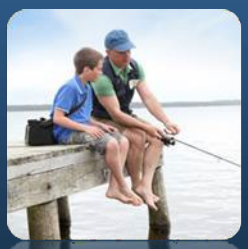
St. Clair County Community Mental Health

Promoting Discovery & Recovery Opportunities for Healthy Minds & Bodies

Employee Benefits Enrollment Guide

Plan Year: 2024



Welcome to your 2024 Benefits Enrollment!

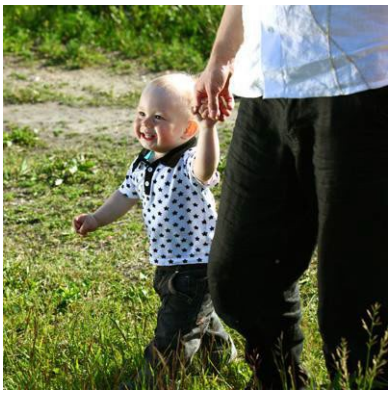
This handbook is designed to acquaint you with and provide you with general information about the benefit plans you may be eligible for as an employee of St. Clair County Community Mental Health Authority (SCCCMHA).

The handbook is a summary of our benefits, which are presented here only as a matter of information and is not intended to interpret or change the terms of the official plan documents. To the extent that any of the information contained in this document is inconsistent with the official plan documents, the provisions of the official plan documents will govern in all cases.

We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Health Benefits Summary

1. **Medical & Pharmaceutical** – BC/BS (West Michigan Health Insurance Pool)
2. **Dental** – Delta Dental – *No cost to Regular Full Time Employees*
3. **Vision** – EyeMed – *No cost to Regular Full Time Employees*
4. **Flexible Spending Account (FSA) - Medical & Dependent Care** – Wex Benefits
5. **Health Savings Account (HSA)** Wex Benefits
6. **Life Insurance** – Symetra Life Insurance
7. **Long Term Disability** – Symetra Life Insurance
8. **Did You Know?** Information on free health-related services and opportunities can be found by visiting www.BCBSM.com



Who is Eligible?

If you are a SCCCMHA full-time employee, you are eligible to enroll in the benefits described in this enrollment guide. For calendar year 2024, employees shall be eligible to enroll their lawful spouse in a SCCCMHA health plan of the employee's choosing. Employees must provide legal documentation of lawful marriage (marriage license) at time of enrollment in order for spouse to be eligible. Your dependent children to age 26 may also enroll in the benefit plans, along with totally disabled adult children who were enrolled in the plan prior to their 26th birthday. Legal documentation is required to enroll dependents on any benefit plan (birth certificate, adoption certificate, legal guardian paperwork).

How to Enroll

Make your benefit elections and complete the enrollment process in ADP. Once you have made your elections, you will not be able to change them until the next open enrollment period, which will be in November 2024, unless you have a qualified change in status.

When to Enroll

As a new employee, you should enroll within 31 days of your eligibility date. No elections will be allowed after your initial eligibility period until the next open enrollment. The open enrollment period occurs every November. The benefits you elect during open enrollment will be effective on January 1 of the next year.

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or change in spouse's or domestic partner's benefits or employment status. You will be required to show proof of the qualified change in status.

Medical and Prescription Drugs

SCCCMHA offers its employees a comprehensive range of Medical/Prescription Plans. Employees have the option to choose from:

PPO Select 1 – lowest copays, no deductible or coinsurance; highest payroll deductions

Versatile 3 PPO – lower copays, low deductibles, 90% coinsurance; moderate payroll deductions

PPO Simply Blue Plan 6 - lower copays, low deductibles and 80% coinsurance; mid-range payroll deductions

PPO Simply Blue Plan 7 – higher copays, higher deductibles and 80% coinsurance; lowest payroll contributions

PPO Flex Blue 3 (a Qualified High Deductible Health Plan) – HSA qualified plan where the plan does not pay until you have met your deductible; lower payroll deductions, tax advantages

PPO Minimal Essential Plan HDHP – HSA qualified plan where the plan does not pay until you have met your deductible; 80% coinsurance; tax advantages; Zero cost payroll deduction. For 2024, employees electing to participate in this plan will be provided a contribution by SCCCCMHA into a Health Savings Account (HSA) to help off-set the high-deductible associated with the plan. The contributions by SCCCMHA will be the difference between the PA152 hard-cap amount and the premium cost for the plan. Employees enrolled in the plan will receive $484/single, $1,012/2 person, and $1320/family.

All of the plans offered by SCCCMHA are administered through Blue Cross Blue Shield (BCBS) obtained through the agency's membership in the Western Michigan Health Insurance Pool (WMHIP), with AJ Gallagher as the representing agent for the Blue Cross plans.

You will receive a Member ID Card from BCBS.

Interested in Opting Out of Medical and Prescription Coverage?

For 2024, eligible employees who elect not to participate in the medical plan are entitled to annual compensation of $2,500/single, $3,000 /2 Person, or $3,500/family, payable in equal bi-weekly installments. To be eligible for this payment, the employee must provide evidence of other health care coverage for themselves and their entire tax family which meets minimum essential coverage (MEC) standards and is not obtained through the Healthcare Exchange and sign an attestation stating as such.

Regular Full Time Employee
Benefit Plan Costs CY 2024

For regular full-time employees, your cost is represented below and is based on the plan you elect and your pay frequency.

	2024 Bi-Weekly Payroll Contribution*
PPO Select 1 ($0 deductible / 100% coinsurance)	
Employee Only	$202.17
Employee + 1	$422.81
Family	$551.31
Versatile 3 PPO ($250/$500 deductible / 90% coinsurance)	
Employee Only	$123.90
Employee + 1	$259.10
Family	$337.86
PPO Simply Blue Plan 6 ($500/$1000 deductible / 80% coinsurance)	
Employee Only	$68.38
Employee + 1	$143.00
Family	$186.46
PPO Simply Blue Plan 7 ($1000/$2000 deductible / 80% coinsurance)	
Employee Only	$42.90
Employee + 1	$89.69
Family	$116.95
PPO Flex Blue 3 HDHP ($2000/$4000 deductible / 100% coinsurance)	
Employee Only	$54.59
Employee + 1	$114.17
Family	$148.86
PPO Minimal Essential HDHP Plan ($3000/$6000 deductible / 80% coinsurance)	
Employee Only	0 Premium
Employee + 1	0 Premium
Family	0 Premium

Comparison of Benefits

The plans utilize the Blue Cross Blue Shield of Michigan network with OptumRx managing the pharmacy benefit.

Please note that all the plans have out-of-network benefits; however, if you choose to see a provider that is not in- network you will have higher out of pocket costs due to increased out-of-network deductibles and coinsurance.

All plans are compliant with the Patient Protection and Affordable Care Act (PPACA).

St. Clair County Community Mental Health Authority - 2024 Medical Plan Options

PLAN(S)	PPO Select 1		Versatile 3 PPO		PPO Simply Blue Plan 6		PPO Simply Blue Plan 7		PPO Flex Blue 3 (HDHP)		PPO Minimal Essential Plan (HDHP)	
NETWORK(S)	BCBS		BCBS		BCBS		BCBS		BCBS		BCBS	
Plan Basics	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Individual Deductible	$0	$250	$250	$500	$500	$1,000	$1,000	$2,000	$2,000	$4,000	$3,000	$6,000
Family Deductible	$0	$500	$500	$1,000	$1,000	$2,000	$2,000	$4,000	$4,000	$8,000	$6,000	$12,000
Coinsurance Level	100%	80%	90%	70%	80%	60%	80%	60%	100%	80%	20%	40%
Coinsurance Max Ind	N/A	N/A	$1,000	30%	$2,500	40%	$2,500	40%	N/A	N/A	N/A	N/A
Coinsurance Max Fam	N/A	N/A	$2,000	30%	$5,000	40%	$5,000	40%	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum Ind	$2,250	$2,250	$2,500	$2,500	$4,500	$4,500	$4,500	$4,500	$3,000	$6,000	$4,000	$8,000
Out-of-Pocket Maximum Fam	$4,500	$4,500	$5,000	$5,000	$9,000	$9,000	$9,000	$9,000	$6,000	$12,000	$8,000	$16,000
Other Plan Details												
Hospital Services	100%	80% after Ded	90% after Ded	70% after Ded	80% after Ded.	60% after Ded	80% after Ded	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Inpatient Care	100%	80% after Ded	90% after Ded	70% after Ded	80% after Ded.	60% after Ded	80% after Ded	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Urgent Care	100%	80% after Ded	Facility 90% after Ded; Professional $20 Copay	70% after Ded	$60 Copay	60% after Ded	$60 Copay	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Emergency Care ***(waived if admitted)***	$50 Copay		$50 Copay; then 90%		$150 Copay		$150 Copay		100% after Ded		80% after Ded	
Primary Care Office Visits	$5 Copay	80% after Ded	$20 Copay	70% after Ded	$30 Copay	60% after Ded	$30 Copay	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Online Office Visits ***(approved providers)***	$5 Copay	80% after Ded	$20 Copay	70% after Ded	$30 Copay	60% after Ded	$30 Copay	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Specialist Visit	$5 Copay	80% after Ded	$20 Copay	70% after Ded	$50 Copay	60% after Ded	$50 Copay	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
OP Beh Health ***(f/f and online)***	$5 Copay	80% after Ded	$20 Copay	70% after Ded	80% after Ded	60% after Ded	80% after Ded	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Diagnostic, X-ray, Lab	100%	80% after Ded	90% after Ded	70% after Ded	80% after Ded	60% after Ded	80% after Ded	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Durable Medical Equipment	100%	80% after Ded	90% after Ded	70% after Ded	80% after Ded	60% after Ded	80% after Ded	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Chiropractic Spinal Manip.	100%	80% after Ded	90% after Ded	70% after Ded	$30 Copay	60% after Ded	$30 Copay	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
	(Max 24 visits annually)		(Max 24 visits annually)		(Max 12 visits annually)		(Max 12 visits annually)		(Max 24 visits annually)		(Max 24 visits annually)	
Hearing Care Coverage	Yes		Yes		Yes		Yes		Yes		Yes	
Prescription Drugs												
Generic	$10 Copay		$10 Copay		$20 Copay		$20 Copay		$10 Copay after Ded		$10 Copay after Ded	
Formulary Brand	$40 Copay		$40 Copay		$40 Copay		$40 Copay		$40 Copay after Ded		$40 Copay after Ded	
Non-Formulary Brand	$40 Copay		$40 Copay		$80 Copay		$80 Copay		$40 Copay after Ded		$80 Copay after Ded	
Preferred Specialty	$40 Copay		$40 Copay		$40 Copay		$40 Copay		$40 Copay after Ded		$40 Copay after Ded	
Non-Preferred Specialty	$40 Copay		$40 Copay		$80 Copay		$80 Copay		$40 Copay after Ded		$80 Copay after Ded	
Mail Order Rx ***(90 Days)***	2x Copay		2x Copay		2x Copay		2x Copay		2x Copay after Ded		2x Copay after Ded	
2024 Per Pay Employee Cost (Annual Employee Cost / 26 pays)												
Single	$202.10		$123.89		$68.38		$42.89		$54.59		$0.00	
2 Person	$422.81		$259.10		$143.00		$89.69		$114.17		$0.00	
Family	$551.36		$337.86		$186.46		$116.96		$148.86		$0.00	

The above comparison is a high level overview of the medical plans offered to you as an employee of SCCCMHA. If any statement conflicts with the applicable plan document, the applicable plan documents will govern.

Regular Part Time Employee - Benefit Plan Costs CY 2024

Plan	Full Cost Per Month	Full Cost Per Pay
PPO Select 1 ($0, 100%)		
Employee Only	$1,079.95	$498.44
Employee + 1	$2,258.50	$1,042.38
Family	$2,945.24	$1,359.34
PPO Versatile 3 ($250/$500, 90%)		
Employee Only	$910.34	$420.16
Employee + 1	$1,903.80	$878.68
Family	$2,482.68	$1,145.85
PPO Simply Blue Plan 6 ($500/$1000, 80%)		
Employee Only	$790.06	$364.64
Employee + 1	$1,652.25	$762.58
Family	$2,154.65	$994.45
PPO Simply Blue Plan 7 ($1000/$2000, 80%)		
Employee Only	$734.84	$339.16
Employee + 1	$1,536.76	$709.27
Family	$2,004.05	$924.25
PPO Flex Blue 3 HDHP ($2000/$4000, 100%)		
Employee Only	$760.19	$350.86
Employee + 1	$1,589.78	$733.74
Family	$2,073.19	$956.86
PPO Minimal Essential HDHP ($3000/$6000, 80%)		
Employee Only	$748.25	$345.35
Employee + 1	$1,564.94	$722.28
Family	$2,041.23	$942.11
Delta Dental		
One Person/Family (same rate)	$74.36	$34.32
Vision - EyeMed		
Employee Only	4.77	2.20
Employee + 1	9.06	4.18
Family	13.31	6.14

PPO Select 1 Plan

Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 009
Section Code(s): 1010, 1110
PPO - PPO Select 1, Hearing, RX26
Effective Date: 01/01/2020
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	None	$250 per member $500 per family
Copays • Fixed Dollar Copays	$5 copay for : • Office visits $50 copay for : • Facility medical emergency	$50 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	0%	20% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$2,250 per member $4,500 per family Includes Deductible, Coinsurance and Copays	$2,250 per member $4,500 per family Excludes Deductible and includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 80% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 80% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $5 copay	Covered - 80% after deductible
Telemedicine Visits	Covered - 100% after $5 copay	Covered - 80% after deductible
Blue Cross Online Visits Note: Services are payable when rendered through Blue Cross Online Visits℠	Covered - 100% after $5 copay	Not Covered
Office Consultations	Covered - 100% after $5 copay	Covered - 80% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered - 80% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $50 copay; copay waived if admitted or for an accidental injury	Covered - 100% after $50 copay; copay waived if admitted or for an accidental injury
Non-Emergency use of the Emergency Room	Covered - 100% after $50 copay	Covered - 100% after $50 copay
Facility Urgent Care Services	Covered - 100%	Covered - 80% after deductible
Physician Urgent Care Services	Covered - 100%	Covered - 80% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 100%	Covered - 100%

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 100%	Covered - 80% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 100%	Covered - 80% after deductible
Radiation Therapy and Chemotherapy	Covered - 100%	Covered - 80% after deductible

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

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 80% after deductible
Delivery and Nursery Care	Covered - 100%	Covered - 80% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 100%	Covered - 80% after deductible
Inpatient Medical Care	Covered - 100%	Covered - 80% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100%	Covered - 100%
Home Health Care	Covered - 100%	Covered - 100%
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 100%	Covered - 100%

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 100%	Covered - 80% after deductible
Bariatric Surgery	Covered - 100%	Covered - 80% after deductible
Oral Surgery Wisdom teeth extractions	Covered - 100%	Covered - 100%
Sterilization - males only excludes reversal sterilization	Covered - 100%	Covered - 80% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 80% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 100%	Covered - 80% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care	Covered - 100%	Covered - 80% after deductible
Inpatient Substance Use Disorder Treatment	Covered - 100%	Covered - 100% after deductible
Outpatient Mental Health Care	Covered - 100% after $5 copay	Covered - 80% after deductible
• Telemedicine Mental Health Care	Covered - 100% after $5 copay	Covered - 80% after deductible
• Blue Cross Online Mental Health Care	Covered - 100% after $5 copay	Not Covered
Outpatient Substance Use Disorder Treatment	Covered - 100% after $5 copay	Covered - 90% after deductible

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

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 100%	Covered - 80% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 100%	Covered - 80% after deductible
Nutritional Counseling	Covered - 100%	Covered - 80% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 100%	Covered - 80% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 24 visits per member, per calendar year	Covered - 100%	Covered - 80% after deductible
Durable Medical Equipment	Covered - 100%	Covered - 80% after deductible
Prosthetic and Orthotic Devices	Covered - 100%	Covered - 80% after deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 100%	Covered - 80% after deductible
Private Duty Nursing Care	Covered - 90%	Covered - 90% after deductible
Allergy Testing and Therapy	Covered - 100%	Covered - 80% after deductible
Facility Clinic Visit	Covered - 100%	Covered - 80% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 100%	Covered - 80% after deductible
Massage Therapy Limited to a maximum of 24 visits per calendar year	Covered - 100%	Covered - 80% after deductible

Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 009
Section Code(s): 1010, 1110
Hearing Care Coverage
Effective Date: 09/01/2012
Benefits-at-a-glance

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Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 009
Section Code(s): 1010, 1110
Prescription Drugs
Effective Date: 01/01/2021
Benefits-at-a-glance

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BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30 day supply	$10 copay - Generic drugs $40 copay - Brand drugs $0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Mail Order - 90 day supply	$20 copay - Generic drugs $80 copay - Brand drugs
Specialty Drugs – 30 day supply Retail and Mail Order	$10 copay - Generic drugs $40 copay - Brand drugs Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance.

Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies. Also see *Other Covered Services* for Test Strips, Lancets, Needles and Syringes.

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 005
Section Code(s): 1010, 1110
PPO - Versatile Plan 3, Hearing, RX 1
Effective Date: 01/01/2020
Benefits-at-a-glance

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BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$250 per member $500 per family	$500 per member $1,000 per family
Copays • Fixed Dollar Copays	$20 copay for : • Office visits • Professional Urgent care services $50 copay for : • Facility medical emergency	$50 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	10% up to a maximum of: $1,000 per member $2,000 per family	30% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$2,500 per member $5,000 per family Includes Deductible, Coinsurance and Copays	$2,500 per member $5,000 per family Excludes Deductible and includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 70% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 70% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $20 copay	Covered - 70% after deductible
Telemedicine Visits	Covered - 100% after $20 copay	Covered - 70% after deductible
Blue Cross Online Visits Note: Services are payable when rendered through Blue Cross Online Visits℠	Covered - 100% after $20 copay	Not Covered
Office Consultations	Covered - 100% after $20 copay	Covered - 70% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered - 70% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - $50 copay then 90% after deductible; copay waived if admitted or for an accidental injury	Covered - $50 copay then 90% after deductible; copay waived if admitted or for an accidental injury
Non-Emergency use of the Emergency Room	Covered - $50 copay then 90% after deductible	Covered - $50 copay then 70% after deductible
Facility Urgent Care Services	Covered - 90% after deductible	Covered - 70% after deductible
Physician Urgent Care Services	Covered - 100% after $20 copay	Covered - 70% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 90% after deductible	Covered - 90% after deductible

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

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 90% after deductible	Covered - 70% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 90% after deductible	Covered - 70% after deductible
Radiation Therapy and Chemotherapy	Covered - 90% after deductible	Covered - 70% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 70% after deductible
Delivery and Nursery Care	Covered - 90% after deductible	Covered - 70% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Medical Care	Covered - 90% after deductible	Covered - 70% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 90% after deductible	Covered - 90% after deductible
Home Health Care	Covered - 90% after deductible	Covered - 90% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 90% after deductible	Covered - 90% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 90% after deductible	Covered - 70% after deductible
Bariatric Surgery	Covered - 90% after deductible	Covered - 70% after deductible
Oral Surgery Wisdom teeth extractions	Covered - 90% after deductible	Covered - 90% after in-network deductible
Sterilization - males only excludes reversal sterilization	Covered - 90% after deductible	Covered - 70% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 70% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 90% after deductible	Covered - 70% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Substance Use Disorder Treatment	Covered - 90% after deductible	Covered - 90% after deductible
Outpatient Mental Health Care • Telemedicine Mental Health Care • Blue Cross Online Mental Health Care	Covered - 100% after $20 copay Covered - 100% after $20 copay Covered - 100% after $20 copay	Covered - 70% after deductible Covered - 70% after deductible Not Covered
Outpatient Substance Use Disorder Treatment	Covered - 100% after $20 copay	Covered - 90% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 90% after deductible	Covered - 70% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 90% after deductible	Covered - 70% after deductible
Nutritional Counseling	Covered - 90% after deductible	Covered - 70% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 90% after deductible	Covered - 70% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 24 visits per member, per calendar year	Covered - 90% after deductible	Covered - 70% after deductible
Durable Medical Equipment	Covered - 90% after deductible	Covered - 70% after deductible
Prosthetic and Orthotic Devices	Covered - 90% after deductible	Covered - 70% after deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 90% after deductible	Covered - 70% after deductible
Private Duty Nursing Care	Covered - 90% after deductible	Covered - 90% after deductible
Allergy Testing and Therapy	Covered - 90% after deductible	Covered - 70% after deductible
Facility Clinic Visit	Covered - 90% after deductible	Covered - 70% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 90% after deductible	Covered - 70% after deductible
Massage Therapy Limited to a maximum of 24 visits per calendar year	Covered - 90% after deductible	Covered - 70% after deductible

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 005
Section Code(s): 1010, 1110
Hearing Care Coverage
Effective Date: 09/01/2012
Benefits-at-a-glance

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Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

Blue Cross Blue Shield of Michigan

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Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 005
Section Code(s): 1010, 1110
Prescription Drugs
Effective Date: 01/01/2021
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30 day supply	$10 copay - Generic drugs $40 copay - Brand drugs $0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Mail Order - 90 day supply	$20 copay - Generic drugs $80 copay - Brand drugs
Specialty Drugs – 30 day supply Retail and Mail Order	$10 copay - Generic drugs $40 copay - Brand drugs Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance.

Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies. Also see *Other Covered Services* for Test Strips, Lancets, Needles and Syringes.

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 095
Section Code(s): 1020, 1120
PPO - SB Plan 6, Hearing, RX37
Effective Date: 01/01/2020
Benefits-at-a-glance

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Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$500 per member $1,000 per family	$1,000 per member $2,000 per family
Copays • Fixed Dollar Copays	$30 copay for : • Primary Care Physician (PCP) office visits • Chiropractic spinal manipulations $50 copay for : • Specialist office visits $60 copay for : • Facility Urgent care services • Professional Urgent care services $150 copay for : • Facility medical emergency	$150 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	20% up to a maximum of: $2,500 per member $5,000 per family	40% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$4,500 per member $9,000 per family Includes Deductible, Coinsurance and Copays	$4,500 per member $9,000 per family Excludes Deductible and includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $30 pcp copay; $50 specialist copay	Covered - 60% after deductible
Telemedicine Visits	Covered - 100% after $30 pcp copay; $50 specialist copay	Covered - 60% after deductible
Blue Cross Online Visits Note: Services are payable when rendered through Blue Cross Online Visits℠	Covered - 100% after $30 copay	Not Covered
Office Consultations	Covered - 100% after $30 pcp copay; $50 specialist copay	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $150 copay; copay waived if admitted	Covered - 100% after $150 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Facility Urgent Care Services	Covered - 100% after $60 copay	Covered - 60% after deductible
Physician Urgent Care Services	Covered - 100% after $60 copay	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care Limited to lifetime maximum of 360 days	Covered - 100%	Covered - 100%
Home Health Care	Covered - 80% after deductible	Covered - 60% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 50% after deductible	Covered - 50% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
• Telemedicine Mental Health Care	Covered - 80% after deductible	Covered - 60% after deductible
• Blue Cross Online Mental Health Care	Covered - 80% after deductible	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 80% after deductible	Covered - 60% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 60% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 12 visits per member, per calendar year	Covered - 100% after $30 copay	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Not Covered	Not Covered
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 60% after deductible
Facility Clinic Visit	Covered - 80% after deductible	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 30 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 095
Section Code(s): 1020, 1120
Hearing Care Coverage
Effective Date: 01/01/2021
Benefits-at-a-glance

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Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 095
Section Code(s): 1020, 1120
Prescription Drugs
Effective Date: 01/01/2021
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30 day supply	$20 copay - Generic drugs $40 copay - Preferred brand drugs $80 copay - Non-Preferred brand drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Mail Order - 90 day supply	$40 copay - Generic drugs $80 copay - Preferred brand drugs $160 copay - Non-Preferred brand drugs
Specialty Drugs – 30 day supply Retail and Mail Order	$20 copay - Generic drugs $40 copay - Preferred brand drugs $80 copay - Non-Preferred brand drugs Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance.

Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies. Also see *Other Covered Services* for Test Strips, Lancets, Needles and Syringes.

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

PPO Simply Blue Plan 7

Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 104
Section Code(s): 1020, 1120
PPO - SB Plan 7, Hearing, RX37
Effective Date: 01/01/2020
Benefits-at-a-glance

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Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$1,000 per member $2,000 per family	$2,000 per member $4,000 per family
Copays • Fixed Dollar Copays	$30 copay for : • Primary Care Physician (PCP) office visits • Chiropractic spinal manipulations $50 copay for : • Specialist office visits $60 copay for : • Facility Urgent care services • Professional Urgent care services $150 copay for : • Facility medical emergency	$150 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	20% up to a maximum of: $2,500 per member $5,000 per family	40% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$4,500 per member $9,000 per family Includes Deductible, Coinsurance and Copays	$4,500 per member $9,000 per family Excludes Deductible and includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $30 pcp copay; $50 specialist copay	Covered - 60% after deductible
Telemedicine Visits	Covered - 100% after $30 pcp copay; $50 specialist copay	Covered - 60% after deductible
Blue Cross Online Visits Note: Services are payable when rendered through Blue Cross Online Visits℠	Covered - 100% after $30 copay	Not Covered
Office Consultations	Covered - 100% after $30 pcp copay; $50 specialist copay	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $150 copay; copay waived if admitted	Covered - 100% after $150 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Facility Urgent Care Services	Covered - 100% after $60 copay	Covered - 60% after deductible
Physician Urgent Care Services	Covered - 100% after $60 copay	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care Limited to lifetime maximum of 360 days	Covered - 100%	Covered - 100%
Home Health Care	Covered - 80% after deductible	Covered - 60% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 50% after deductible	Covered - 50% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
• Telemedicine Mental Health Care	Covered - 80% after deductible	Covered - 60% after deductible
• Blue Cross Online Mental Health Care	Covered - 80% after deductible	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment - Up to and including age 18

Benefits	In-Network	Out-of-Network
Applied Behavioral Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 80% after deductible	Covered - 60% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 60% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 12 visits per member, per calendar year	Covered - 100% after $30 copay	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Not Covered	Not Covered
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 60% after deductible
Facility Clinic Visit	Covered - 80% after deductible	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 30 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 104
Section Code(s): 1020, 1120
Hearing Care Coverage
Effective Date: 01/01/2021
Benefits-at-a-glance

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Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

Blue Cross Blue Shield of Michigan

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Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 104
Section Code(s): 1020, 1120
Prescription Drugs
Effective Date: 01/01/2021
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30 day supply	$20 copay - Generic drugs $40 copay - Preferred brand drugs $80 copay - Non-Preferred brand drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Mail Order - 90 day supply	$40 copay - Generic drugs $80 copay - Preferred brand drugs $160 copay - Non-Preferred brand drugs
Specialty Drugs – 30 day supply Retail and Mail Order	$20 copay - Generic drugs $40 copay - Preferred brand drugs $80 copay - Non-Preferred brand drugs Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance.

Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies. Also see *Other Covered Services* for Test Strips, Lancets, Needles and Syringes.

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

Blue Cross Blue Shield of Michigan

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

THE POOL
Western Michigan Health Insurance

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 040, 041
Section Code(s): 3000, 3100
PPO - Flexible Blue 3, RX7
Effective Date: 01/01/2023
Benefits-at-a-glance

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Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	$2,000 per member $4,000 per family	$4,000 per member $8,000 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	0%	20% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums The full family out of pocket maximum must be met before it is considered satisfied.	$3,000 per member $6,000 per family Includes Deductible, Coinsurance and Copays	$6,000 per member $12,000 per family Excludes Deductible and includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered

Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 80% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 80% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after deductible	Covered - 80% after deductible
Telemedicine Visits	Covered - 100% after deductible	Covered - 80% after deductible
Blue Cross Online Visits Note: Services are payable when rendered through Blue Cross Online Visits℠	Covered - 100% after deductible	Not Covered
Office Consultations	Covered - 100% after deductible	Covered - 80% after deductible
Pre-Surgical Consultations	Covered - 100% after deductible	Covered - 80% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after deductible	Covered - 100% after deductible
Non-Emergency use of the Emergency Room	Covered - 100% after deductible	Covered - 80% after deductible
Facility Urgent Care Services	Covered - 100% after deductible	Covered - 80% after deductible
Physician Urgent Care Services	Covered - 100% after deductible	Covered - 80% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 100% after deductible	Covered - 100% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 100% after deductible	Covered - 80% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 100% after deductible	Covered - 80% after deductible
Radiation Therapy and Chemotherapy	Covered - 100% after deductible	Covered - 80% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 80% after deductible
Delivery and Nursery Care	Covered - 100% after deductible	Covered - 80% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 100% after deductible	Covered - 80% after deductible
Inpatient Medical Care	Covered - 100% after deductible	Covered - 80% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100% after deductible	Covered - 100% after deductible
Home Health Care	Covered - 100% after deductible	Covered - 100% after deductible
Skilled Nursing Limited to a maximum of 90 days per calendar year	Covered - 100% after deductible	Covered - 100% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 100% after deductible	Covered - 80% after deductible
Bariatric Surgery	Covered - 100% after deductible	Covered - 80% after deductible
Oral Surgery Wisdom teeth extractions	Covered - 100% after deductible	Covered - 100% after in-network deductible
Sterilization - males only excludes reversal sterilization	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 80% after deductible
Elective Abortions	Not Covered	Not Covered

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100% after deductible	Covered - 80% after deductible
Kidney, Cornea, Bone Marrow and Skin	Covered - 100% after deductible	Covered - 80% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100% after deductible	Covered - 80% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100% after deductible	Covered - 80% after deductible
Telemedicine Mental Health Care	Covered - 100% after deductible	Covered - 80% after deductible
Blue Cross Online Mental Health Care	Covered - 100% after deductible	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network

Applied Behavior Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 100% after deductible	Covered - 80% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 100% after deductible	Covered - 80% after deductible
Nutritional Counseling	Covered - 100% after deductible	Covered - 80% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 100% after deductible	Covered - 80% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 24 visits per member, per calendar year	Covered - 100% after deductible	Covered - 80% after deductible
Durable Medical Equipment	Covered - 100% after deductible	Covered - 80% after deductible
Prosthetic and Orthotic Devices Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 100% after deductible Covered - 100% after deductible	Covered - 80% after deductible Covered - 80% after deductible
Private Duty Nursing Care	Covered - 80% after deductible	Covered - 80% after deductible
Allergy Testing and Therapy	Covered - 100% after deductible	Covered - 80% after deductible
Facility Clinic Visit	Covered - 100% after deductible	Covered - 80% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 100% after deductible	Covered - 80% after deductible

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 040, 041
Section Code(s): 3000, 3100
Hearing Care Coverage
Effective Date: 01/01/2021
Benefits-at-a-glance

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Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 040, 041
Section Code(s): 3000, 3100
Prescription Drugs
Effective Date: 01/01/2023
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Deductible	$2,000 per member $4,000 per family
Retail - 30-day supply	$10 copay after deductible - Generic drugs $40 copay after deductible - Brand drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 80% of the approved amount, less the member's copay.
Mail Order - 90-day supply	$20 copay after deductible - Generic drugs $80 copay after deductible - Brand drugs
Specialty Drugs – 30-day supply Retail and Mail Order	$10 copay after deductible - Generic drugs $40 copay after deductible - Brand drugs Members are restricted to a 30-day supply at both retail and mail order and certain specialty drugs are limited to only a 15-day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum. Note - Adjustments may be required to accurately reflect your annual out-of-pocket maximum with your true out-of-pocket costs.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	

Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies.

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

PPO Minimal Essential Plan

Blue Cross Blue Shield of Michigan

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

THE POOL
Western Michigan Health Insurance

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 059, 060
Section Code(s): 3000, 3100
PPO - Minimal Essential Plan, RX 23
Effective Date: 01/01/2023
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	$3,000 per member $6,000 per family	$6,000 per member $12,000 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	20%	40% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums All members on the contract can contribute to the family out of pocket maximum; however, a single member will not exceed the individual out of pocket maximum.	$4,000 per member $6,550 per member in family plan $8,000 per family Includes Deductible, Coinsurance and Copays	$8,000 per member $16,000 per family Excludes Deductible and includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered

Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 80% after deductible	Covered - 60% after deductible
Telemedicine Visits	Covered - 80% after deductible	Covered - 60% after deductible
Blue Cross Online Visits Note: Services are payable when rendered through Blue Cross Online Visits℠	Covered - 80% after deductible	Not Covered
Office Consultations	Covered - 80% after deductible	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 80% after deductible	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 80% after deductible	Covered - 80% after deductible
Non-Emergency use of the Emergency Room	Covered - 80% after deductible	Covered - 60% after deductible
Facility Urgent Care Services	Covered - 80% after deductible	Covered - 60% after deductible
Physician Urgent Care Services	Covered - 80% after deductible	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 80% after deductible	Covered - 80% after deductible
Home Health Care	Covered - 80% after deductible	Covered - 80% after deductible
Skilled Nursing Limited to a maximum of 90 days per calendar year	Covered - 80% after deductible	Covered - 80% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible
Elective Abortions	Not Covered	Not Covered

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 80% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Telemedicine Mental Health Care	Covered - 80% after deductible	Covered - 60% after deductible
Blue Cross Online Mental Health Care	Covered - 80% after deductible	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Pre-authorization required **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by an approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Covered - 80% after deductible	Covered - 60% after deductible

Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 60% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 12 visits per member, calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Covered - 80% after deductible	Covered - 60% after deductible
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 60% after deductible
Facility Clinic Visit	Covered - 80% after deductible	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 30 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 059, 060
Section Code(s): 3000, 3100
Hearing Care Coverage
Effective Date: 01/01/2021
Benefits-at-a-glance

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Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 059, 060
Section Code(s): 3000, 3100
Prescription Drugs
Effective Date: 01/01/2023
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Deductible	$3,000 per member $6,000 per family
Retail - 30-day supply	$10 copay after deductible - Generic drugs $40 copay after deductible - Preferred brand drugs $80 copay after deductible - Non-Preferred brand drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Retail and Mail Order - 90-day supply	$20 copay after deductible - Generic drugs $80 copay after deductible - Preferred brand drugs $160 copay after deductible - Non-Preferred brand drugs
Specialty Drugs – 30-day supply Retail and Mail Order	$10 copay after deductible - Generic drugs $40 copay after deductible - Preferred brand drugs $80 copay after deductible - Non-Preferred brand drugs Members are restricted to a 30-day supply at both retail and mail order and certain specialty drugs are limited to only a 15-day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum. Note - Adjustments may be required to accurately reflect your annual out-of-pocket maximum with your true out-of-pocket costs.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%

Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies.

Features of your prescription drug plan

Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

Dental Insurance

- Dental Insurance is provided through Delta Dental of Michigan.
- Dental Insurance is provided at no cost to regular full-time employees.
    - If you waive Dental insurance as a regular full-time employee, you have three options: 1) A $200 credit (or $7.70/pay) to your Flexible Spending Account (FSA) for those eligible for a FSA; 2) A $200 credit (or $7.70/pay) to your Health Saving Account (HSA) for those participating in a qualified high deductible health plan; or 3) A $150 cash rebate (or $5.77/pay).

DELTA DENTAL®

DeltaPremier
Summary of Dental Plan Benefits
For Group#0001481-0009
ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

This Summary of Dental Plan Benefits should be read in conjunction with your Dental Care Certificate. Your Dental Care Certificate will provide you with additional information about your Delta Dental plan, including information about plan exclusions and limitations. In the event that you seek treatment from a dentist that does not participate in any of Delta Dental`s programs, you may be responsible for more than the percentage indicated below.
Control Plan - Delta Dental Plan of Michigan
Benefit Year - January 1 through December 31

Covered Services -	Plan Pays	You Pay
Class I Benefits		
Diagnostic and Preventive Services - Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings and fluoride treatments)	100%	0%
Emergency Palliative Treatment - Used to temporarily relieve pain	100%	0%
Class II Benefits		
Radiographs - X-rays	50%	50%
Oral Surgery Services - Extractions and dental surgery, including preoperative and postoperative care	50%	50%
Endodontic Services - Used to treat teeth with diseased or damaged nerves (for example, root canals)	50%	50%
Periodontic Services - Used to treat diseases of the gums and supporting structures of the teeth	50%	50%
Relines and Repairs - Relines and repairs to bridges and dentures	50%	50%
Minor Restorative Services - Used to repair teeth damaged by disease or injury (for example, fillings)	50%	50%
Major Restorative Services - Used when teeth can`t be restored with another filling material (for example, crowns)	50%	50%
Class III Benefits		
Prosthodontic Services - Used to replace missing natural teeth (for example, bridges and dentures)	50%	50%
Class IV Benefits		
Orthodontic Services (no age limit) - Used to correct malposed teeth (for example, braces)	50%	50%

~ The orthodontic age limitations are hereby waived for eligible Subscribers, spouses and dependent children.
~ Oral exams, prophylaxes (cleanings), and fluoride treatment (to age 19) are payable twice in any period of 12 consecutive months.
~ Bitewing X-rays are payable once in any period of 12 consecutive months and full mouth X-rays are payable once in any five-year period.
~ Composite resin (white) restorations and porcelain crowns are not Covered Services on posterior teeth.
~ Implants and related services are Covered Services.
~ People with certain high-risk medical conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.

Having Delta Dental coverage makes it easy for our enrollees to get dental care almost everywhere in the world! You can now receive expert dental care when you're outside of the United States through our Passport Dental program. This program gives you access to the International SOS Assistance (I-SOS) worldwide network of dentists and dental clinics. English-speaking I-SOS operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment - $1,000 per person total per benefit year on Class I, Class II and Class III Benefits. Delta Dental's payment for Class IV Benefits will not exceed a lifetime maximum of $1,500 per eligible person.

Deductible - None.

Waiting Period - Employees who are eligible for dental benefits are covered on the first day of the month following 1 full calendar month of employment.

Eligible People - All regular full-time employees.

Also eligible are your legal spouse, your dependent children to the end of the calendar year in which they turn 26, and your dependent unmarried children who are eligible to be claimed by you as a dependent under the U.S. Internal Revenue code during the current calendar year.

If you and your spouse are both eligible under this contract, you may be enrolled as both a Subscriber on your own application card and as a dependent on your spouse's application card. Your dependent children may be enrolled on both application cards as well. Delta Dental will coordinate benefits.

Benefits will cease on the last day of the month in which the employee is terminated.

Regular part-time employees may purchase dental benefits with 100% of the cost at the employee's expense.

Vision Insurance

- Vision Insurance is provided through EyeMed.
- Vision Insurance is provided at no cost to regular full-time employees.
- Regular part-time employees may purchase vision coverage with 100% of the cost at the employee's expense.
- Also eligible to regular full-time employees, are your legal spouse, your dependent children to the end of the calendar year in which they turn 26, and your dependent unmarried children who are eligible to be claimed by you as a dependent under the U.S. Internal Revenue code during the current calendar year.
- You may use any in-network licensed Optician, Optometrist or Ophthalmologist.
- The EyeMed network is quite extensive. To locate an in-network provider, use this link: https://www.eyemedvisioncare.com/locator/locator.emvc?execution=e1s1

Plan Basics	In-Network
Exam Co-Pay	$5.00
Exam Frequency	Once per plan year
Contacts Co-Pay	$0
Contacts Frequency	Once every other plan year
Lenses Co-Pay	$10
Lenses Frequency	Once every other plan year
Frame Co-Pay	$0
Frame Frequency	Once every other plan year
Maximum Annual Benefit for Frames and Contact Lenses	$130

Flexible Spending Accounts

Account Highlights

- You may establish a Flexible Spending Account (FSA) to pay for medical and dependent care expenses with pretax dollars.
- The agency is utilizing Wex Benefits to manage the FSA benefit.
- Medical expenses – you can contribute up to $3,200 per year.
    - Note, if you are participating in the PPO Flex Blue 3 HDHP w/Health Savings Account (HSA), you cannot contribute to a Medical Flexible Spending Account.
- Dependent care expenses – you can contribute up to $5,000 per year.
- You will receive a debit card from Wex Benefits to use at the pharmacy or other health care providers.
    - Keep in mind that any expense you use your debit card for, that is not equal to a flat dollar copay amount associated with your health plan, may require a receipt to be submitted to Wex Benefits for substantiation. Alternately, you can pay for expenses out of pocket and submit your receipts to Wex Benefits for reimbursement.
- The SCCCMHA Medical FSA plan allows a $640 rollover into the next plan year if you do not spend all of the money you have contributed to your FSA. Any amount over that is forfeited.
- Both the medical and dependent care FSA's are use it or lose it (outside of the $640 rollover on the Medical FSA), plan your contributions according to your usual annual expense.
- For a complete listing of eligible expenses, visit https://fsastore.com/fsa-eligibility-list

Health Savings Account

What is a Health Savings Account (HSA)?

- Tax protected savings account that can be used to pay for qualified medical expenses.
- You must be enrolled in an HSA Qualified Medical Plan (PPO Flex Blue 3 HDHP or PPO Minimal Essential) to be eligible to contribute to an HSA.
- You make contributions into your HSA through pre-tax payroll deductions and you may change your HSA contributions once per month.
    - You can contribute up to $4,150 (single) or $8,300 (family) (an additional $1,000 "catch-up" can be added for those 55 and older) in 2023.
    - All HSA contributions remain in your account until you choose to use them - like any other bank account.
    - No "use it or lose it" feature.

How does an HSA work?

You must be enrolled in an HSA Qualified Plan (QHDHP) to be eligible to contribute to an HSA.

- If you elect the PPO Flex Blue 3 HDHP or PPO Minimal Essential, SCCCMHA has preferred partnership with Wex Benefits, where you can open an HSA account at no cost to you.
- You elect an amount to be deducted pre-tax from each of your paychecks and those funds will be direct deposited into the HSA Account that you open.
- You can also make contributions to your HSA bank account as you would any other bank account. You would then deduct the deposit to your HSA account from your taxable income on your Form 1040.
- You own your HSA bank account like you would own any other bank account– funds in the account are yours.
- You will receive a debit card to use to pay for qualified medical expenses.
- You are responsible for keeping receipts in the event you are audited, but you are **not** required to submit receipts to your HSA bank account.
- Should you terminate your enrollment in a QHDHP, you can no longer make contributions to your HSA account.
    - If you terminate your enrollment in a QHDHP and still have a balance in your HSA Account, you can continue to use your available funds for qualified medical expenses.
- Adult children up to the age of 26 can be covered by their parent's QHDHP
    - If the adult child does not qualify as a tax dependent, the parent's HSA may not be used to pay for their medical expenses
    - Adult children who have coverage under a parent's family QHDHP can open their own HSA and contribute up to the yearly family maximum
- If you are enrolled in any parts of Medicare, you cannot contribute pre-tax dollars to the HSA. You can continue to use funds from the HSA account, but you cannot contribute to the account. You should stop contributing to the HSA account at least six months before you plan to enroll in Medicare, otherwise you may incur a tax penalty.
- What if I already have an established HSA account? You can have 2 accounts, but will only be able to contribute the IRS maximum contribution, single or family, to the accounts.
- If I have two accounts are they be able to use both accounts? Yes, as long as you are enrolled in a QHDHP
- Can a person transfer money from one HSA to another without penalty? You can transfer one time in a 12 month period without penalty.

LTD and Life Insurance

Local 3385 Employees – **Life Insurance**

- SCCCMHA provides Local 3385 Employees with a $40,000 Basic Life/Accidental Death and Dismemberment policy through Symetra Life Insurance Company at no cost to the employee.
- Life Insurance - Employees can choose to purchase additional Life Insurance in the amounts of:
  - $40,000
  - $80,000
- Additional Life Insurance is paid for with a payroll deduction from your bi-weekly pay.
  - To calculate the amount of your payroll deduction, choose the amount of coverage you would like to purchase, find your age in the table below to determine your rate and use the calculation below the table to determine your cost.

Age	Rates* per $1000	Age	Rates* per $1000
00 – 24	$0.0900	45 – 49	$0.2300
25 – 29	$0.0900	50 – 54	$0.3700
30 – 34	$0.0900	55 – 59	$0.5900
35 – 39	$0.1100	60 – 99	$0.5900
40 – 44	$0.1600		

_____ X _____ ÷ 1000 = $ _____ X 12 ÷ 26 = _____

Coverage amount | Rate | *Monthly Cost | *Employee CostPer Pay Period

*Final costs may vary slightly due to rounding.

Local 1518, Chapter 20 Employees – **Life Insurance**

- SCCCMHA provides Local 1518, Chapter 20 Employees with a $50,000 Basic Life/Accidental Death and Dismemberment policy through Symetra Life Insurance Company at no cost to the employee.
- Life Insurance - Employees can choose to purchase additional Life Insurance in the amounts of:
  - $50,000
  - $100,000
- Additional Life Insurance is paid for with a payroll deduction from your bi-weekly pay.
  - To calculate the amount of your payroll deduction, choose the amount of coverage you would like to purchase, find your age in the table below to determine your rate and use the calculation below the table to determine your cost.

Age	Rates* per $1000	Age	Rates* per $1000
00 – 24	$0.0900	45 – 49	$0.2300
25 – 29	$0.0900	50 – 54	$0.3700
30 – 34	$0.0900	55 – 59	$0.5900
35 – 39	$0.1100	60 – 99	$0.5900
40 – 44	$0.1600		

_____ X _____ ÷ 1000 = $ _____ X 12 ÷ 26 = _____

Coverage amount | Rate | *Monthly Cost | *Employee CostPer Pay Period

*Final costs may vary slightly due to rounding.

If you decline to purchase additional life insurance when you are originally eligible, you will have to submit Evidence of Insurability to purchase the additional life insurance at a later date. Changes to your life insurance elections can only be made during open enrollment.

Long Term Disability Insurance

- SCCCMHA provides employees with a Long Term Disability Insurance (LTD) policy at no cost to the employee.
    - LTD benefits begin after you have been out of work due to a sickness or injury for 180 days.
    - Your monthly benefit, if approved for LTD is:
        - 66.67% of your monthly salary to a maximum of $4,000 per month for up to 5 years
- You may choose a buy-up LTD Insurance option through payroll deductions.
    - LTD benefits begin after you have been out of work due to a sickness or injury for 180 days.
    - Your monthly benefit, if approved for LTD, and you choose the buy-up option will be:
        - 70% of your monthly salary to a maximum of $6,000 per month up to age 65

Long Term Disability: *Check the option below you wish to elect)*	**Cost**
A) 66.6667% to a maximum monthly benefit of $4,000	*Funded by your Employer*
B) 70% to a maximum monthly benefit of $6,000	***See calculation table below***

Age	**Rates* per $100**	**Age**	**Rates* per $100**
00 – 24	$0.1430	45 – 49	$0.8850
25 – 29	$0.1580	50 – 54	$1.1700
30 – 34	$0.2930	55 – 59	$1.0800
35 – 39	$0.4200	60 – 99	$0.0360
40 – 44	$0.6080		

_____ / 100 = _____ X $0.2260 = $ _____ = LTD Option A
Monthly Income to a Maximum of $4,000 — Rate — Employer Monthly Cost

_____ / 100 = _____ X _____ = $ _____ = LTD Option B
Monthly Income to a Maximum of $6,000 — Rate — Total Monthly Cost

_____ - _____ = _____ X 12 ÷ 26 = _____
Option B Amount — Option A Amount — *Employee Monthly Cost — *Employee Cost Per Pay Period

*Final costs may vary slightly due to rounding.

If you decline to purchase the buy-up LTD option when you are originally eligible, you will have to submit Evidence of Insurability to purchase the buy-up LTD option at a later date. Changes to your LTD elections can only be made during open enrollment.

Contact Information

Carrier	Coverage	Web Address	Phone Number
Blue Cross Blue Shield Blue Care Network of Michigan	Medical	www.bcbsm.com	877-752-1233
DELTA DENTAL	Dental	www.deltadentalmi.com	800-524-0149
SYMETRA RETIREMENT | BENEFITS | LIFE	Life and LTD	www.symetra.com	800-796-3872
eyeMed	Vision	www.eyemedvisioncare.com	866-299-1358
wex™	Flexible Spending - Medical or Dependent Care & Health Savings Accounts	https://customer.wexinc.com/login/benefits-login/	866-451-3399
OPTUMRx®	Prescription	www.optumrx.com	Customer service, home delivery: 1-800-356-3477

Did you know?

As an enrolled member in the West Michigan Health Insurance Pool (WMHIP) you have many FREE health-related services and opportunities available to you? Below is a brief overview, and flyers for many are located on your ADP home page, under Resources and then Tools/References.

Create an account! By creating an **Online Account** at www.BCBSM.com you can look up participating providers, view claims and Explanation of Benefits (EOB's), check your deductible amount (and see how much has been met), access benefit information, and order additional ID cards? Get started by going to www.BCBSM.com.

Convenient Online Visits! BCBS offers **Online Visits** giving you 24/7 access to medical services from anywhere in the United States, this includes primary care and behavioral health services. A copay or deductible still applies per your plan selection, but this is an added convenience to access care. Get started by going to www.bcbsmonlinevisits.com or by calling 1-844-606-1608. You can also download the BCBSM Online Visits℠ app.

Want a Second Opinion?! **2nd MD** is an Expert Second Opinion services that is FREE to use for all WMHIP participants. It connects you to the world's top physicians from institutions like the Mayo Clinic, John's Hopkins, Harvard, etc. by phone or video within days to discuss things like a new medical diagnosis, ongoing medical conditions, possible surgeries, medications, etc. For access go to the 2nd.MD Portal at www.2nd.md/WMHIP.

Prevention Tools! WMHIP has partnered with **Omada**, a digitally-delivered lifestyle change program aimed at preventing diabetes and other chronic disease. It is FREE if you qualify and includes a mobile app, a cellular scale, easy-to-navigate web portal, a personalized plan, coaching and real time feedback. To find out more, go to www.omadahealth.com/wmhip.

Need help Managing your Diabetes? WMHIP has partnered with **Livongo** to deliver best-in-class diabetes management. For those who have already been diagnosed with diabetes. Includes a free cellular-enabled glucometer, real time support by certified diabetes educators on call 24/7/365, and free unlimited supplies (strips and lancets) shipped directly to you. Text GO WMHIP to 85240 to learn more and join. You can also go to join.livongon.com/WMHIP/register or call (800) 945-4355 and use registration code WMHIP.

Required Notices

IMPORTANT NOTICE from St. Clair County Community Mental Health Authority about your prescription drug coverage and Medicare under the employer medical and pharmacy plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the employer 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 costs, 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. Employer has determined that the prescription drug coverage offered by the EHIM plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday (including the month you turn 65), and continues for the ensuing three months. You may also enroll each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-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 employer coverage will not be affected. For most persons covered under the plan, the plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the plan's summary plan description or contact Medicare at the telephone number or web address listed herein. If you do decide to join a Medicare drug plan and drop your current employer coverage, be aware that you and your dependents will not be able to get this coverage back.

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 the employer 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 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage

Contact the person listed at the end of these notices for further information. 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 your employer 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 Medicare Part D 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 are required to pay a higher premium (a penalty).

- Date: October 15, 2023
- St. Clair County Community Mental Health Authority
- Contact: Kimberly Prowse, Human Resources Director

Women's Health and Cancer Rights Act Enrollment Notice

The Women's Health and Cancer Rights Act of 1998 was signed into law on Oct. 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which a mastectomy has been preformed
- Surgery and reconstruction of the other breast to produce asymmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient and will be subject to the same annual deductibles and coinsurance provisions which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description or contact Human Resources.

Women's preventive services

Under the Affordable Care Act, many insurers are required to cover certain preventive services at no cost to individuals. This list will expand to include additional services for women including annual well-woman visits, screening for gestational diabetes, human papillomavirus testing, also known as HPV testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, or HIV, contraceptive methods and counseling, breastfeeding support, supplies and counseling, and screening and counseling for interpersonal and domestic violence.

Notice regarding newborns' and mothers' health protection act

Group health plans and health insurance issuers offering group health insurance may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer to prescribe a length of stay not in excess of the above periods.

Michelle's law

If a full-time student engaged in a post-secondary education loses their full-time student status due to a severe illness or injury, they will maintain dependent status until the earlier of (1) one year after the first day of a medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the plan. A medically necessary leave of absence or change in enrollment at that institution must be certified by the dependent's attending physician.

HIPAA privacy and security

The health insurance portability and accountability act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. The notice of privacy practices has been recently updated.

For a full copy of the notice of privacy practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at HRDepartment@scccmh.com .

HIPAA special enrollment rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements.

New health insurance marketplace coverage options and your health coverage

Today, there is a new way to buy health insurance: the health insurance marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new marketplace.

What is the health insurance marketplace?

The marketplace is designed to help you find health insurance that meets your needs and fits your budget. The marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

The 2023 open enrollment period for health insurance coverage through the marketplace runs from Nov. 1, 2022, through to Jan. 15, 2023.

Individuals must enroll or change plans prior to January 15, 2023, for coverage starting as early as Jan. 1, 2023. After Jan. 15, 2023, you can get coverage through the marketplace for 2023 only if you qualify for a special enrollment period or are applying for Medicaid or the children's health insurance program (CHIP).

Can I save money on my health insurance premiums in the marketplace?

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

Does employer health coverage affect eligibility for premium savings through the marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health

plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12 percent of your household income for the year (9.61% for 2022), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the human resources department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.healthcare.gov for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Continuation coverage rights under COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, you should review the plan's Summary Plan Description or contact the plan administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific to 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the plan due to either one of the following qualifying events: 1) your hours of employment are reduced, or 2) Your employment ends for any reason other than your gross misconduct. If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the plan due to any 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)
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose coverage under the plan due to any 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
- The child stops being eligible for coverage under the plan as a "dependent child"

When is COBRA Coverage Available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. When the qualifying event is 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), the employer must notify the plan administrator of the qualifying event.

You Must Give Notice of a Qualifying Event

For the other qualifying events (divorce, legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the plan administrator within 60 days after the qualifying event occurs. You must provide written notice to: SME, Human Resources Department. You will be required to provide a copy of the court document showing the date the divorce or legal separation occurred.

How is COBRA Coverage Provided?

Once the plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which employment terminates, COBRA continuation coverage for his/her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPPA), 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 the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Premium Assistance Under Medicaid and theChildren's Health Insurance Program (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: 678-564-1162, Press 2	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: https://www.in.gov/medicaid/ Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium- assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information onspecial enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Name	Kimberly Prowse –Human Resources Director
	St. Clair County Community Mental Health Authority
	3111 Electric Avenue
City, State	Port Huron, MI 48060
Telephone	810-985-8900
E-mail	kprowse@scccmh.org

Note: If you or your dependents enroll during a **special enrollment period**, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a pre-existing condition exclusion period.