Brown & Brown INSURANCE

EMPLOYEE BENEFITS

Benefit Plan Year: **01/01/2022** through **12/31/2022**

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

Welcome To Open Enrollment

OPEN ENROLLMENT FOR BENEFIT PLAN YEAR 01/01/2022—12/31/2022

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

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

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

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

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

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QUESTIONS?

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

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

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

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

Plan	Carrier	Phone	Website
Medical	Blue Cross Blue Shield of Michigan	313-225-9000	www.bcbsm.com
Dental	The Standard	888-547-9515	www.thestandard.com
Life/Disability	New York Life	800-225-5695	www.newyorklife.com

Brown & Brown of Central Michigan Claim Advocacy Services			
Name	**Direct Number**	**Email**	**Fax**
Farran Braman	989-399-0467	fbraman@bbcmich.com	989-607-2243
Rebecca Castillo	989-399-0460	rcastillo@bbcmich.com	989-607-9997
Olga Roberson	989-399-0455	oroberson@bbcmich.com	989-607-2241
Judy Robinson	989-399-0465	jrobinson@bbcmich.com	989-607-2240

ANNUAL OPEN ENROLLMENT

PLAN YEAR 01/01/2022—12/31/2022

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

Open Enrollment for our benefit plans will be conducted November 1—November 12. Elections you make during open enrollment will become effective January 1, 2022.

WHO IS ELIGIBLE?

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

MID - YEAR CHANGES?

Unless you have a qualifying event, you cannot make changes to the benefits You elect until the next open enrollment period. The Health Insurance Portability And Accountability Act of 1996 (HIPAA) provides employees additional opportunities to enroll in a group health plan if they experience a loss of other coverage or certain life events. If you are declining coverage at this time for either yourself or your eligible dependents, you may be able to enroll yourself And/or your eligible dependents in coverage at a later date if there is a loss of other coverage. If you experience a qualified "change in status," you must make any associated enrollment or benefit changes within 30 days of the event except for a Medicare or Medicaid entitlement event, in which case you must make changes within 60 days of the event. You have the right to elect coverage during the plan year if your or your dependent's Medicaid/Children's Health Insurance Program (CHIP) coverage terminates due to discontinuation of eligibility under the program or if you become eligible for a Medicaid/CHIP premium assistance subsidy (if available in your state) providing you request enrollment within 60 days of the loss of coverage or eligibility for premium subsidy. **Qualified changes in status include:** Change in legal marital status; Change in number of dependents; Change in employment status of employee, spouse, or dependent; A dependent newly satisfies or ceases to satisfy eligibility requirements; Change in place of residence; Loss of certain other health coverage; Court judgment, decree, or order; Medicare or Medicaid entitlement; Significant cost or other coverage changes; Family Medical Leave Act (FMLA) leave of absence; Reduction of hours; Exchange/Marketplace enrollment. Please note that there are several conditions and/or limitations that apply to the events listed above. **Please contact Human Resources if you have any questions or believe that you may qualify for an election change.**

MEDICAL PLAN - BCBSM H.S.A $1,400

Benefit Comparison	H.S.A $1,400
Annual Deductible/Individual	$1,400
Annual Deductible/ Two-Person or Family	$2,800
Coinsurance	0%
Office Visit/Exam	0% after deductible
Specialist Visit	0% after deductible
Telemedicine	0% after deductible
Annual Out-of-Pocket Limit/Individual	$2,250
Annual Out-of-Pocket Limit/Family	$4,500
Inpatient Hospitalization	0% after deductible
Emergency Room	0% after deductible
Urgent Care Facility	0% after deductible
Inpatient Care	0% after deductible
Inpatient Hospitalization - Substance Abuse/Mental Health	0% after deductible
Outpatient Services - Substance Abuse/Mental Health	0% after deductible
Prescription Drug Benefits	**In-Network (for HDHP, Copays after Deductible)**
Generic	$10
Preferred Specialty	15% but no more than $150
Non-preferred Specialty	25% but no more than $300
Brand (Formulary/Preferred)	$40
Brand (Non-Formulary/Non-preferred)	$80
Number of Days Supply	30 Days
Mail Order	
Generic	$20
Preferred Specialty	No Coverage
Non-preferred Specialty	No Coverage
Brand (Formulary/Preferred)	$80
Brand (Non-Formulary/Non-preferred)	$160
Number of Days Supply for Mail Order	90 Days

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

Coverage Period: Beginning on or after 01/01/2022

CITY OF GRAND HAVEN/POAM

Simply Blue PPO HSA℠ ASC with Rx

Coverage for: Individual/Family | **Plan Type:** PPO

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

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

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$1,400 Individual/ $2,800 Family	$2,800 Individual/ $5,600 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	$2,250 Individual/ $4,500 Family	$4,500 Individual/ $9,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of network providers.		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.		You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	20% coinsurance	None
	Specialist visit	No Charge	20% coinsurance	None
	Preventive care/ screening/ immunization	No Charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/druglists	Generic or select prescribed over-the-counter drugs	$10 copay for retail 30-day supply; $20 copay for retail or mail order 90-day supply	In-Network copay plus an additional 20% of the approved amount	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network. Select diabetic supplies and devices may be covered under the prescription drug program.
	Preferred brand-name drugs	$40 copay for retail 30-day supply; $80 copay for retail or mail order 90-day supply	In-Network copay plus an additional 20% of the approved amount	
	Nonpreferred brand-name drugs	$80 copay for retail 30-day supply; $160 copay for retail or mail order 90-day supply	In-Network copay plus an additional 20% of the approved amount	
	Generic and preferred brand-name specialty drugs	15% coinsurance of the approved amount, but no more than $150 copay for retail or mail order 30-day supply	In-Network copay plus an additional 20% of the approved amount	Preauthorization is required. Specialty drugs limited to a 15 or 30-day supply. Pharmacy Specialty drugs obtained from other than an Exclusive Specialty Pharmacy Network provider will not be covered.
	Nonpreferred brand-name specialty drugs	25% coinsurance of the approved amount, but no more than $300 copay for retail or mail order 30-day supply	In-Network copay plus an additional 20% of the approved amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No Charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	No Charge	No Charge	None
	Emergency medical transportation	No Charge	No Charge	Mileage limits apply
	Urgent care	No Charge	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance	Preauthorization is required
	Physician/surgeon fee	No Charge	20% coinsurance	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	No Charge	No Charge for mental health; 20% coinsurance for substance use disorder	None
	Inpatient services	No Charge	20% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	Prenatal: No Charge; deductible does not apply Postnatal: No Charge	Prenatal: 20% coinsurance Postnatal: 20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services cost share may apply. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge	20% coinsurance	None
	Childbirth/delivery facility services	No Charge	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Physician certification required.
	Rehabilitation services	No Charge	20% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	No Charge	No Charge	Preauthorization is required. Limited to 90 days per member per calendar year
	Durable medical equipment	No Charge	No Charge	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	No Charge	No Charge	Physician certification required. Visit limits apply.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

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

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

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See http://provider.bcbs.com
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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

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

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

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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

Language Access Services: **See Addendum**

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

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

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

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

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,470**

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

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

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

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

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,410**

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

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

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

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

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

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

[illegible] 877-469-2583 TTY:711

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

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

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

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

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

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

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

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

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

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

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

Important disclosure

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You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

SBC Uniform Glossary

Glossary of Health Coverage and Medical Terms

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

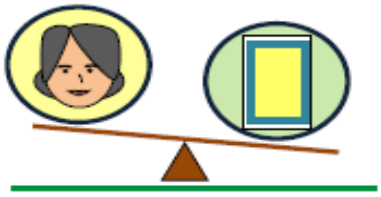
Allowed Amount
This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

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

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

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

Coinsurance
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

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

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

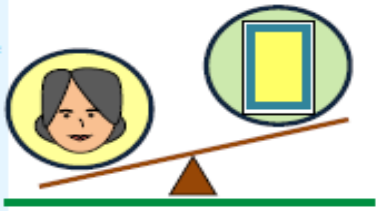
Cost Sharing
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs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

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

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

SBC Uniform Glossary

Deductible
An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



(See page 6 for a detailed example.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SBC Uniform Glossary

In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered health care services. Your share is usually lower for in-network covered services.

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

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

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

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

Minimum Essential Coverage
Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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

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

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

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

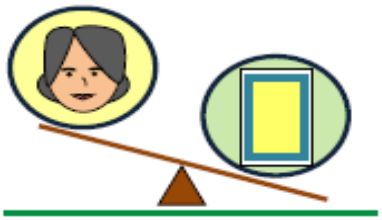
Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

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

Out-of-network Provider (Non-Preferred Provider)
A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

SBC Uniform Glossary

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



(See page 6 for a detailed example.)

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

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

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

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

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

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

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

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

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

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

Provider
An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

SBC Uniform Glossary

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

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

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

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

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

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

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

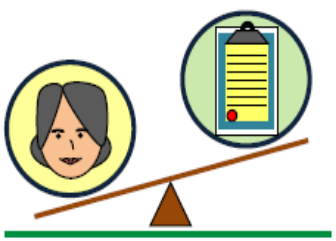
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

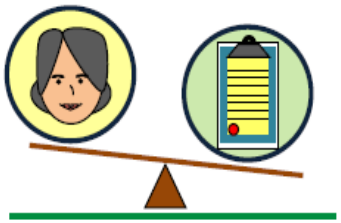
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

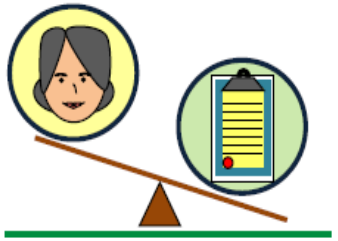
December 31st
End of Coverage Period



more costs



more costs



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

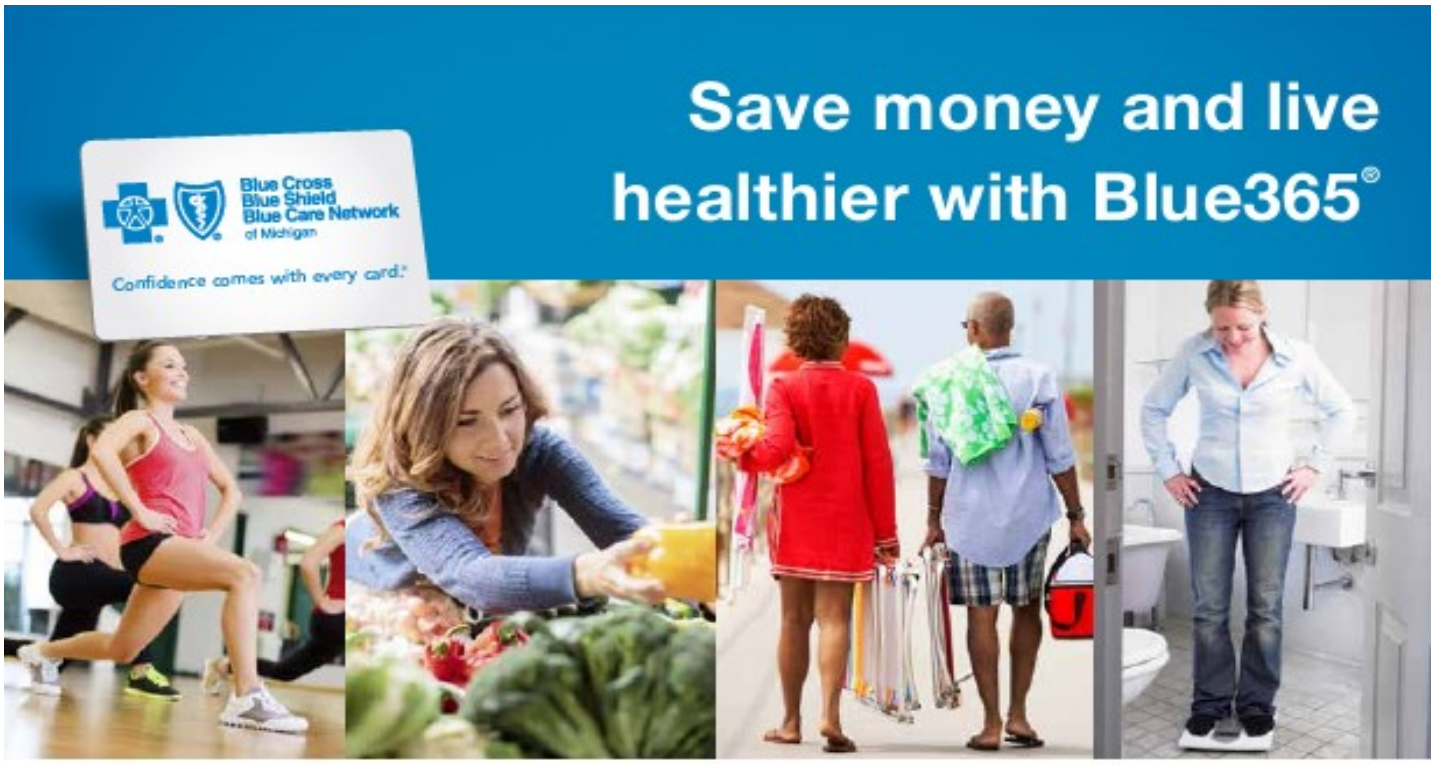
Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

BLUE 365



Membership has its benefits

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

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

Member discounts with Blue365 offers exclusive deals on things like:

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

Cash in on discounts

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

Blue Cross Blue Shield Blue Care Network of Michigan | Blue365®
Because health is a big deal℠

BLUE 365

Member discounts with Blue365

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

SEA LIFE Michigan
LEGOLAND DISCOVERY CENTER MICHIGAN
METROPARKS
fitbit
Bicycling RUNNER'S World Men's Health Women's Health
BetterHealth
GARMIN.
Dunham's SPORTS
LasikPlus VISION CENTER
Reebok
jenny
Fairmont HOTELS & RESORTS
Simple Organics
TruHearing Bringing You the Sounds of Life
fitness your way by Tivity Health
dentalsolutions
WeightWatchers

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

Blue Cross Blue Shield Blue Care Network of Michigan

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

Program information valid as of August 2018.

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

BCBSM APP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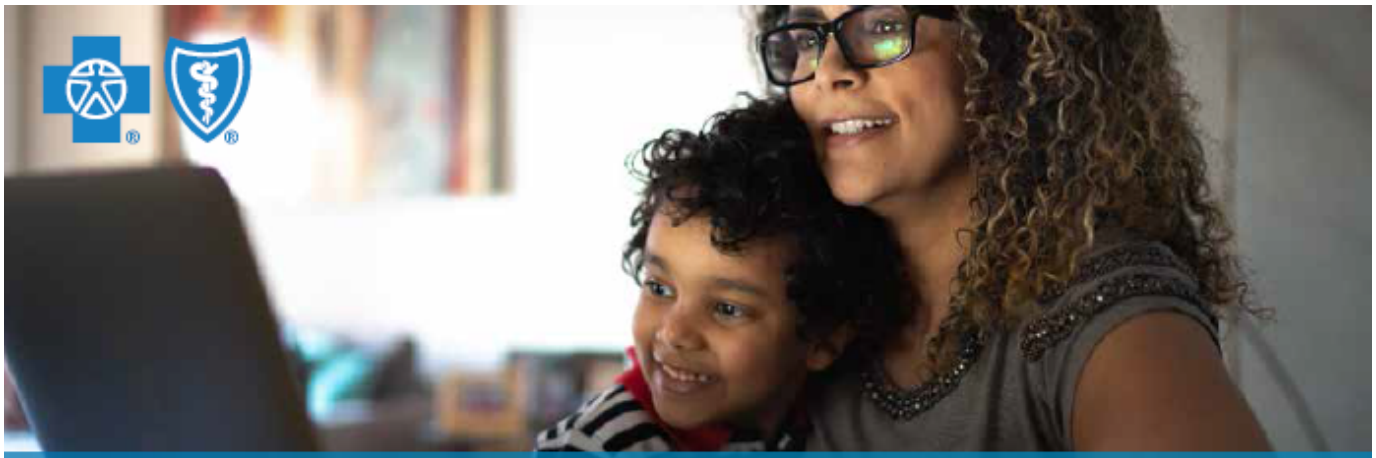
Blue Shield
Blue Care Network
of Michigan
Confidence comes with every card.*
My Coverage
My Claims
ID Card
Find a Doctor
Health & Well-Being
Spending Accounts
Blue Cross Blue Shield Of Michigan
POWER
know. compare. choose.
Get the app.
Download on the App Store
GET IT ON Google Play
Search BCBSM.
Or, text APP to 222764.
Get the Blue Cross mobile app
Check your coverage, claims and balances.
Show and share your plan's ID card.
Find in-network care and compare costs.*
Check hospital and doctor quality.
Get answers fast to questions about your plan with the 24/7 support of MIBlue Virtual Assistant℠.
Your health care plan — at your fingertips.
MICHIGAN
Tap the app.

BCBSM ONLINE HEALTH CARE



Anytime, anywhere, you have care that's always there

BLUE CROSS ONLINE VISITS℠

When you're not feeling well and can't see your primary care provider, you have convenient, affordable health care virtually with Blue Cross Online Visits℠. You can connect virtually with a U.S. board-certified doctor, nurse practitioner or therapist using your smartphone, tablet or computer.

You can meet face-to-face online with:

- A doctor or nurse practitioner for minor illnesses, such as sinus and respiratory infections, colds and flu, eye irritation or redness, and rashes, when your primary care provider isn't available
- A therapist or psychiatrist to help you work through challenges, such as anxiety, depression, grief or insomnia

Why use Blue Cross Online Visits?

- Available 24/7 anywhere in the U.S., even when you're traveling
- Medical care available anytime, without an appointment
- Specially trained doctors, nurse practitioners and therapists with backgrounds, such as pediatrics, family medicine, counseling, psychology and psychiatry
- Family members on your health plan can use it, too
- Therapy and psychiatry available by appointment only, with evening and weekend hours available.

Get started today.
Download the BCBSM Online Visits℠ app or visit **bcbsmonlinevisits.com**.

YOU HAVE CHOICES FOR CARE. LEARN MORE AT BCBSM.COM/FINDCARE.

If you have questions about your Blue Cross Online Visits account, call 1-844-606-1608.
Remember to coordinate all your care with your primary care provider. Follow up with him or her after receiving care elsewhere.

This information isn't intended to be medical advice. In an emergency, call 911 or go to an emergency room near you.

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BCBSM ONLINE HEALTH CARE

Frequently asked questions

Convenient and affordable virtual medical and behavioral health care

WHAT IS BLUE CROSS ONLINE VISITS℠?

Taking care of yourself and your family's health can be as easy as using your smartphone, tablet or computer for a virtual visit with a U.S. board-certified doctor, nurse practitioner or licensed therapist.

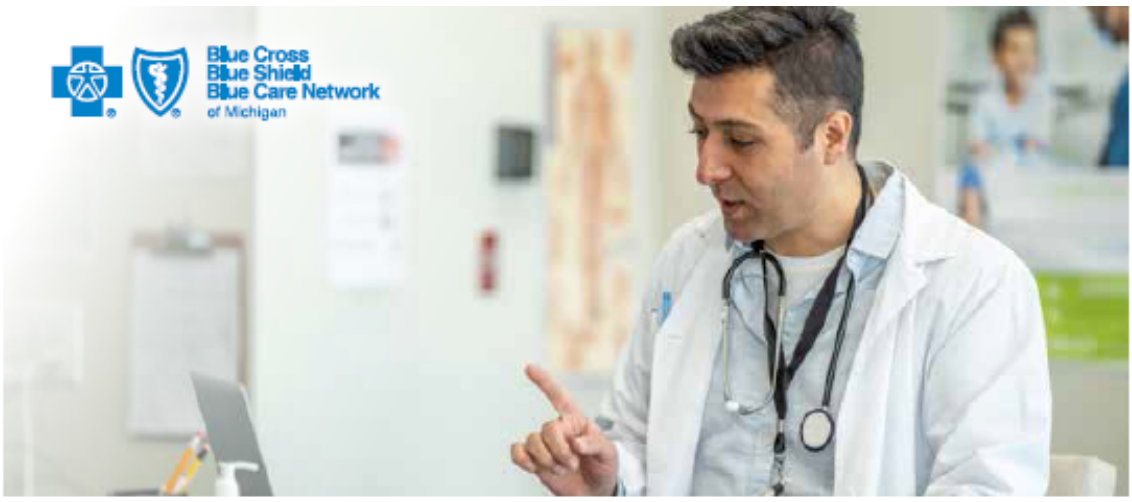
With Blue Cross Online Visits, no appointment is necessary for medical care, although you'll need an appointment for behavioral health visits.

HOW DO I SIGN UP?

To start a visit or sign up, just download the BCBSM Online Visits℠ app or visit **bcbsmonlinevisits.com**.

You'll need your Blue Cross member ID card. Remember to choose your health plan and enter your enrollee ID number when updating or creating your account so your coverage is applied correctly.

BCBSM ONLINE HEALTH CARE



WHEN WOULD I USE *MEDICAL* CARE?

When your primary care provider isn't available, you can talk to a U.S. board-certified doctor or nurse practitioner about minor illnesses such as:

- Sinus and respiratory infections
- Cold and flu
- Painful urination
- Eye irritation or redness
- Sore throat

Your primary care provider may offer virtual visits. Talk to your provider about the services he or she offers.

If your life is at risk, call 911 or go to the nearest emergency room.

WHEN WOULD I USE *THERAPY* OR *PSYCHIATRY*?

You can have a virtual visit with a therapist or psychiatrist when you're struggling with challenges such as anxiety, depression and grief.

This private and confidential behavioral health care gives you more options and access to this kind of care. It's meant to provide ongoing, long-term support.

For immediate behavioral health care, call the behavioral health care number on the back of your Blue Cross member ID card.

Blue Cross Online Visits does not treat substance use disorder.

HOW DO I HAVE A VIRTUAL VISIT?

1. Launch the online visits app or website, and log in to your account.
2. Choose a service: *Medical*, *Therapy* or *Psychiatry*.
3. Pick a doctor or begin a scheduled visit.
4. Meet with the doctor or therapist online.
5. Get a prescription, if appropriate, sent to your preferred pharmacy.
6. After your visit, you can share an optional visit summary with your primary care provider.

HOW LONG DOES IT TAKE?

For medical visits, the average wait time is five minutes. Most visits take about 10 minutes.

Therapy visits are scheduled for 45 minutes. Psychiatry visits are 45 minutes for the initial visit; follow-up visits are 15 minutes.

DO I NEED TO MAKE AN APPOINTMENT?

Medical care is available 24/7 without an appointment.

Behavioral health visits are available by appointment only.

- Therapists are available from 7 a.m. to 11 p.m. for adults and children ages 10 and older.
- Psychiatrists set their own hours and some may offer evening or weekend appointments. Visits are for adults ages 10 and older.

BCBSM ONLINE HEALTH CARE

HOW MUCH DOES IT COST?

Medical visits are $59 or less. If you have a plan with a copay, it's generally equal to or less than what you pay for a primary care office visit.

Costs for behavioral health visits vary depending on the type of provider and the services you receive. Your out-of-pocket costs are based on your existing outpatient behavioral health benefits or start at $85.

You'll see your cost before you start your visit. Be sure you've added your Blue Cross health plan information to your Blue Cross Online Visits account.

WILL I GET A PRESCRIPTION DURING A VISIT?

If a prescription is needed, the doctor will send an electronic prescription to a pharmacy you choose. Make the most of your benefits by choosing an in-network pharmacy. You'll pay for the prescription at the pharmacy according to your pharmacy benefit.

Doctors won't prescribe controlled substances.

WHAT KIND OF PROVIDERS ARE AVAILABLE?

The doctors, nurse practitioners and therapists are specially trained in online visits. You can read their profiles to learn more about them such as languages they speak and their experience.

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

The master's- and doctoral-level therapists are psychologists, licensed clinical social workers, marriage and family therapists and professional counselors. They're licensed and credentialed in the state where you're having a visit.

WILL A DOCTOR PROVIDE MEDICAL FORMS OR BACK TO SCHOOL NOTES?

If appropriate, doctors may provide back-to-work or school notes. You can print these at the end of your visit. Check with your school or employer to see if they will accept these notes.

Blue Cross Online Visits providers can't supply federal or state forms that require in-person evaluations (for example, Family Medical Leave Act, disability, handicap parking permits).

CAN MY FAMILY USE BLUE CROSS ONLINE VISITS?

Yes. Everyone on your health care plan can use it. Parents and guardians can add children ages 17 and younger to their account and have medical visits on their behalf.

Spouses and adult children ages 18 and older must set up their own accounts.

WHAT IF I NEED HELP WITH BLUE CROSS ONLINE VISITS?

If you have questions or need help with your Blue Cross Online Visits account or an online visit, please call 1-844-606-1608, 24/7.

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

Claim Your Livongo Welcome Kit Today

Join today!
Use registration code: **BCBSM**

Online: **join.livongo.com/BCBSM/hi**
Phone: **(800) 945-4355**

EL PROGRAMA LIVONGO ESTÁ DISPONIBLE EN ESPAÑOL

Cuando se registre, usted seteará el idioma de preferencia y luego el medidor y el programa estarán en Español. Para registrarse en Español, visite ***bienvenido.livongo.com/BCBSM*** *o llámenos al* ***(800) 945-4355****.*

Blue Cross Blue Shield Blue Care Network of Michigan

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

Livongo

Say hello to

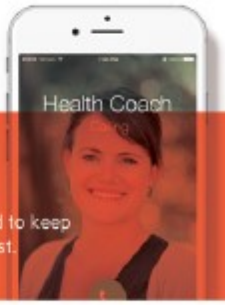
omada

A WHOLE NEW WAY TO GET HEALTHY

Omada® is a digital health program that surrounds you with the support and tools you need to make better choices in the moment—and for life.

Learn more at:

omadahealth.com/grandhaven



1 A HEALTH COACH ON YOUR SIDE

Your personal, full-time health coach is trained to keep you on track—on your best days and your worst.

2 TOOLS TO MOTIVATE YOU

We'll mail you smart technology to track your progress, and reveal what is (and isn't) working for you.

3 INFORMATION BECOMES INSIGHT

Each week, you'll learn simple rules for better eating, fitness, sleep, and stress management that will have an immediate impact on the choices you make.

4 BOUNCE BACK BETTER

Slip-ups are inevitable. But we'll teach you to recover quickly from setbacks and avoid them more easily next time.

5 ENJOY EVERY MEAL

Deprivation doesn't work. You'll learn to prepare easy but delicious meals that leave you feeling good, not guilty—and focus on nutrition and pleasure without obsessing about calories.

6 WILLPOWER COMES INCLUDED

You can't do this alone. You'll gain the support of a small group of peers just like you for encouragement and empathy at every step.

Save money on specialty and other expensive drugs with our high-cost drug discount program

Specialty and other high-cost prescription drugs have made headlines in recent years for their rising costs nationwide. If you're taking any of these medications regularly, you may be paying hundreds of dollars each time you get a refill. That can make it hard to afford your medicine, even though you know how important it is to take it as your doctor ordered.

We can help

Blue Cross Blue Shield of Michigan and Blue Care Network can help you meet that challenge. Our high-cost drug discount program helps you find and take advantage of manufacturer copayment assistance programs that significantly lower your out-of-pocket costs for these expensive medications. You may even pay nothing for your medicine. You'll never pay more than your usual copayment.

And the program is free.

How it works

Blue Cross and BCN will include in the program all members who are taking a qualifying medication. Our vendor, PillarRx, will send you introductory information and then call to enroll you. A representative will explain how the program works, what to expect at the pharmacy and answer your questions.

We'll take care of the rest, and you save money. PillarRx sends all the information needed for your discount to your pharmacy. You don't need to do anything. You simply reap the savings.

If you have questions about your copay assistance at any time, call PillarRx at **1-636-614-3126**.

Schedule your annual check-up today

You go to the doctor when you're sick, but what about when you're healthy? Annual check-ups and tests can help find health problems early, and sometimes, before they even start. By having an annual health exam, you'll be taking important steps toward a longer, healthier life.

A routine health exam is a chance for your health care provider to:

- Screen for diseases
- Assess risk of future medical problems
- Encourage a healthy lifestyle
- Update vaccinations
- Maintain a relationship with you in case of illness

An annual check-up will allow you to talk with your doctor about specific health concerns. He or she may ask questions about your lifestyle behaviors, such as smoking, alcohol use, diet and exercise, vaccination status and family medical history. Your exam may also involve checking:

- Blood pressure
- Heart rate
- Respiration rate
- Temperature
- Heart and lung health
- Head and neck health
- Abdomen
- Blood and urine levels
- Prostate and testicles, for males
- Breasts and pelvis, for females

To find out what screenings and exams you might need, contact your primary care physician. If you don't currently have one, log in to your online member account or the mobile app and use the *Find a Doctor* tool.

Need to activate your online member account? Go to **bcbsm.com/register** and select *Register Now*, or download the app from the App Store® or Google Play™ (search **BCBSM**) and select *Register.*

Cancer screenings can save your life

This year, an estimated 1.8 million Americans will be diagnosed with cancer. Preventive care, including cancer screenings, can help doctors find and treat cancer early. The earlier the detection, the easier it may be to treat. That's why Blue Cross Blue Shield of Michigan encourages members to keep the American Cancer Society cancer screening guidelines in mind and schedule screenings regularly.

Breast cancer

- Beginning at **age 40**, women have the choice to start annual breast cancer screenings with mammograms, or X-rays of the breast.
- Women **ages 45 to 54** should get mammograms every year.
- Women **55 and older** should switch to mammograms every two years, or can continue yearly with screening.
- Women should know how their breasts normally look and feel, and report any changes to a health care provider immediately.

Cervical cancer

- Cervical cancer screening should start at **age 25**.
- From **ages 25 to 65**, women should get a primary HPV, or human papillomavirus, test every five years, or a Pap test every three years. Talk with your health care provider about your screening options.
- Women **over age 65** who've had regular cervical cancer testing in the last 10 years with normal results can stop getting tested.

Prostate cancer

- Men **ages 50 to 64** should ask their health care provider about being tested for prostate cancer. You shouldn't be tested until you've spoken with your provider about the potential risks and benefits of testing and treatment.
- If you're African American or have a father or brother who had prostate cancer before age 65, talk with your provider about testing starting at **age 45**.

Colon and rectal cancer

- If you're at average risk for colorectal cancer, you should start getting regular screenings at **age 45**. This can be done with a stool-based test or colonoscopy, the latter of which is a visual exam that looks at the colon and rectum. Talk with your health care provider about which option is good for you.
- If you're in good health, you should continue regular screenings through **age 75**.

CANCER SCREENINGS

If you have a family history of cancer, you may need to schedule screenings outside of the normal age recommendations. As always, talk with your health care provider about any concerns.

To help reduce your cancer risk:

- Get annual check-ups and regular cancer screening tests.
- Know yourself, your family history and your risks.
- Get to and stay at a healthy weight, and incorporate regular physical activity.
- Eat healthy with plenty of fruits and vegetables.
- Avoid tobacco and keep alcohol to a minimum.
- Protect your skin.

For more information about cancer and screenings, visit **mibluesperspectives.com** and **cancer.org**.

DENTAL PLAN - THE STANDARD

Dental	Plan 1: Non-Union / SEIU	Plan 2: POLC

Benefit Comparison	In-Network	In-Network
Annual Deductible/Individual	$0	$0
Annual Deductible/Family	$0	$0
Annual Plan Maximum	$1,000	$800
Lifetime Orthodontia Plan Maximum	$1,000	$1,250
Diagnostic & Preventive Services	100%	100%
Basic Services	75%	75%
Major Services	75%	75%
Orthodontia Services	65%	65%

City of Grand Haven

Group Dental Insurance

Help protect your oral health with regular dental exams and procedures.

This summary of benefits and coverage shows how you and The Standard would share the cost for covered dental care services.
NOTE: This is only a summary; for detailed information on coverage, please consult your certificate of coverage.

Plan 1: Dental Plan Summary **Effective Date: 1/1/2022**

Plan Benefit	
Type 1 (Preventive)	100%
Type 2 (Basic)	75%
Type 3 (Major)	75%
Waiting Period	None
Deductible	$0/Calendar Year
	Type 1,2,3
	No Family Maximum
Maximum *(per person)*	$800 per calendar year
Allowance	95% usual and customary
Max Builder℠	Included
Annual Eye Exam	None
Annual Open Enrollment	Included

Orthodontia Summary - Child Only Coverage

Allowance	Usual and customary
Plan Benefit	65%
Lifetime Maximum *(per person)*	$1,250
Waiting Period	None

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (2 per benefit period) • Bitewing X-rays (2 per benefit period) • Full Mouth/Panoramic X-rays (1 in 3 years) • Periapical X-rays • Cleaning (2 per benefit period) • Fluoride for Children 18 and under (1 per benefit period) • Sealants (age 18 and under) • Space Maintainers	• Restorative Amalgams • Restorative Composites • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Simple Extractions • Complex Extractions • Anesthesia	• Onlays • Crowns (1 in 5 years per tooth) • Crown Repair • Implants • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

DENTAL PLAN - THE STANDARD

Max Builder[SM]

This dental plan includes a valuable feature that allows plan participants to carry over part of their unused annual maximum. A participant must submit at least one claim during the benefit year while staying at or under the plan-specific threshold amount. Earns an extra reward, called the PPO Bonus, by seeing a Network Provider. Employees and their covered dependents may accumulate rewards up to the stated maximum carry-over amount, then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards will be lost; but he or she can begin earning rewards again the very next year.

Benefit Threshold	$250	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$125	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$50	Additional bonus is earned if the participant sees a network provider
Maximum Carryover	$500	Maximum possible accumulation for Max Builder and PPO Bonus combined

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member provider are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit **http://www.standard.com/services** and click on "Find a Dentist."

Your provider network is Classic Network.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1. If you do not enroll during your company's open enrollment period, then you will be subject to the Late Entrant Provision.

Submitting a claim

Your policy requires all claims be received by The Standard within 90 days of the date of service. You may submit a claim, or your Dentist can file your claim on your behalf and you can assign payment to your Dentist. If the 90 day deadline is missed, you will be responsible for covering the cost of the service. *Requirements for claims submission vary by state, please consult your group certificate for details.

City of Grand Haven

Group Dental Insurance

Help protect your oral health with regular dental exams and procedures.

This summary of benefits and coverage shows how you and The Standard would share the cost for covered dental care services.
NOTE: This is only a summary; for detailed information on coverage, please consult your certificate of coverage.

Plan 2: Dental Plan Summary **Effective Date: 1/1/2022**

Plan Benefit	
Type 1 (Preventive)	100%
Type 2 (Basic)	75%
Type 3 (Major)	75%
Waiting Period	None
Deductible	$0/Calendar Year
	Type 1,2,3
	No Family Maximum
Maximum *(per person)*	$1,000 per calendar year
Allowance	95% usual and customary
Max Builder[SM]	Included
Annual Eye Exam	None
Annual Open Enrollment	None

Orthodontia Summary - Child Only Coverage

Allowance	Usual and customary
Plan Benefit	65%
Lifetime Maximum *(per person)*	$1,000
Waiting Period	None

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (2 per benefit period) • Bitewing X-rays (2 per benefit period) • Full Mouth/Panoramic X-rays (1 in 3 years) • Periapical X-rays • Cleaning (2 per benefit period) • Fluoride for Children 18 and under (1 per benefit period) • Sealants (age 18 and under) • Space Maintainers	• Restorative Amalgams • Restorative Composites • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Simple Extractions • Complex Extractions • Anesthesia	• Onlays • Crowns (1 in 5 years per tooth) • Crown Repair • Implants • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

DENTAL PLAN - THE STANDARD

Max Builder℠

This dental plan includes a valuable feature that allows plan participants to carry over part of their unused annual maximum. A participant must submit at least one claim during the benefit year while staying at or under the plan-specific threshold amount. Earns an extra reward, called the PPO Bonus, by seeing a Network Provider. Employees and their covered dependents may accumulate rewards up to the stated maximum carry-over amount, then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards will be lost; but he or she can begin earning rewards again the very next year.

Benefit Threshold	$500	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$100	Additional bonus is earned if the participant sees a network provider
Maximum Carryover	$1,000	Maximum possible accumulation for Max Builder and PPO Bonus combined

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member provider are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit **http://www.standard.com/services** and click on "Find a Dentist."

Your provider network is Classic Network.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Submitting a claim

Your policy requires all claims be received by The Standard within 90 days of the date of service. You may submit a claim, or your Dentist can file your claim on your behalf and you can assign payment to your Dentist. If the 90 day deadline is missed, you will be responsible for covering the cost of the service. *Requirements for claims submission vary by state, please consult your group certificate for details.

DENTAL PLAN - THE STANDARD

Prior Extraction Limitation

Your policy has a prior extraction limitation, also known as the "missing tooth clause". This means that if you had a tooth extracted prior to enrolling in your plan with The Standard, we may or may not pay for any benefits towards replacing that tooth. Please review your policy or contact Customer Service for details.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Customer Service

Customer service is available to plan participants through our well-trained and helpful service representatives. Call or go online to locate the nearest network provider, view plan benefit information and more.

Call Center: 800.547.9515
Service representative hours:
5 a.m. to 10 p.m. Pacific Monday through Thursday
5 a.m. to 4:30 p.m. Pacific Friday
Interactive Voice Response available 24/7

View plan benefit information at:
www.standard.com/services.

About The Standard

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at **www.standard.com**.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard or your employer for additional information, including costs and complete details of coverage.

PROTECT YOUR EYES

For protection, ask for

BLUTECH LENSES

BluTech users report better sleep—allowing you to be more productive the next day. Experience less eye strain and fewer headaches from digital devices and artificial light.

Available in prescription and non-prescription for contact lense wearers.

SUN SOLUTIONS

Protect your eyes from UV exposure and glare from the sun.

Customize your Sunglasses with Polarized or Drivewear Sun Solutions for both prescription or non-prescription sun lenses with a designer frame of your choice.

Ray-Ban OAKLEY Maui Jim OLIVER PEOPLES

LOCATIONS

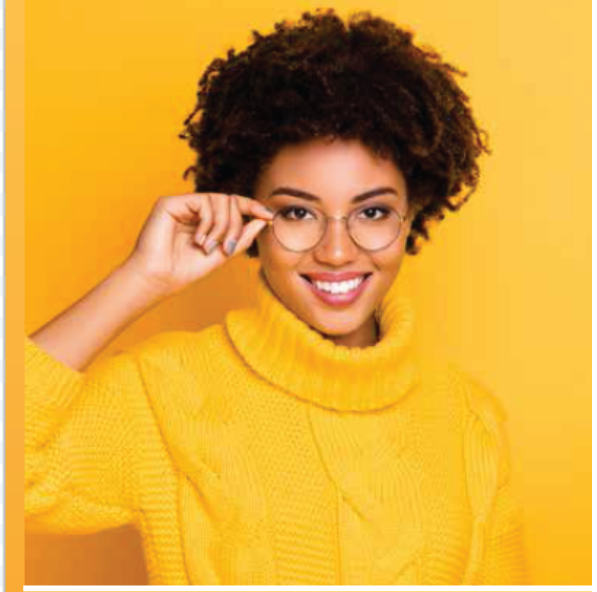
DETROIT/EASTERN MICHIGAN OFFICES		
Ann Arbor	3275 Washtenaw Ave.	(734) 545-7988
Ann Arbor	867 W. Eisenhower Pkwy.	(734) 213-3529
Saline	900 E. Michigan Ave.	(734) 295-9241
Allen Park	23055 Outer Dr.	(313) 359-9075
Livonia	29474 Seven Mile Rd.	(248) 615-2815
Plymouth	44429 Ann Arbor Rd.	(734) 416-0348
Southgate	15204 Eureka Rd.	(734) 282-9500
Woodhaven	22750 Allen Rd.	(734) 676-4300
GRAND RAPIDS OFFICES		
Breton Village	1858 Breton Rd. SE	(616) 949-9660
Cascade	6749 Cascade Rd.	(616) 957-3099
Grand Rapids	3083 28th St. SE	(616) 949-8974
Grandville	4555 Wilson Ave. SW	(616) 249-8490
Jenison	381 Baldwin St.	(616) 457-4443
Kentwood	2350 44th St. SE	(616) 281-1011
Kentwood (South)	6143 Kalamazoo Ave.	(616) 554-7775
Knapp's Crossing	2000 East Beltline NE	(616) 608-0466
Plainfield (North)	5429 Northland Dr. NE	(616) 365-7600
Plainfield Twp.	4022 Plainfield Ave. NE	(616) 363-1868
Rockford	507 E. Division St.	(616) 866-3933
Walker	3576 Alpine Ave. NW	(616) 784-4999
Walker/Standale	4482 Lake Michigan Dr.	(616) 791-6944
Wyoming	1717 28th St. SW	(616) 531-4370
KALAMAZOO OFFICES		
Downtown	155 W. Michigan Ave.	(269) 342-0134
Kalamazoo	1727 S. Park St.	(269) 342-3910
Kalamazoo	2067 S. Drake Rd.	(269) 366-3664
Kalamazoo (East)	5465 Gull Rd.	(269) 349-7631
Kalamazoo (West)	5349 W. Main St.	(269) 349-7627
Kalamazoo Oakwood	3013 Oakland Dr.	(269) 382-3453
Portage	6123 S. Westnedge Ave.	(269) 327-7079
INDIANA OFFICES		
Angola, IN	1400 N. Wayne St.	(260) 668-8881
Kendallville, IN	208 W. North St.	(260) 349-1008
Elkhart, IN	2224 Cassopolis St.	(574) 206-1533
MICHIGAN OFFICES		
Battle Creek	65 E. Columbia Ave.	(269) 965-5106
Benton Harbor	1761 S. M 139	(269) 934-0424
Charlotte	1315 Lansing Rd.	(517) 543-7577
Coldwater	755 E. Chicago St.	(517) 278-9004
Grand Haven	1125 S. Beacon Rd.	(616) 846-4454
Hastings	803 W. State St.	(269) 945-9724
Holland (North)	12659 Riley St.	(616) 399-1440
Holland (Central)	590 E. 16th St.	(616) 928-9640
Holland (South)	1148 S. Washington Ave.	(616) 396-8814
Ionia	3125 S. State Rd.	(616) 527-9279
Jackson (East)	3132 E. Michigan Ave.	(517) 783-9000
Jackson (West)	1617 N. West Ave.	(517) 780-3828
Jonesville	855 Olds St.	(517) 849-2200
Lansing	5204 W. Saginaw Hwy.	(517) 886-2888
Muskegon	2159 E. Apple Ave.	(231) 767-1600
Muskegon/Fruitport	1720 E. Sternberg Rd.	(231) 798-7230
Norton Shores	3445 Henry St.	(231) 220-0223
Niles	1421 S. 11th St.	(269) 684-1330
Plainwell	1281 W. M 89	(269) 685-1071
St. Joseph	2008 Washington Ave.	(269) 983-1303
Sturgis	500 S. Centerville Rd.	(269) 651-1958
Three Rivers	111 S. US 131	(269) 273-9515

120-VA

RxOptical

VISION ADVANTAGE PROGRAM

CITY OF GRAND HAVEN



VISION ADVANTAGE PROGRAM

For locations go to RxOptical.com, or call 1-800-792-2737.

CITY OF GRAND HAVEN

membership# CGH5876 PLAN 321
expiration date: 06/30/2022

RxOptical
RxOptical.com

CGH5876

VISION ADVANTAGE PROGRAM

Rxoptical SAFETY | Rxoptical VISIONCARE | RXtra VisionCare Program

EXAM FOR GLASSES: $10 OFF RETAIL
OR YOUR INSURANCE CO-PAY

EYEGLASSES Best Value

See $20/$20 in 2021

- $20 OFF Frames
- $20 OFF Lenses
- $20 OFF TitanGUARD premium non-glare coating

$20/$20 discounts are applied to retail purchase prices on glasses OR we apply your vision insurance discount pricing if it is a BETTER Savings for you.

Vision Advantage Program (VAP) prices are subject to change without notice. Some restrictions may apply based on your insurance coverage. Customized VAP discounts may be applied to certain insurance plans only. VAP discount cannot be used on insurance plan copays.

MEMBERSHIP CARD Please present this card at time of service.

Your Network Vision Insurance Provider.
Rx Optical will bill your vision insurance for you. We are a provider for most insurance plans including, **but not limited to:**

PriorityHealth | Heritage Vision Plans | UnitedHealthcare | EyeMed | NVA | hap | DavisVision | Vision Service Provider | spectera

The **Vision Advantage Program** may be used with some insurance plans. Some restrictions may apply depending on your vision insurance coverage.

CONTACT LENSES

Prices and Rebates Savings available on all contact lens purchases. Ask your optician for details on your contact lenses.

Contact Lens Exam: $10 off retail

DON'T LET UNCOMFORTABLE CONTACTS LEAD TO COMPROMISED HYGIENE

ACUVUE®
MAKES CONTACT LENSES
UNBEATEN IN COMFORT®

MAKE AN APPOINTMENT TODAY
AND ASK FOR ACUVUE®

*The following ACUVUE® brand contact lenses have substantiated unbeaten in comfort claims: ACUVUE® OASYS Brand Family (including daily disposable), 1-DAY ACUVUE® MOIST Brand Family (within the category of hydrogel daily disposable), and ACUVUE® VITA® Brand spherical only. 1,2,3

1. JJV data on file 2020 - Claim for the family of ACUVUE® OASYS Brand Contact Lenses (2-week reusable) and ACUVUE® OASYS 1-Day with HydraLuxe® Technology using clinical trials cited on www.clinicaltrials.gov website. (March 24th 2020). 2. JJV data on file 2020 - Claim for ACUVUE® VITA® with HydraMax® Technology. Unbeaten in Comfort in Monthly Lens Category– using clinical trials cited on www.clinicaltrials.gov website. (March 27th 2020). 3) JJV data on file 2020 - Unbeaten Comfort of 1-DAY ACUVUE® MOIST FAMILY Brand Contact Lenses. (March 27, 2020).

Important Safety Information: For more information on proper wear, care and safety, talk to your eye care professional, call 1-800-843-2020 or visit acuvue.com

MADE IN MICHIGAN FOR OVER 70 YEARS

WORRY FREE WARRANTY

We offer the most comprehensive and worry-free warranty for scratched, broken or lost eyeglasses for 25 months.

LASER VISION CORRECTION

Are you considering LASIK?
For information and a free consultation, call our laser vision coordinator at 1-800-792-2737.

ABOUT THE PROGRAM

Who is eligible?
All employees,members and their families can use the Vision Advantage Program at any Rx Optical location.

Use the Vision Advantage Program with a Flexible Spending Account.

Kids' Care Program
Ask your optician for details.

For more information please call our Vision Care team at 1-800-792-2737.

Savings programs cannot be used on sales tax, insurance co-pays or with special pricing offers. Some restrictions may apply.

NAUTICA | Ray-Ban | NINE WEST | PRADA | COACH | RALPH | OAKLEY | TIFFANY & Co. | OLIVER PEOPLES

HealthBridge provides something your health plan alone can't — financial security.

HealthBridge is a first-of-its-kind employee benefit that helps you and your covered family members manage and pay for out-of-pocket medical expenses. The City of Grand Haven supplies HealthBridge to you at no cost!

How HeathBridge works

- As a HealthBridge member, the HealthBridge benefit applies when you or a covered family member receive medical care covered by your employer-sponsored health plan from a HealthBridge Network Provider.

- You'll be able to repay HealthBridge with flexible terms, including:
  - A **10% discount** at any time when you pay your statement in full.
  - Take up to 2 years to pay each new claim. Minimum payments apply.
  - Option to pay your account over time **interest free**!

- When you visit a provider, let them know you have HealthBridge and show your HealthBridge Membership Card. Prefer an electronic card? It's always available on the HealthBridge Member Portal.

- When the HealthBridge benefit applies, you don't pay HealthBridge Network Providers directly for copays, deductibles or coinsurance. HealthBridge pays them up front and on your behalf.

- Monthly you'll receive a HealthBridge statement consolidating your portion of each claim, and have the ability to manage your account online, over the phone, or by mail.

Have you looked at HealthBridge lately?

Still have questions?

Call one of our local specialists at 800.931.8890
8 am to 8 pm EST Monday – Friday; 9 am to 1 pm EST
Saturday Se habla español

CITY OF GRAND HAVEN MICHIGAN

HealthBridge™
myhealthbridge.com

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HealthBridge℠ Benefits-at-a-Glance

Your employer sponsors a group health plan ("Companion Group Health Plan"). The Companion Group Health Plan provides benefits through a variety of component parts. The HealthBridge Program ("HealthBridge") is one component of your Companion Group Health Plan.

HealthBridge pays HealthBridge Network Providers for out-of-pocket medical expenses (copayments, coinsurance and/or deductibles) incurred under and covered by a Member's Companion Group Health Plan on the Member's behalf. Each month, HealthBridge sends Members a statement consolidating the applicable expenses for each claim.

Members have up to 24 months to pay each new claim for the applicable out-of-pocket expense at 0% interest. Minimum payments apply.

Upon receipt of each monthly statement, a member has the option to: (1) pay the balance in full by the statement due date and receive a 10% Quick Pay Discount on the remaining balance or (2) pay at least the minimum payment required.

HealthBridge is a financial security program which is an employee benefit offering — a Healthcare Expense Consolidation & Flexible Payment Plan. This is not a contract for insurance.

Program Administrator Information	HealthBridge Financial, Inc. PO Box 888284 Grand Rapids, MI 49588 (800) 931-8890 myhealthbridge.com
Eligibility	Any Employee or Dependent who is covered by an Employer's Companion Group Health Plan is eligible as a HealthBridge Member under the HealthBridge Program.
HealthBridge Member	Any Employee, Former Employee or Dependent who is enrolled in and covered by the Employer's Companion Group Health Plan.
Effective Date of Coverage	The HealthBridge Program coverage begins on whichever day is later: (1) the date the Employer adopts HealthBridge or (2) the date the Employee, or their Dependent, becomes eligible under the Employer's Companion Group Health Plan.
Waiting Period	There is no waiting period.
Coverage Termination	The HealthBridge Program coverage will terminate on whichever day is earlier: (1) the date the Member ceases to be covered under Employer's Companion Group Health Plan or (2) the date the HealthBridge Program is terminated.
Interest Rate	0%. HealthBridge will not charge Members interest.

HEALTH BRIDGE

Current Balance	The total balance of a Member's account at any given time (including any Late Fees assessed). Members can check the Current Balance by logging in to the HealthBridge Member Portal.
Monthly Statement	Member statements are generated monthly on the twelfth day after the first Claim is purchased on a member's behalf. The due date will be set as the day before the next statement generation date.
Statement Balance	The Current Balance on a Member's account on the date the Monthly Statement is generated.
QuickPay Discount	10%. QuickPay Discount is available if the Member pays the HealthBridge Statement Balance by its due date.
Claims	Claims listed on a Member's account activity represent the Member's patient liability on claims generated by a HealthBridge Network Provider and adjudicated by a Member's health plan. HealthBridge has already paid the HealthBridge Network Provider on the Member's behalf to satisfy the Member's patient liability on his or her Adjudicated Claims. Patient liability is limited to in-network copayments, coinsurance, and/or deductibles, as outlined in the Employer's Companion Group Health Plan, that are attributable to a HealthBridge Network Provider. HealthBridge Statements do not include prescription drug out-of-pocket costs, claims from providers who are not HealthBridge Network Providers, or other out-of-pocket expenses that do not qualify as in-network copayments, coinsurance, or deductibles for Adjudicated Claims.
Adjudicated Claims	Adjudicated Claims are those claims processed by your health plan after receipt from a HealthBridge Network Provider. HealthBridge does not process your claims and receives only the amount owed by you (your patient liability) based on your health plan's adjudication.
HealthBridge Network Provider	Healthcare providers accepting payments directly from HealthBridge for Member out-of-pocket expenses in lieu of collecting payments from Members or billing Members directly.
Minimum Payment Due	The Minimum Payment Due is either: • A calculated amount plus applicable late fees OR • $25, if the calculated amount is less than $25, plus applicable late fees OR • An amount less than $25 if it is a payment which brings the account balance to zero The calculated amount of the Minimum Payment Due on a Monthly Statement is equal to the sum of 1/24 of the value of each claim and applicable claim adjustments received during that billing cycle, less any payments received during that billing cycle.
Late Fee	• You must make the minimum monthly payment noted on your monthly statement on or before the statement due date. • If HealthBridge does not receive your monthly payment by the statement due date, or your payment is less than the minimum payment due, HealthBridge reserves the right to assess a Late Fee to your account after two consecutive missed monthly payments. • The amount of the Late Fee is up to 3% (not to exceed $25 in any given month) of the last Statement Balance. • Any assessed Late Fees will be added to the amount of the Minimum Payment Due and reflected as such on your statement.

Still have questions?

Call one of our local specialists at 800.931.8890 or visit myhealthbridge.com

9 am to 8 pm EST Monday – Friday; 9 am to 1 pm EST Saturday

Se habla español

HealthBridge
myhealthbridge.com

Frequently Asked Questions

About HealthBridge

HealthBridge is a new type of employee benefit that helps you and your covered family members manage and pay for your portion of covered medical services - copayments, coinsurance, or deductibles. By participating in your employer's health plan, you are automatically enrolled in this additional benefit at no cost to you.

When you receive covered medical services from a HealthBridge Network Provider, HealthBridge pays the provider directly on your behalf – just show them your HealthBridge membership card. HealthBridge consolidates your settled bills in a monthly statement with discounts and extended repayment options.

Does this change my health plan?
No, having HealthBridge doesn't affect your health plan coverage. The HealthBridge benefit only applies when you are receiving a covered medical service from a HealthBridge Network Provider. For providers not in the HealthBridge Provider Network, you will be billed directly by that provider – the same as today.

Where is the list of HealthBridge Providers?
The HealthBridge Provider Location Directory is available in Resources on the HealthBridge Member Portal.

How can I access my membership card?
Log in to the HealthBridge Member Portal at member.myhealthbridge.com to view, download a PDF, or print a membership card. You also receive a membership card with your welcome letter.

Privacy

How does HealthBridge protect my private health information?
HealthBridge protects the privacy, confidentiality, and security of your information online and in our databases. HealthBridge complies with HIPAA, the Health Insurance Portability and Accountability Act, for data privacy and security of medical data.

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

Online Account Management

How do I activate my online account?
Either use your temporary password (sent in your new member welcome email) or complete an online verification process to securely activate your account on the HealthBridge Member Portal.

What if I forget my password?
From the HealthBridge Member Portal choose Forgot Password to receive a reset link. Also our client service specialists can help you reset your password via phone or secure chat.

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

How can I access a family member's account online?

If your family member is under 18, you will automatically have access to their account. If your family member is 18 or over, to access their account, you will need to follow a HIPAA authorization process. Before requesting/accepting access, you both first have to activate your online accounts.

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

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

Payments

How will I be billed by HealthBridge?

Your portion of covered medical services from HealthBridge Network Providers will be consolidated on a monthly statement. Whenever you pay your full statement balance – at any time – you receive a 10% discount off the remaining balance.

What payment methods can I use?

You can make a payment with Visa, Mastercard, check, debit card, funds from your Health Savings Account (HSA), or Flexible Spending Account (FSA). Payments can be made online, via mail or by phone. Setting up an automatic payment profile is an easy way to make on-time payments a snap!

Will I still receive an Explanation of Benefits (EOB)?

Yes. Your health plan is still required to send you an Explanation of Benefits which contains more comprehensive details of your service and your appeal rights. Your HealthBridge statement will reference the claim number on your EOB, but it does not include details about visit type or diagnosis.

What if I am covered by two or more health plans (Coordination of Benefits)?

Complete a **Coordination of Benefits Notification Form** if you, or a covered family member, have more than one health plan (including government plans). Form is available on the HealthBridge Member Portal under **Resources**, or by contacting HealthBridge Member Services.

What if I receive a bill from a provider for the same service listed on my HealthBridge statement?

Contact HealthBridge Member Services, who will verify whether the provider you saw is in the HealthBridge Network. Do not pay the provider directly for copayments, coinsurance, or deductibles when the HealthBridge benefit applies.

What if I receive a HealthBridge statement after I've paid a provider?

Contact HealthBridge Member Services. HealthBridge will help coordinate either a refund or a transfer of credit to reconcile your HealthBridge balance and discount. In most cases, the provider has not yet added HealthBridge as 'secondary payer' to your account in their billing system.

LIFE / DISABILITY—NEW YORK LIFE

Whatever life throws at you – throw it our way.

Life Assistance Program from New York Life Group Benefit Solutions.

Life. Just when you think you've got it figured out, along comes a challenge. Whether your needs are big or small, New York Life Group Benefit Solutions (NYL GBS) is there for you with our NYL GBS Life Assistance Program. It can help you and your family find solutions and restore your peace of mind.

Call us anytime, any day

We're just a phone call away whenever you need us. At no extra cost to you. An advocate can help you assess your needs and develop a solution. He or she can also direct you to community resources and online tools.

Visit a specialist

You have three face-to-face sessions with a behavioral counselor available to you – and your household members. Call us to request a referral.

Monthly webinars

Educational seminars on a variety of relevant topics such as managing your life, work, money and health, are available in a quarterly calendar of monthly webcasts distributed to your employer.

Achieve work/life balance

For help handling life's challenges, go online for articles and resources on family, care giving, pet care, aging, grief, balancing priorities, working smarter, and more.

Legal consultation and referrals*

Receive a free 30-minute consultation with a network attorney. And up to a 25% discount on select fees.

Financial consultations

Receive a free 30-minute consultation and 25% discount on tax planning and preparation.

Life Assistance Program 24/7 support

Phone: **(800) 538-3543**

Website: www.cignalap.com

*Legal consultations and discounts are excluded for employment-related issues.

These programs are NOT insurance and do not provide reimbursement for financial losses. Some restrictions may apply. Employee assistance services are provided by Cigna Behavioral Health, Inc. Customers are required to pay the entire discounted charge for any discounted products or services available through these programs. Programs are provided through third party vendors who are solely responsible for their products and services. Full terms, conditions and exclusions are contained in the applicable client program description, and are subject to change. Program availability may vary by plan type and location, and are not available where prohibited by law. These programs are not available under policies insured by New York Life Group Insurance Company of NY.

New York Life Group Benefit Solutions products and services are provided by Life Insurance Company of North America and New York Life Group Insurance Company of NY, subsidiaries of New York Life Insurance Company.

New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010

923865 a 0521 SMRU 1903057 Exp. Date 06.08.2023

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

FSA/HSA Eligible and Non-Eligible Expenses

HSA Eligible Health Care Expenses

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

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

*if prescribed for a particular ailment or medical condition; provider letter required.

Important Notice About Over-the-Counter (OTC) Medications

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

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

FSA/HSA Eligible OTC Medications and Products

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

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

All OTC items listed are examples

FSA/HSA Non-Eligible Health Care Expenses

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

FSA/HSA Non-Eligible OTC Products

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

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

REQUIRED NOTICES

Preventive Care

Medical

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

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

http://www.bcbsm.com/content/dam/public/Consumer/Documents/help/documents-forms/pharmacy/preventive-drug-list.pdf

Pharmaceutical

Certain preventive care prescription drugs are covered 100%.

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

Lifetime Limit No Longer Applies and Enrollment Opportunity

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

(616) 847-4887.

Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in City of Grand Haven's BCBSM plan. Enrollment will be effective January 1, 2022. For more information contact Zac VanOsdol at (616) 847-4887.

Special Enrollment Notice

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

(616) 847-4887.

Michelle's Law

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

REQUIRED NOTICES

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

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

at (616) 847-4887

Newborns' and Mothers' Health Protection Act

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

Tell Us When You're Medicare Eligible

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

Genetic Information Nondiscrimination Act of 2008

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

Nondiscrimination Notice

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

City of Grand Haven:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary Language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Zac VanOsdol at

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

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

by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20211

1-800-368-1019, 800-537-7697 (TDD)

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	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

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

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP

IOWA – Medicaid and CHIP (Hawki)	MONTANA – 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: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – 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	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – 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: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

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

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	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 July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

CREDITABLE COVERAGE NOTICE

Important Notice from City of Grand Haven About

Your Prescription Drug Coverage and Medicare

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

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

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

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

CREDITABLE COVERAGE NOTICE

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

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

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

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

CREDITABLE COVERAGE NOTICE

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with **City of Grand Haven** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information about Your Current Prescription Drug Coverage…

Contact your Benefits Administrator for **City of Grand Haven** at 616-847-4887. For a further explanation of the prescription drug coverage plan provisions/ options under the **City of Grand Haven Health Plan** please consult the relevant plan document provisions.

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

CREDITABLE COVERAGE NOTICE

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

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

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov

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

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

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

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

Date:	1/1/2022
Name of Entity/Sender:	**City of Grand Haven**
Contact--Position/Office:	Zac VanOsdol
Address:	519 Washington Avenue
	Grand Haven, MI 49417
Phone Number:	616-847-4887

GLOSSARY OF TERMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CITY OF GRAND HAVEN EMPLOYEE BENEFIT GUIDE

January 1, 2022 through December 31, 2022