maximum of $96 per pay per period Plan Year.
- You may choose not to participate in the benefit.

Dependent Care Reimbursement Account (DCRA)

Families often need help with child and elder day care. A Dependent Care Reimbursement Account (DCRA) lets you save on dependent day care expenses using pretax dollars. You can spend your dependent day care savings account funds on a wide range of care for eligible members of your family. Some of the expenses covered include senior day care, child day care, babysitting, before and after school programs and sick child care. If you have any of these expenses, or other recurring eligible dependent care expenses a DCRA may be right for you and your dependents.

You can contribute between $4 and $192 per pay period to a DCRA for your eligible expenses to care for your qualified dependents, which allow you (and your spouse, if you are married) to work. The caregiver can even be a relative of yours, as long as he or she is not also one of your dependents for tax purposes. Also, you are required by law to provide your caregiver's Federal Tax ID number or Social Security number. Your caregiver does not need to be licensed, but must claim your payments as income.

IRS regulations identify eligible dependents as:

- A child (including adopted children, step-children, and foster children) under age 13, who qualifies as your tax dependent
- A person who is physically or mentally incapable of self-care (for example, a child or elderly parent living with you), who qualifies as your tax dependent
- A spouse who is physically or mentally incapable of self-care.

If you separate from County employment, you have until April 30 following the end of the Plan Year to submit your requests for Dependent Care reimbursements. Dependent care expenses may be incurred after contributions cease and after separation for the remainder of the Plan Year. Please refer to the Reimbursement Account Claim Procedures section of this workbook for information on submitting claims for reimbursement.

Eligible Dependent Care Expenses

IRS regulations define eligible expenses as those dependent care expenses "incurred to enable the taxpayer to be gainfully employed". You may contact Customer Service at (877) 924-3967 for more details. These expenses may include:

Adult day care center	Day care center (e.g. Little Oaks)
Babysitter in your home	Senior center
Before and/or after-school care	Summer camp

Ineligible Dependent Care Expenses – Even if Incurred on Behalf of a Dependent

Clothing	Insurance premiums
Food	Medical equipment
Health care expenses	Sleep-away summer camps

A Note About Little Oaks

Little Oaks is an affordable, high quality, family-oriented, on-site child development center. It is open to all county employees' children and grandchildren (between the ages of 6 weeks to 5 years old). The center is managed by Bright Horizons and is accredited by the National Association for the Education for Young Children (NAEYC). For more information, please visit their website at https://www.oakgov.com/hr/discover/Pages/On-Site-Childcare.aspx.

Advantages for Oakland County Employees:

- Discounted rates
- Simplified commute and convenience
- Open door policy welcomes family visits and family events
- On-site security

Planning Your Account

To calculate the right amount for your Dependent Care Reimbursement Account for you during the Plan Year, complete the guide below. Dependent care expenses can only be reimbursed to the extent of your payroll deductions to date at the time you submit the expense for payment.

Cost of care per week	$	_____
Multiplied by number of weeks needed	x	_____
TOTAL (See note below)	$	_____

Make sure that your TOTAL amount is not more money than you expect to use in a Plan Year or you will lose whatever is left over.

Divide by number of pay periods		÷ 26
Round to nearest whole dollar (to a maximum of $192) for per pay period deduction.	$	_____

Thoughts to Consider

To assist you in deciding whether or not to participate in the Dependent Care Reimbursement Account, consider the following:

- Do you have a child(ren) under the age of 13, who requires caregiving services, to enable you (and your spouse, if married) to work outside the home?
- Do you have a disabled spouse for whom you must provide care to enable you to work?
- Do you have a parent who is incapable of self-care who qualifies as your tax dependent?
- Did you compare the Federal Tax Credit vs. the Reimbursement Account to see which is best for you? (See the worksheet at the end of this workbook.)

Your Choices

- You may select any qualifying dollar amount from a minimum of $4 per pay to a maximum of $192 per pay period for a Plan Year.
- You may choose not to participate in this benefit.

Federal Tax Credit vs. Dependent Care Reimbursement Account

The maximum amount you are eligible to deduct in any taxable year may not exceed the lesser of your earned income, or up to $5,000 combined income if you are married; amounts are per family, not per plan. If you and your spouse file separate tax returns, you are each limited to an annual reimbursement account limit of $2,600. If your spouse is a student continuing his/her education, the IRS limits the amount of earned income that will affect the amount of your contribution. Some higher paid employees may be restricted to lower limits for this reimbursement account.

You may be claiming a Federal Tax Credit for childcare expenses now. Use the following worksheets to see if the Federal Tax Credit or the Dependent Care Reimbursement Account is best for you. You may also contact your tax preparer.

Federal Tax Credit for Dependent Care Expenses: Calculating the Federal Tax Credit

1. The estimated annual dependent care expenses (cannot exceed the lesser of your income or that of your spouse). $_____
2. Maximum expenses eligible for tax credit ($3,000 for one dependent, $6,000 for more than one dependent) $_____
3. Estimated adjusted gross income for you and your spouse $_____
4. Tax credit percentage from Table 1 below, based on adjusted gross income _____%
5. Estimated tax credit (multiply line 4 by the smaller of line 1 or line 2) $_____

Table 1

2019 Adjusted Gross Income is Over	Tax Credit Percentage
$0 - $15,000	35%
15,000-17,000	34%
17,000-19,000	33%
19,000-21,000	32%
21,000-23,000	31%
23,000-25,000	30%
25,000-27,000	29%
27,000-29,000	28%
29,000-31,000	27%
31,000-33,000	26%
33,000- 35,000	25%
35,000- 37,000	24%
37,000- 39,000	23%
39,000- 41,000	22%
41,000- 43,000	21%
43,000- No limit	20%

Tax Savings Calculator
Calculating Withholding Tax Savings Using the Reimbursement Account

1. The amount of deposit to your Dependent Care Reimbursement Account must not exceed the lesser of your income, or that of your spouse's or $4,996 ($192 x 26 pays) or $2,500 if married but filling separate returns $_____
2. Marginal Federal tax rates (using your combined annual income for you and your spouse) from Table 2 below _____%
3. Social Security tax rate: Enter 5.65% if your annual salary is equal to or less than the Social Security annual wage base maximum ($118,500). Otherwise, enter 1.45% _____%
4. State tax rate _____%
5. City tax, if applicable _____%
6. Total tax rate (add lines 2,3,4, and 5) _____%
7. Estimated tax savings (multiply line 1 by line 6) $_____

Table 2

Single		Married, Filing Jointly	
Income	Tax Rate[4]	Income	Tax Rate
Up to $9,700	10%	Up to $19,400	10%
$9,701 - $39,475	12%	$19,401 - $78,950	12%
$39,476 - $84,200	22%	$78,951 - $168,400	22%
$84,201 - $160,725	24%	$168,401 - $321,450	24%
$160,726 - $204,100	32%	$321,451 - $408,200	32%
$204,101 - $510,300	35%	$408,201 - 612,350	35%
$510,301 +	37%	$612,351 +	37%

Comparing the Calculations
After you have estimated your dependent care expenses, calculate the Federal Tax Credit and the withholding tax savings, and compare the two calculations. You can then make an informed choice as to which alternative is best for you.

The Federal Tax Credit is for federal income tax purposes and does not include Social Security or state taxes.

[4] Federal Tax Rates (in effect as of 01/01/19)

Reimbursement Account Claim Procedures

If you elect to participate in a Health Care Reimbursement Account and/or Dependent Care Reimbursement Account, you will receive claim filing instructions and claim forms before the Plan Year begins, directly from WageWorks. If you participated in a Health Care and/or Dependent Care Reimbursement Account in the current Plan Year you will not receive a "new participant welcome" packet. Do not discard your WageWorks Health Care Card if you will continue to participate during the next Plan Year.

Your request for reimbursement will be processed within five business days, provided no additional information is required, from the time your properly completed and signed claim form is received. Reimbursement checks are mailed, or direct deposited into your bank account, within 48 hours of claim approval.

Receipts for Health Care Reimbursements need to include:

- Name of patient
- A list of services
- The date of each service listed
- Name of provider
- What insurance will pay (an Explanation of Benefits – EOB) or proof of payment

Receipts for Dependent Care Reimbursements need to include:

- Name of employee
- Name and address of provider
- The date of each service listed
- Federal Tax ID number or social security number of provider
- Proof of payment (receipt) from provider

If your reimbursement claim is denied, WageWorks will inform you by e-mail notification and advise you to log into your account at www.wageworks.com for claims denial information.

Please Note: WageWorks will send an e-mail to your e-mail address on file with them if substantiation is needed on a claim submitted and to notify you of claims being processed. *You may want to check your spam mail periodically to ensure messages were not sent there in error.* WageWorks suggests using your personal e-mail address and not your work e-mail. If you do not check your e-mails regularly, you may want to delete your e-mail address from your profile with WageWorks to ensure correspondence is mailed to your home instead.

If you have any questions concerning the reimbursement of a Health Care and/or Dependent Care expense, you can call Customer Service toll-free at (877) 924-3967.

Claims for reimbursement can be faxed to (877) 353-9236 or submitted online at **http://www.wageworks.com**. Online you may also use the Pay My Provider option to pay you, and your dependents, eligible expenses directly from your Health Care or Dependent Care Reimbursement Account. You may also mail your Claim Form to: **CLAIMS ADMINISTRATOR, PO BOX 14053, LEXINGTON, KY 40512.**

If you need a Pay Me Back Claim Form for Health Care and/or Dependent Care expenses, or a Direct Deposit Authorization Form, you can download one from **www.oakgov.com/benefits** or **www.wageworks.com.**

All requests for changes to your Health Care Reimbursement and/or Dependent Care Reimbursement Account amounts during a Plan Year must be reviewed in accordance with IRS guidelines and approved by Human Resources – Employee Benefits **within 30 days from the date of the event**.

Consider both accounts carefully. Utilizing the accounts requires a little planning, but the tax savings could make the planning effort worthwhile.

OTHER EMPLOYEE BENEFITS

Employees have other employee benefits that are not part of the program such as Disability, Retirement, Paid Time Off, etc.

DISABILITY

Although not currently a part of the program, the County provides short- and long-term disability income protection, to those employees eligible, in the event you are totally disabled. Your disability plans provide for replacement of 60% of your salary at the time of disability. Since this coverage is provided totally by the County, any benefits paid will be taxable income.

The monthly benefit maximum payment from all sources is $8,000 per month.

As long as the short-term disability claim is approved, health benefits are continued and the bi-weekly health contributions will go into arrears until you return to work. At such time, the past due deductions are taken out of your payroll check in $300.00 (maximum) increments, plus the regular bi-weekly employee contribution.

Keep in mind, you can supplement disability payments with your leave banks to decrease the amount owed for healthcare deductions when returning to work. The Disability Supplemental Form can be downloaded at www.oakgov.com/benefits.

You become eligible after you have completed six (6) consecutive months of service since the date of your most recent hire. A pre-existing condition investigation will apply to employees who file a claim within the first 12 months of disability coverage. Pre-existing conditions may not be covered during the first 12 months of coverage.

Elected officials are not eligible for short- or long-term disability.

Plan B employees are covered by a different non-occupational short-term disability program, and are not eligible for long-term disability.

Important Notes:

- If your disability is expected to last more than 7 consecutive calendar days (the waiting period), you must call the County's disability provider, The Hartford, at 1-800-898-2458 to provide them with the details of your disability and the contact information for your doctor.
- While you have 30 calendar days from your first day off work to contact The Hartford, this will significantly delay your disability payments. Oakland County Merit Rule 22 requires that you contact The Hartford no later than 30 days of your first day missed from work due to disability. More information is available at www.oakgov.com/benefits.
- Remember to keep your department informed at all times from your very first day off as to the expected duration of your absence.
- Your Plan Number is **402334**
- You can track your claim online at www.thehartford.com

The information provided above is only a very brief overview of the disability plans provided through The Hartford. For detailed coverage information see the plan information available at www.oakgov.com/benefits or contact The Hartford directly.

RETIREMENT

The Retirement websites (www.oakgov.com/retirement and oaklandcounty.retirepru.com) have a wealth of resources to help you make wise decisions for your retirement. Your Retirement Plan is a valuable benefit offered to you as an employee of Oakland County. The Retirement Plans available to you depend upon your date of hire and union status. Information you will find on the website include:

- Defined Benefit (DB) pension plan
- Defined Contribution (DC) 401(a) plan
- Deferred Compensation 457(b) plan
- Part-Time Non-Eligible (PTNE) 457(b) plan
- Retiree health, prescription, dental, and vision plans
- Retirement Health Savings Account (RHS)
- Retirement Health Eligibility Schedules

For detailed information contact the Human Resources Retirement Unit or refer to the Retirement website (www.oakgov.com/retirement).

Judges and certain Union represented benefits may differ.

PAID TIME OFF

Full-time employees are provided with the following paid leave time:

- Personal Leave (PLV) – 5 days per calendar year
- Floating Holiday (FLT) – 1 day per calendar year
- Annual Leave (VAC) – 10 days for the first year of service, then 12 days beginning on year two; up to 24 days after 24 years of service.
- County Paid Holidays – 10 to 12 days per calendar year

The information provided above is only a very brief overview of the paid time off plans provided to eligible County employees. For detailed information refer to the Merit System Rule Book (http://my.oakgov.com/sites/hr/Pages/MeritSystemRules.aspx) or contact the Human Resources/Employee Records and HRIS Unit.

Elected officials are not eligible for these leave times.
****Refer to Collective Bargaining Agreement for Union represented holidays.***

PARENTAL LEAVE

Parental Leave is available for all full-time employees who have completed six (6) months of County service. This includes full-time appointed and non-merit employees and employees serving a one year probationary period. An eligible parent is a mother or father with parental rights to the child. Employees will receive 6 weeks of paid leave at 100% of their current salary. Parental Leave can be utilized for both the birth and adoption of a child.

ANNUAL LEAVE BUY BACK

Annual Leave Buy Back is offered once a year to all full-time, eligible employees with 60 (or more) annual leave hours in the bank. This program offers interested employees the option to "cash out" annual leave hours in order to receive a payout. Employees can "cash out" a minimum of 20 hours to a maximum of 40 hours (each calendar year).

TUITION REIMBURSEMENT

The Tuition Reimbursement Program at Oakland County is a benefit offered to all full-time employees designed to further support educational and professional development within topics and fields of study that are directly related to the County's operations, activities, and objectives as a way to progress within the County. HR Training and Development administers the Tuition Reimbursement Program in accordance to the parameters that are established in Merit Rule 20.

Any employee eligible for benefits in accordance with Merit Rule 22 can immediately apply for Tuition Reimbursement. Employees must be employed and eligible for benefits when the application is filed and also when reimbursement is issued in order to receive tuition reimbursement. Employees must attend an accredited institution that is approved and certified by a nationally recognized accrediting association.

The Tuition Reimbursement Program allows up to two (2) courses each session to be reimbursed up to $1,400 per session with a maximum of $4,200 per fiscal year. All applications should be filled out prior to the starting date of the class to secure funding. However, applications can be accepted 30 days after the course has started but cannot be guaranteed. All applications are approved on a first come, first serve basis.

The information provided is a brief overview of the Tuition Reimbursement Program. For more detailed information contact the HR Training Unit or refer to the HR Training website at (http://my.oakgov.com/sites/hr/Training/Pages/TuitionReimbursement.aspx).

OAKFIT WELLNESS PROGRAM

The mission of the OakFit Wellness Program is to assist Oakland County employees, retirees, and dependents in taking ownership of their health in order to improve the quality of their life, enhance productivity, and stabilize long-term employee/employer health care costs. OakFit offers weight management, exercise, tobacco cessation, Lunch n' Learns, wellness challenges, an annual wellness fair, on-site health screenings, and more.

The website, www.oakgov.com/wellness, is open to employees, retirees and dependents highlighting the resources and programs available. Employees can subscribe to receive program updates or request to follow OakFit on social media. There is something for everyone in this program. Questions? Contact the Wellness Coordinator at 248-858-5473.

*It's important to emphasize the **CONFIDENTIAL** nature of the OakFit Wellness on-site health screening program. Oakland County utilizes a third party vendor to ensure that any individual health data is stored outside of Oakland County as part of this program. No individual health care data is shared with Oakland County. Employee health information is protected by federal law. **HIPAA** (Health Insurance Portability and Accountability Act) ensures individual health information is not provided to Oakland County. The County only receives aggregate (summary) reports from our third party vendor.

Nondiscrimination Notice Under Section 1557 of the Affordable Care Act

Discrimination is against the law. Oakland County complies with applicable Federal and State civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Oakland County does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Oakland County provides free aid 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)

Oakland County 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 the Human Resources Department at (248) 858-0530.

If you believe that Oakland County 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: Human Resources Department, Oakland County, 2100 Pontiac Lake Road, Waterford, MI 48328. Telephone: 1-248-858-0530. You can file a grievance in person, by mail, or e-mail. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

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 http://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)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Michigan Languages:

Language	Message About Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1- 248-858-0530.
Arabic	ملحوظة: إذا تـنك تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر كـلا بالمجان. اتصل 1-248-858-0530
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-248-858-0530.
Syriac	[illegible] 1-248-858-0530
Vietnamese	CHU Y: Nêu bạn nói Tiêng Việt, có các dịch vụ hô trợ ngôn ngữ miên phí dành cho bạn. Gọi sô 1-248- 858-0530.
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në. 1-248-858-0530
Korean	주의: 한국어를사용하시는경우, 언어지원 서비스를무료로이용하실수있습니다. 1-248-858-0530 번으로전화해주십시오.

Bengali	ল◌য◌্করনঃি◌◌◌যদি◌আপনবাংলা, কথ◌া ে◌◌বলত প◌াে◌◌◌◌রন, তাে◌◌◌হল ি◌◌◌◌নঃখরচ◌ায় ভ◌াষাসহায়ত◌া ি◌◌ে◌◌পরষবা উপল◌ে◌◌◌আছ। ে◌◌◌◌ফানকরন১- 1-248-858-
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-248-858-0530.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-248-858-0530.
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-248-858-0530.
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-248-858-0530　まで、お電話にてご連絡ください。
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-248-858-0530.
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-248-858-0530.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-248-858-0530.

Group Health Continuation Coverage Under COBRA

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

Oakland County will automatically offer COBRA continuation coverage to qualified beneficiaries when any of the following qualifying events have occurred:

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Oakland County Human Resources – Employee Benefits within 60 days after the qualifying event occurs. You must provide this notice to: Oakland County Human Resources – Employee Benefits by completing the Membership and Record Change and Supplemental Membership and Record Change Forms found on the www.oakgov.com/benefits website.

How is COBRA continuation coverage provided?

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

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

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

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

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

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

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

Keep your Plan informed of address changes
To protect your family's rights, let Oakland County Human Resources – Employee Benefits know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to Oakland County Human Resources – Employee Benefits.

Plan contact information
If you have any questions about COBRA, or if you have changed marital status, or you or your spouse have changed addresses, please contact Oakland County Human Resources – Employee Benefits, 2100 Pontiac Lake Road, Waterford, MI 48328 or by telephone at (248) 858-5205.

Michelle's Law

Michelle's Law allows seriously ill or injured college students who are covered dependents under group health plans to continue coverage for up to one year while on medically necessary leaves of absence. More specifically, Oakland County cannot terminate coverage of a dependent child, as defined by Oakland County's Plan Document, due to a "medically necessary leave of absence" before a date that is the earlier of:

- the date that is one year after the first day of the medically necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage.

A "dependent child" for these purposes is a beneficiary under the group health plan who:

- is a dependent child, under the terms of the plan or coverage, of a participant under the plan or coverage; and
- was enrolled in the plan or coverage, as a student at a post-secondary educational institution (including colleges and universities), immediately before the first day of the medically necessary leave of absence involved.

A "medically necessary leave of absence" means, with respect to a dependent child in connection with a group health plan or health insurance coverage offered in connection with such plan, a leave of absence of the child from a post-secondary educational institution, or any other change in enrollment of the child at the institution, that:

- commences while the child is suffering from a serious illness or injury;
- is medically necessary; and
- causes the child to lose student status for purposes of coverage under the terms of the plan or coverage.

Written certification must be provided by a treating physician of the dependent child to Human Resources – Employee Benefits in order for the continuation coverage requirement to apply. The physician's certification must state that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary (as defined above).

Notice of Patient Protection

If your health plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact ASR Health Benefits at (800) 968-2449, Blue Cross/Blue Shield of Michigan at (800) 245-8401, or Health Alliance Plan at (313) 872-8100 depending on the medical plan you elect.

You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. However, the health care professional may be required to comply with certain procedures, including obtaining authorization for certain services, following a pre-approved treatment plan, or following certain procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact ASR Health Benefits at (800) 968-2449, Blue Cross/Blue Shield of Michigan at (800) 245-8401, or Health Alliance Plan at (313) 872-8100 depending on the medical plan you elect.

Women's Health and Cancer Rights Act of 1998 (Also Known As "Janet's Law")

Did you know that your health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services? These services include reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment of complications resulting from a mastectomy (including lymphedema). Contact ASR Health Benefits at (616) 957-1751 or (800) 968-2449, Blue Cross/Blue Shield of Michigan at (877)790-2583, or Health Alliance Plan at (313) 872-8100 depending on the medical plan you elect for more information.

Notice to Plan Participants - Notice of Privacy Practices Available

The U.S. Department of Health and Human Services has issued regulations as part of the Health Insurance Portability and Accountability Act of 1996. These regulations, known as the Standards for

Privacy of Individually Identifiable Health Information, were effective on April 14, 2003 (or April 14, 2004 for small health plans) and control how your medical information may be used and disclosed and how you can access this information. Please be advised that your health benefits plans maintain a current Notice of Privacy Practices to inform you of the policies that they have established to comply with the Standards for Privacy. This Notice describes the responsibilities of the plans and any third party assisting in the administration of claims regarding the use and disclosure of your protected health information, and your rights concerning the same.

This Notice is available to you upon request by contacting your company's Privacy Official or Human Resources Director.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are 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 are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. You should contact your state for further information on eligibility.

ALABAMA – Medicaid	NEW JERSEY – Medicaid & CHIP
Website: http://myalhipp.com Phone: 1-855-692-5447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid Medicaid Phone: 609-631-2392 CHIP Website: http://njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
ALASKA – Medicaid	**NEW YORK – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.health.ny.gov/health_care/medicaid Phone: 1-800-541-2831
ARKANSAS – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://myarhipp.com Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://dma.ncdhhs.gov Phone: 919-855-4100
COLORADO – Medicaid & CHIP	**NEW DAKOTA – Medicaid**
Health First Colorado Website: http://www.healthfirstcolorado.com Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: http://Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/State Relay 711	Website: http://nd.gov/dhs/services/medicalserv/medicaid Phone: 1-844-365-3742
FLORIDA – Medicaid	**OKLAHOMA – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
GEORGIA – Medicaid	**OREGON – Medicaid**
Website: http://dch.georgia.gov/medicaid Phone: 404-656-4507	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
INDIANA – Medicaid	**PENNSYLVANIA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone: 1-800-403-0864	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
IOWA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhs.iowa.gov/ime/members/mediciaid-a-to-z/hipp Phone: 1-888-346-9562	Website: http://www.eohhs.ri.gov Phone: 1-88-549-0820
KANSAS – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: http://www.kdheks.gov/hcf Phone: 1-785-296-3512	Website: https://www.scdhhs.gov Phone: 1-88-549-0820
KENTUCKY – Medicaid	**SOUTH DAKOTA – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://dss.sd.gov Phone: 1-888-828-0059
LOUISIANA – Medicaid	**TEXAS – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://gethipptexas.com Phone: 1-800-440-0493
MAINE – Medicaid	**UTAH – Medicaid & CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003/Maine Relay 711	Medicaid Website: https://medicaid.utah.gov CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
MASSACHUSETTS – Medicaid	**VERMONT – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth Phone: 1-800-862-4840	Website: http://www.greenmountaincare.org Phone: 1-877-543-7669

MINNESOTA – Medicaid	VIRGINIA – Medicaid & CHIP
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Medicaid & CHIP Website: http://coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
MISSOURI – Medicaid	**WASHINGTON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
MONTANA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://mywvhipp.com Phone: 1-855-MyWVHIPP (1-855-699-8447)
NEBRASKA – Medicaid	**WISCONSIN – Medicaid & CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: 855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
NEVADA – Medicaid	**WYOMING – Medicaid**
Website: https://dhcfp.ne.gov Phone: 1-800-992-0900	Website: https://wyequalitycare.acs-inc.com Phone: 307-777-7531
NEW HAMPSHIRE – Medicaid	
Website: https://www.dhhs.nh.gov/ombp/nhhpp Phone: 603-271-5218 Hotline: NH Medicaid Service Centers at 1-888-901-4999	

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

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

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

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Oakland County has determined that the prescription drug coverage offered by Navitus and Health Alliance Plan are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered

Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage with Oakland County will not be affected, as it remains your primary coverage. If you do decide to join a Medicare drug plan and drop your current Oakland County coverage, be aware that you and your dependents will not be able to get this coverage back until the next Open Enrollment period. In addition, dropping your prescription coverage would also drop your medical coverage for you and your dependents.

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

For more information about this Notice or your current prescription drug coverage contact Stephanie Bedricky at (248) 858-5212.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Oakland County changes. You also may request a copy of this notice at any time.

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

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

For more 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 (TTY 1-800-325-0778).

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

Date:	10/01/2019
Name of Entity/Sender:	Oakland County Human Resources
Contact--Position/Office:	Stephanie Bedricky
Phone Number:	(248) 858-5212
Address:	Human Resources – Benefits 2100 Pontiac Lake Road, Bldg. 41 W, Waterford, MI 48328

The following pages contain the Summary of Benefits and Coverage (SBC) for the medical plans offered through Oakland County.

These are only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.oakgov.com/benefits or by calling (248) 858- 0465 or faxing a request to (248) 858-1511.

If you have questions regarding any of the SBCs visit us at www.oakgov.com/benefits or by calling (248) 858-0465 or faxing a request to (248) 858-1511.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary in the back of this workbook or at www.oakgov.com/benefits or call (248) 858-0465 or faxing a request to (248) 858-1511.

AFFORDABLE CARE ACT OUT-OF-POCKET MAXIMUM LIMITS ON COST-SHARING REQUIREMENT

As a result of the Affordable Care Act (ACA), all health plans (including prescription coverage) will be subject to maximum out-of-pocket limits. The ACA defines cost-sharing as deductibles, coinsurance, copayments or similar charges and any other expenditure required of an individual that is a qualified medical expense with respect to an essential health benefit covered by the plan. Cost-sharing does not include contributions, premiums, balance-billing for non-participating providers or spending for non-covered services.

In order to comply with this requirement (and as allowed by the ACA), the County assigns a portion of the annual out-of-pocket maximum to the prescription drug plan and the remaining portion to the medical plan(s). Maximum Out-of-Pocket Limits change annually. When annual limits change, the Benefit Guide will be updated. At that time, the revised date on the last page will be updated. The revised Benefit Guide will be placed on the www.oakgov.com/benefits website for reference.

The Maximum Out-of-Pocket Limits will be:

Plan	Self-Only (1-person)	Family (2 or more persons)
Prescription	$3,500	$5,000
Medical	$3,850	$9,700
Total	**$7,350**	**$14,700**

Should the maximum be reached in a calendar year in the prescription and/or medical plan, your out-of-pocket costs would be zero for the remainder of the calendar year.

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, go to www.asrhealthbenefits.com. 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 www.healthcare.gov/sbc-glossary or call 616-957-1751 or 1-800-968-2449 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0/individual or $0/family for most covered services. $200/individual and $400/family for the limited number of covered services identified throughout this summary as Master Medical Coverage.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Those covered services not categorized as Master Medical Coverage, including, but not limited to, preventive care, outpatient physician services (primary care, urgent care, specialist visits), emergency room care, and hospitalization, 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?	The out-of-pocket limit for medical coinsurance is $1,000/individual or family. The total out-of-pocket limits for medical services are $4,125/individual and $10,250/family. These figures include the deductibles (if applicable) and the coinsurance out-of-pocket limits shown above as well as in-network medical copayments.	The out-of-pocket limit is the most you could pay in a year for covered services. For the coinsurance out-of-pocket limit: if you have other family members in this plan, the overall family out-of-pocket limit must be met. For the total out-of-pocket limits: if you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why this Matters:
What is not included in the out-of-pocket limit?	Deductibles (if applicable) and copayments are not included in the above out-of-pocket limits applicable to medical coinsurance. In general, out-of-pocket limits do not include out-of-network medical copayments; prescription drug coverage copayments (however these expenses will count towards a separate out-of-pocket limit that is not specified in this summary); penalties; charges that exceed the plan's usual, customary, and reasonable fee allowance or are in excess of stated maximums; premiums; balance-billing charges; and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.asrhealthbenefits.com or call 616-957-1751 or 1-800-968-2449 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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit; deductible does not apply	$20 copay/visit and 15% coinsurance; deductible does not apply	Out-of-network copayment costs do not track towards the plan's out-of-pocket limit.
	Specialist visit	$20 copay/visit (or copay/day for most chiropractic care); deductible does not apply	$20 copay/visit (or copay/day for most chiropractic care) and 15% coinsurance; deductible does not apply	Out-of-network copayment costs do not track towards the plan's out-of-pocket limit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic, cont.	Preventive care/screening/ immunization	No charge	Not covered for most preventive care services; otherwise, depending on service type, either no charge or 15% coinsurance applies (deductible does not apply)	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. Coverage for a breast pump purchased from an out-of-network provider is limited to $250/birth. Certification (sometimes called preauthorization) is recommended for the rental and purchase of breast pumps. Preventive care, including in-network well-baby and routine child care visits, are subject to various frequency limitations. This benefit includes one routine mammogram and one routine/ diagnostic colonoscopy (and any mammogram- and colonoscopy-related services) per year. All diagnostic mammograms or any subsequent routine mammograms and routine/diagnostic colonoscopies performed in that year will be subject to coinsurance and deductible.
If you have a test	Diagnostic test (X-ray, blood work)	No charge	15% coinsurance; deductible does not apply	None
	Imaging (CT/PET scans, MRIs)	No charge	15% coinsurance; deductible does not apply	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.navitus.com or the Medical Option Comparison chart in your Natural Select workbook.	Generic drugs	Not covered when purchased through a pharmacy or mail order program		No coverage for prescription drugs purchased through a pharmacy or mail order program under the plan's medical coverage.
	Preferred brand drugs	Not covered when purchased through a pharmacy or mail order program		
	Non-preferred brand drugs	Not covered when purchased through a pharmacy or mail order program		
	Specialty drugs	Not covered when purchased through a pharmacy or mail order program		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	15% coinsurance; deductible does not apply	None
	Physician/surgeon fees	No charge	15% coinsurance; deductible does not apply	None
If you need immediate medical attention	Emergency room care	$100 copay/visit; deductible does not apply	$100 copay/visit; deductible does not apply	Copayment may be waived if admitted inpatient or for an accidental injury.
	Emergency medical transportation	10% coinsurance; Master Medical Coverage deductible applies	10% coinsurance; Master Medical Coverage deductible applies	
	Urgent care	$20 copay/visit; deductible does not apply	$20 copay/visit and 15% coinsurance; deductible does not apply	Out-of-network copayment costs do not track towards the plan's out-of-pocket limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	15% coinsurance; deductible does not apply	Certification (sometimes called preauthorization) is recommended.
	Physician/surgeon fees	No charge	15% coinsurance; deductible does not apply	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for autism services, including ABA therapy; otherwise $20 copay/office visit and no charge for other outpatient services; deductible does not apply	No charge for ABA therapy; otherwise 15% coinsurance ($20 copay/office visit may also apply); deductible does not apply	Out-of-network copayment costs do not track towards the plan's out-of-pocket limit. Coverage for Applied Behavior Analysis (ABA) therapy is limited to $50,000 annually (outpatient and inpatient services combined). For inpatient services only, certification (sometimes called preauthorization) is recommended.
	Inpatient services	No charge	No charge for ABA therapy; otherwise 15% coinsurance; deductible does not apply	
If you are pregnant	Office visits	No charge	15% coinsurance; deductible does not apply	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	15% coinsurance; deductible does not apply	
	Childbirth/delivery facility services	No charge	15% coinsurance; deductible does not apply	
If you need help recovering or have other special health needs	Home health care	No charge	15% coinsurance; deductible does not apply	Certification (sometimes called preauthorization) is recommended.
	Rehabilitation services	No charge	15% coinsurance; deductible does not apply	Certification (sometimes called preauthorization) is recommended.
	Habilitation services	No charge	15% coinsurance; deductible does not apply	Certification (sometimes called preauthorization) is recommended.
	Skilled nursing care	*Private-Duty Nursing:* 10% coinsurance (Master Medical Coverage deductible applies); *Other:* No charge	*Private-Duty Nursing:* 25% coinsurance (Master Medical Coverage deductible applies); *Other:* 15% coinsurance (deductible does not apply)	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs, cont.	Durable medical equipment	*Diabetic Supplies:* 10% coinsurance (deductible does not apply); *Other:* 10% coinsurance (Master Medical Coverage deductible applies)	*Diabetic Supplies:* 25% coinsurance (deductible does not apply); *Other:* 25% coinsurance (Master Medical Coverage deductible applies)	Certification (sometimes called preauthorization) is recommended for the rental and purchased of certain durable medical equipment. Vehicle and home modifications are excluded. Breastfeeding equipment is covered under the plan as preventive care.
	Hospice services	No charge	15% coinsurance; deductible does not apply	None
If your child needs dental or eye care More information about eye care coverage is available at www.bcbsm.com. More information about dental care coverage is available at www.deltadentalmi.com. Also refer to the Medical Option Comparison chart in your *Natural Select* workbook.	Children's eye exam	Not covered (except to the extent required by law)	Not covered (except to the extent required by law)	No coverage for routine eye care under the medical plan, except as required by Health Care Reform.
	Children's glasses	Not covered	Not covered	No coverage for glasses under the medical plan.
	Children's dental check-up	Not covered (except to the extent required by law)	Not covered (except to the extent required by law)	No coverage for routine dental care under the medical plan, except as required by Health Care Reform.

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
- Cosmetic surgery
- Dental care (except to the extent required to be covered by Health Care Reform)
- Glasses
- Hearing aids
- Infertility treatment (except the treatment of the underlying cause of infertility may be covered)
- Long-term care
- Non-emergency care when traveling outside the U.S. (except certain care may be covered in specific situations as detailed in the plan document)
- Prescription drugs purchased through a pharmacy or mail order program
- Routine eye care (except to the extent required to be covered by Health Care Reform)
- 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 up to 38 visits allowed annually	• 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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: ASR Health Benefits at 616-957-1751 or 1-800-968-2449 or at www.asrhealthbenefits.com. Additionally, a Consumer Assistance Program may be able to help you file your appeal. Visit www.dol.gov/ebsa/healthreform or http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ to see if your state has a Consumer Assistance Program that may be able to help you file your appeal.

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

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

Language Access Services:
Para obtener asistencia en Español, llame al 616-957-1751 o 1-800-968-2449.

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** **$0**
- **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$ 80**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **10%**

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$ 820**

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

- **The plan's overall deductible** **$200**
- **Specialist copayment** **$100**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **10%**

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$100
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$ 350**

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

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.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$100 Individual/ $200 Family	$250 Individual/ $500 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
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?	**Medical Coinsurance Limit**		**The medical coinsurance limit includes coinsurance only.** After you meet the deductible, most medical services are subject to coinsurance. You will pay coinsurance until you reach the medical coinsurance out-of-pocket limit.
	$500 Individual/ $1,000 Family	$1,500 Individual/ $3,000 Family	
	Medical Out-of-Pocket Limit		The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. **The medical out-of-pocket limit includes medical deductible, coinsurance and copays. Note that there are separate out-of-pocket limits for medical and prescription drug services.**
	$4,125 Individual/ $10,250 Family	$4,125 Individual/ $10,250 Family	
What is not included in the out-of-pocket limit?	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.

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com 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.
Do you need a referral to see a specialist?	No.		You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/office visit; deductible does not apply	30% coinsurance	None
	Specialist visit	$20 copay/visit; deductible does not apply	30% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible does not apply	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com or the Medical Option Comparison Chart in your *Natural Select* booklet.	Generic or select prescribed over-the-counter drugs	Not covered	Not covered	None
	Preferred brand-name drugs	Not covered	Not covered	
	Nonpreferred brand-name drugs	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay/visit; deductible does not apply	$100 copay/visit; deductible does not apply	Copay waived if admitted or for an accidental injury.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Mileage limits may apply
	Urgent care	$20 copay/visit; deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization may be required
	Physician/surgeon fee	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	10% coinsurance Office Visit: $20 copay	10% coinsurance	Your cost share may be different for services performed in an office setting
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	Prenatal: No Charge; deductible does not apply Postnatal: No Charge; deductible does not apply	Prenatal: 30% coinsurance Postnatal: 30% coinsurance	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	Preauthorization is required.
	Rehabilitation services	10% coinsurance	30% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 combined visits per member, per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	10% coinsurance for Applied Behavioral Analysis; 10% coinsurance for Physical, Speech and Occupational Therapy	10% coinsurance for Applied Behavioral Analysis; 30% coinsurance for Physical, Speech and Occupational Therapy	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization.
	Skilled nursing care	10% coinsurance	10% coinsurance	Preauthorization is required. Limited to 120 days per member per calendar year
	Durable medical equipment	10% coinsurance	10% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge; deductible does not apply	No Charge; deductible does not apply	Preauthorization is required. Visit limits apply.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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
- 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/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.cciio.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	$100
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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:

Cost Sharing	
Deductibles	$100
Copayments	$40
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$1,240**

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

The plan's overall deductible	$100
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

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

The plan's overall deductible	$100
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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:

Cost Sharing	
Deductibles	$100
Copayments	$60
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$260**

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

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.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ئەگەر تۆ یان کەسێک کە یارمەتی دەدەیت پێویستی بە یارمەتی هەیە، مافی ئەوەت هەیە بە بێ هیچ تێچوونێک یارمەتی و زانیاری پێویست بە زمانەکەت وەربگریت. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بە ژمارەی خزمەتگوزاری بەکارهێنەران بکە کە لەسەر پشتەوەی کارتەکەتە، یان 877-469-2583 TTY:711 بۆ ئەندام نەبووان پەیوەندی بکە.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は 877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

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 discriminated 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.

You can also file a civil rights complaint with the U.S. Department of Health & 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, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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, go to www.asrhealthbenefits.com. 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 www.healthcare.gov/sbc-glossary or call 616-957-1751 or 1-800-968-2449 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$250/individual or $500/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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Covered preventive care, most outpatient physician services (primary care, urgent care, specialist visits), most chiropractic care, and most emergency room care 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?	The out-of-pocket limits for medical coinsurance are $1,000/individual and $2,000/family. The total out-of-pocket limits for medical services are $4,125/individual and $10,250/family. These figures include the deductibles, the coinsurance out-of-pocket limits shown above, as well as in-network medical copayments.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why this Matters:
What is not included in the out-of-pocket limit?	Deductibles and copayments are not included in the above out-of-pocket limits applicable to medical coinsurance. In general, out-of-pocket limits do not include out-of-network medical copayments; prescription drug coverage copayments (however these expenses will count towards a separate out-of-pocket limit that is not specified in this summary); penalties; charges that exceed the plan's usual, customary, and reasonable fee allowance or are in excess of stated maximums; premiums; balance-billing charges; and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.asrhealthbenefits.com or call 616-957-1751 or 1-800-968-2449 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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit; deductible does not apply	$20 copay/visit and 15% coinsurance; deductible does not apply	Out-of-network copayment costs do not track towards the plan's out-of-pocket limit.
	Specialist visit	$20 copay/visit (or copay/day for most chiropractic care); deductible does not apply	$20 copay/visit (or copay/day for most chiropractic care) and 15% coinsurance; deductible does not apply	Out-of-network copayment costs do not track towards the plan's out-of-pocket limit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic, cont.	Preventive care/screening/ immunization	No charge	Not covered for most preventive care services; otherwise, depending on service type, either no charge or 15% coinsurance applies (deductible does not apply)	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. Coverage for a breast pump purchased from an out-of-network provider is limited to $250/birth. Certification (sometimes called preauthorization) is recommended for the rental and purchase of breast pumps. Preventive care, including in-network well-baby and routine child care visits, are subject to various frequency limitations. This benefit includes one routine mammogram and one routine/ diagnostic colonoscopy (and any mammogram- and colonoscopy-related services) per year. All diagnostic mammograms or any subsequent routine mammograms and routine/diagnostic colonoscopies performed in that year will be subject to coinsurance and deductible.
If you have a test	Diagnostic test (X-ray, blood work)	20% coinsurance	35% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	35% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.navitus.com or the Medical Option Comparison chart in your Natural Select workbook.	Generic drugs	Not covered when purchased through a pharmacy or mail order program		No coverage for prescription drugs purchased through a pharmacy or mail order program under the plan's medical coverage.
	Preferred brand drugs	Not covered when purchased through a pharmacy or mail order program		
	Non-preferred brand drugs	Not covered when purchased through a pharmacy or mail order program		
	Specialty drugs	Not covered when purchased through a pharmacy or mail order program		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	35% coinsurance	None
	Physician/surgeon fees	20% coinsurance	35% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay/visit and 20% coinsurance; deductible does not apply to most ER services	100 copay/visit and 20% coinsurance; deductible does not apply to most ER services	Copay may be waived if admitted inpatient of for accidental injury.
	Emergency medical transportation	20% coinsurance	35% coinsurance	
	Urgent care	$20 copay/visit; deductible does not apply	$20 copay/visit and 15% coinsurance; deductible does not apply	Out-of-network copayment costs do not track towards the plan's out-of-pocket limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	35% coinsurance	Certification (sometimes called preauthorization) is recommended.
	Physician/surgeon fees	20% coinsurance	35% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance for autism services, including ABA therapy; otherwise $20 copay/office visit and 20% coinsurance for other outpatient services; deductible does not apply when copay is assessed	20% coinsurance for ABA therapy; otherwise generally 35% coinsurance ($20 copay/office visit may also apply); deductible does not apply when copay is assessed	Out-of-network copayment costs do not track towards the plan's out-of-pocket limit. Coverage for Applied Behavior Analysis (ABA) therapy is limited to $50,000 annually (outpatient and inpatient services combined). For inpatient services only, certification (sometimes called preauthorization) is recommended.
	Inpatient services	20% coinsurance	35% coinsurance	
If you are pregnant	Office visits	20% coinsurance	35% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or a deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	35% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	35% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	35% coinsurance	Certification (sometimes called preauthorization) is recommended.
	Rehabilitation services	20% coinsurance	35% coinsurance	Certification (sometimes called preauthorization) is recommended.
	Habilitation services	20% coinsurance	35% coinsurance	Certification (sometimes called preauthorization) is recommended.
	Skilled nursing care	50% coinsurance for private-duty nursing; otherwise 20% coinsurance	50% coinsurance for private-duty nursing; otherwise 35% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs, cont.	Durable medical equipment	20% coinsurance	35% coinsurance	Certification (sometimes called preauthorization) is recommended for the rental and purchased of certain durable medical equipment. Vehicle and home modifications are excluded. Breastfeeding equipment is covered under the plan as preventive care.
	Hospice services	20% coinsurance	35% coinsurance	None
If your child needs dental or eye care More information about eye care coverage is available at www.bcbsm.com. More information about dental care coverage is available at www.deltadentalmi.com. Also refer to the Medical Option Comparison chart in your *Natural Select* workbook.	Children's eye exam	Not covered (except to the extent required by law)	Not covered (except to the extent required by law)	No coverage for routine eye care under the medical plan, except as required by Health Care Reform.
	Children's glasses	Not covered	Not covered	No coverage for glasses under the medical plan.
	Children's dental check-up	Not covered (except to the extent required by law)	Not covered (except to the extent required by law)	No coverage for routine dental care under the medical plan, except as required by Health Care Reform.

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
- Cosmetic surgery
- Dental care (except to the extent required to be covered by Health Care Reform)
- Glasses
- Hearing aids
- Infertility treatment (except the treatment of the underlying cause of infertility may be covered)
- Long-term care
- Non-emergency care when traveling outside the U.S. (except certain care may be covered in specific situations as detailed in the plan document)
- Prescription drugs purchased through a pharmacy or mail order program
- Routine eye care (except to the extent required to be covered by Health Care Reform)
- 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 up to 38 visits allowed annually	• 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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: ASR Health Benefits at 616-957-1751 or 1-800-968-2449 or at www.asrhealthbenefits.com. Additionally, a Consumer Assistance Program may be able to help you file your appeal. Visit www.dol.gov/ebsa/healthreform or http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ to see if your state has a Consumer Assistance Program that may be able to help you file your appeal.

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

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

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

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

Language Access Services:

Para obtener asistencia en Español, llame al 616-957-1751 o 1-800-968-2449.

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	**$250**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$20
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,330**

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

The plan's overall deductible	**$250**
Specialist copayment	**$20**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$300
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,570**

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

The plan's overall deductible	**$250**
Specialist copayment	**$100**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$ 550**

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

Health Alliance Plan

Coverage for: Individual+Family | **Plan Type: HMO**

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, call 1-800-422-4641 or visit www.hap.org. 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 http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-422-4641 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
What is the out-of-pocket limit for this plan?	**$6,600** individual/ **$13,200** 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.
What is not included in the out-of-pocket limit?	Premium, Balance billing, Charges, and Health Care this plan does not cover.	Even though you pay these expenses, they don't count toward the out of pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.hap.org or call 1-800-422-4641** 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.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	Not Covered	Visits are face-to-face, telephonic, or through secure electronic portal
	Specialist visit	$20 copay per visit	Not Covered	----------None----------
	Other practitioner office visit	$20 PCP Other Practitioner copay per visit/ $20 Specialist Other Practitioner copay per visit	Not Covered	Chiropractic Care and Acupuncture Not Covered
	Preventive care/ screening/immunization	No Charge	Not Covered	Coverage information available at www.hap.org. You may have to pay for services that aren't preventive services. Ask your provider if the services needed are preventive services. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Some services require preauthorization.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Some services require preauthorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hap.org	Generic drugs	$5 copay/prescription (retail)	Not Covered	Applies to all categories below. Retail: 30 day supply for non-maintenance drugs at 1 copay. Mail Order: 90 day supply of both maintenance and non-maintenance drugs at 1 copay.
	Preferred brand drugs	$20 copay/prescription (retail)	Not Covered	
	Non-preferred brand drugs	$40 copay/prescription (retail)	Not Covered	
	Specialty drugs	$40 copay/prescription (retail)	Not Covered	Specialty drugs not available at 90 day or mail order
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	No Charge	Not Covered	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copay per visit	$100 copay per visit	Copay will be waived if admitted
	Emergency medical transportation	No Charge	No Charge	Emergency medical transportation Only
	Urgent care	$20 copay per visit	$20 copay per visit	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	Some services require preauthorization .
	Physician/surgeon fees	No Charge	Not Covered	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay per visit	Not Covered	Some services require preauthorization. Services can be accessed by calling 1-800-444-5755
	Inpatient services	No Charge	Not Covered	Services require preauthorization. Services can be accessed by calling 1-800-444-5755
If you are pregnant	Office visits	$20 copay per visit	Not Covered	No Charge for Prenatal care
	Childbirth/delivery professional services	No Charge	Not Covered	----------None----------
	Childbirth/delivery facility services	No Charge	Not Covered	**Some services require preauthorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	----------None----------
	Rehabilitation services	No Charge	Not Covered	Up to 60 combined visits per benefit period - May be rendered at home
	Habilitation services	No Charge	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Services require preauthorization. *See outpatient Mental Health for ABA cost sharing amount.
	Skilled nursing care	No Charge	Not Covered	Covered for authorized services- Up to 730 days, renewable after 60 days
	Durable medical equipment	No Charge	Not Covered	Coverage provided for approved equipment based on HAP's guidelines. Some services require preauthorization.
	Hospice services	No Charge	Not Covered	Up to 210 days per lifetime
If your child needs dental or eye care	Children's eye exam	$20 copay per visit	Not Covered	No Charge for preventive eye exam
	Children's glasses	Not Covered	Not Covered	----------None----------
	Children's dental check-up	Not Covered	Not Covered	----------None----------

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	• Hearing Aids	• Private-Duty Nursing
• Chiropractic Care	• Long-Term Care	• Routine Foot Care (Only when meets plan guidelines)
• Cosmetic Surgery	• Non-Emergency Care When Traveling Outside the U.S.	• Vision Hardware (Unless additional rider purchased)
• Dental Care (Adult)		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery	• Routine Eye Care (Adult)	• Weight Loss Programs
• Infertility Treatment (Only when meets plan guidelines)		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue coverage after it ends. For more information on you rights to continue coverage, contact the plan at 1-800-422-4641; you may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual 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 the plan at 1-800-422-4641; you may also contact the Department of Insurance and Financial Services, Healthcare Appeals Section, Office of General Counsel, 611 Ottawa, 3rd Floor, P.O. Box 30220, Lansing, MI 48909-7720, http://michigan.gov/difs; call 1-877-999-6442 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Financial and Insurance Regulation, P.O.Box 30220, Lansing, MI 48909, phone 1-877-999-6442, website: http://michigan.gov/difs or e-mail 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 pay 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 premium tax credits to help you pay for a plan through the Marketplace.

Language Access Services:
Please see a full list of Language Access Services following the Coverage Examples at the end of the Summary of Benefits of Coverage.

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	**$0**
Specialist copayment	**$20**
Hospital (facility) copayment	**$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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$460

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$20**
Hospital (facility) copayment	**$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:

Cost Sharing	
Deductibles	$0
Copayments	$615
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$670

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

The plan's overall deductible	**$0**
Specialist copayment	**$20**
Hospital (facility) copayment	**$0**
Other coinsurance	**0%**

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$60

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

Language Access Services

VINI RE: Nëse flisni shqip, ju ofrohen shërbime ndihme gjuhësore falas. Për ndihmë të përgjithshme, telefononi numrin (800) 422-4641 (TTY: 711). Për ndihmë nga "Medicare", telefononi numrin (800) 801-1770 (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية مجانًا. للحصول على المساعدة العامة اتصل بالرقم (800) 422-4641 (خدمة الهاتف النصي:711). للحصول على المساعدة المتعلقة بتغطية Medicare، اتصل بالرقم (800) 801-1770 (خدمة الهاتف النصي: 711).

নজর দিন: আপনি বাংলা ভাষায় কথা বললে, ভাষা সহায়তার পরিষেবা বিনামূল্যে আপনার জন্য উপলব্ধ। সধারণ সহায়তার জন্য (800) 422-4641(TTY: 711) নম্বরে ফোন করুন। Medicare সহায়তার জন্য (800) 801-1770 (TTY: 711) নম্বরে ফোন করুন।

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。如需一般援助，請致電 (800) 422-4641 或 TTY 用户請致電 711。如需 Medicare 援助，請致電 (800) 801-1770 或 TTY 用户請致電 711。

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Allgemeine Hilfe erhalten Sie unter der Rufnummer (800) 422-4641 (TTY: 711). Für Medicare-Unterstützung wenden Sie sich bitte an folgende Rufnummer: (800) 801-1770 (TTY : 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Per assistenza generica, chiamare il numero (800) 422-4641 (TTY: 711). Per assistenza Medicare, chiamare il numero (800) 801-1770 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。一般支援については、(800) 422-4641 まで（TTY ユーザーは 711 まで）、お電話にてご連絡ください。Medicare 支援については、(800) 801-1770 まで（TTY ユーザーは 711 まで）、お電話にてご連絡ください。

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 일반 지원은 (800) 422-4641(TTY: 711)번으로 전화해 주십시오. Medicare 지원은 (800) 801-1770(TTY: 711)번으로 전화해 주십시오.

UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 422-4641 (TTY: 711) w celu uzyskania pomocy w sprawach ogólnych. W celu uzyskania wsparcia Medicare zadzwoń pod nr (800) 801-1770 (TTY: 711).

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. По вопросам получения общей помощи обращайтесь по номеру (800) 422-4641 (телетайп: 711). Обращайтесь в Medicare по номеру (800) 801-1770 (телетайп: 711).

NAPOMENA: Ako govorite hrvatski/srpski, dostupna Vam je besplatna podrška na Vašem jeziku. Za opću podršku nazovite na broj (800) 422-4641 (tekstualni telefon za osobe oštećena sluha: 711). Za podršku vezano za program Medicare nazovite na broj (800) 801-1770 (tekstualni telefon za osobe oštećena sluha: 711).

ATENCIÓN: si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Para obtener ayuda general, llame al (800) 422-4641 (los usuarios TTY deben llamar al 711). Para obtener ayuda de Medicare, llame al (800) 801-1770 (los usuarios TTY deben llamar al 711).

ܙܘܗܪܐ: ܐܢ ܐܚܬܘܢ ܝܬܘܢ ܡܗܡܙܡܢܬܘܢ ܠܗ ܠܫܢܐ ܐܣܘܪܝܝܐ\ܐܬܘܪܝܐ، ܡܨܝ ܝܬܘܢ ܕܡܦܠܚܝܬܘܢ ܗܝܪܬܐ ܡܓܢܢܝܬܐ ܒܠܫܢܐ.
ܠܥܕܪܢܐ ܗܝܪܬܐ ܓܘܢܝܬܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ (800) 422-4641 (TTY: 711). ܠܥܕܪܢܐ ܗܝܪܬܐ ܥܡ ܬܗ Medicare،
ܩܪܘܢ ܥܠ ܡܢܝܢܐ (800) 801-1770 (TTY: 711).

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Para sa pangkalahatang tulong, tumawag sa (800) 422-4641 (TTY: 711). Para sa tulong sa Medicare, tumawag sa (800) 801-1770 (TTY: 711).

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Để được trợ giúp chung, hãy gọi (800) 422-4641 (TTY: 711). Để được trợ giúp về y tế (Medicare), hãy gọi (800) 801-1770 (TTY: 711).

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.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$200 Individual/ $400 Family	See the Common Medical Events chart below for your costs for services this plan covers.
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)	**Medical Coinsurance Limit** $1,000 Individual/ $1,000 Family **Medical Out-of-Pocket Limit** $4,125 Individual/ $10,250 Family	**The medical coinsurance limit includes coinsurance only.** After you meet the deductible, most medical services are subject to coinsurance. You will pay coinsurance until you reach the medical coinsurance out-of-pocket limit. The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. **The medical out-of-pocket limit includes medical deductible, coinsurance and copays. Note that there are separate out-of-pocket limits for medical and prescription drug services.**
What is not included in the out-of-pocket limit?	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.
Will you pay less if you use a network provider?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay Participating Provider	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	None
	Specialist visit	10% coinsurance	None
	Preventive care/screening /immunization	No Charge; deductible does not apply	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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance; deductible does not apply	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance; deductible does not apply	May require preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com or from the Medical Comparison Chart in your *Natural Select* workbook	Generic or select prescribed over-the-counter drugs	Not covered	None
	Preferred brand-name drugs	Not covered	
	Nonpreferred brand-name drugs	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge; deductible does not apply	None
	Physician/surgeon fees	No Charge; deductible does not apply	None
If you need immediate medical attention	Emergency room care	$100 copay/visit; deductible does not apply	Copay waived if admitted or for an accidental injury
	Emergency medical transportation	10% coinsurance	Mileage limits may apply
	Urgent care	10% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge; deductible does not apply	Preauthorization may be required
	Physician/surgeon fee	No Charge; deductible does not apply	None

Common Medical Event	Services You May Need	What You Will Pay Participating Provider	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	No Charge; deductible does not apply for Mental Health; No Charge for substance use disorder	None
	Inpatient services	No Charge; deductible does not apply	Preauthorization is required.
If you are pregnant	Office visits	Prenatal: No Charge; deductible does not apply Postnatal: 10% coinsurance	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive.
	Childbirth/delivery professional services	No Charge; deductible does not apply	None
	Childbirth/delivery facility services	No Charge; deductible does not apply	None
If you need help recovering or have other special health needs	Home health care	No Charge; deductible does not apply	Preauthorization is required.
	Rehabilitation services	No Charge; deductible does not apply	None
	Habilitation services	No Charge; deductible does not apply for Applied Behavioral Analysis; No Charge; deductible does not apply for Physical, Speech and Occupational Therapy	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization.
	Skilled nursing care	No Charge; deductible does not apply	Preauthorization is required.
	Durable medical equipment	10% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge; deductible does not apply	Preauthorization is required. Visit limits apply.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administration	Children's eye exam	Not covered	None
	Children's glasses	Not covered	None
	Children's dental check-up	Not covered	None

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
- 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
- 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/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.cciio.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	$200
Specialist coinsurance	10%
Hospital (facility) copayment	$0
Other coinsurance	10%

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:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$400**

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

The plan's overall deductible	$200
Specialist coinsurance	10%
Hospital (facility) copayment	$0
Other coinsurance	10%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

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

The plan's overall deductible	$200
Specialist coinsurance	10%
Hospital (facility) copayment	$0
Other coinsurance	10%

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:

Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$490**

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

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.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話 877-469-2583, TTY: 711。

ئەگەر تۆ یان کەسێک کە یارمەتی دەدەیت پێویستی بە یارمەتی هەیە، مافی ئەوەت هەیە بە بێ هیچ تێچوونێک یارمەتی و زانیاری پێویست بە زمانەکەت وەربگریت. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بە ژمارەی خزمەتگوزاری بەکارهێنەران بکە کە لەسەر پشتەوەی کارتەکەتە، یان 877-469-2583 TTY:711 بۆ ئەو کەسانەی کە ئەندام نین.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号 (メンバーでない方は 877-469-2583, TTY: 711) までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

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 discriminated 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.

You can also file a civil rights complaint with the U.S. Department of Health & 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, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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).

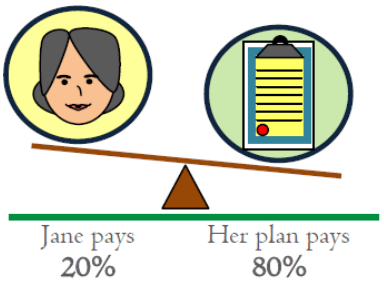
Balance Billing

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.

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



(See page 6 for a detailed example.)

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.)

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

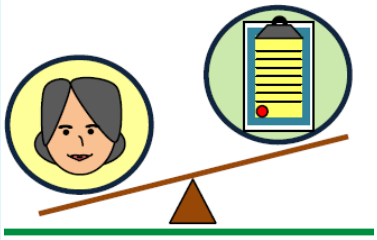
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your 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.

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.)



(See page 6 for a detailed example.)

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.

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.

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 limits 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.

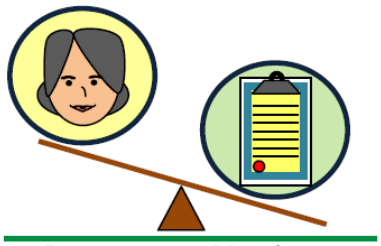
Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

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.



(See page 6 for a detailed example.)

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.

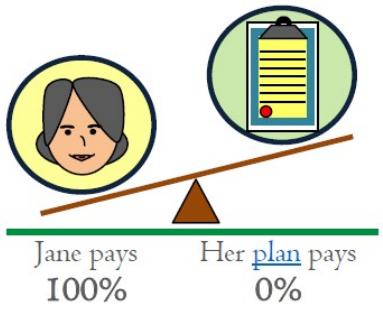
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

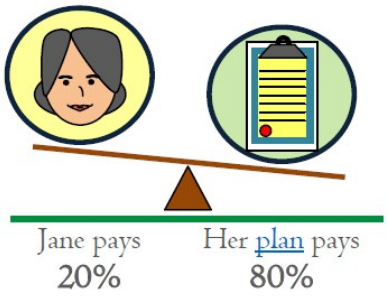
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

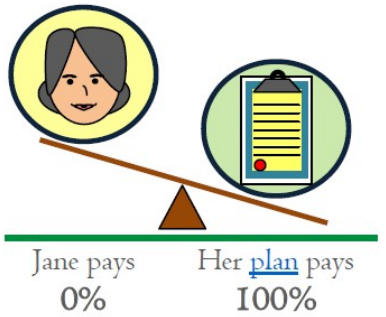
December 31st
End of Coverage Period



more costs



more costs



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 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 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

Our Mission Statement: Assist Oakland County employees, retirees, and dependents in taking ownership of their health and wellness in order to: improve quality of life, enhance productivity, and stabilize long-term employee/employer health care costs.

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www.oakgov.com/wellness