City of Flint

Department of Purchases & Supplies

Sheldon A. Neeley

TO: All Proposers

FROM: Joyce A. McClane, CPPB
Purchasing Manager

DATE: **May 7, 2021**

SUBJECT: **Addendum #01 –** Proposal #22000704 – City of Flint Employee/Retiree Healthcare Consulting & Benefit Administration

This addendum has been issued because of the following:

1. **Attached are Questions and Answers**
2. **Listed below is the Google Meet information for the bid opening date – Friday, May 14, 2021 at 3:00 p.m.**

   Join with Google Meet
   meet.google.com/nzz-mgwz-rgg
   Meeting ID
   meet.google.com/nzz-mgwz-rgg
   Phone Numbers
   (US)+1 617-675-4444
   PIN: 947 960 611 1886#

All other bidding terms, requirements, and conditions continue as indicated in the remaining original bid documents.

The Purchasing Manager, Joyce McClane, is an officer for the City of Flint with respect to this RFP.

In the submission of their proposal, Proposer must acknowledge receipt of this addendum. Proposer shall acknowledge this addendum by signing and returning one copy of this notice with their submission.

Company Name: _____

Address: _____

City / State / Zip: _____

Telephone: _____ Fax: _____ Email: _____

Print Name: _____ Title: _____

Signature: _____ Date: _____

Thank you.

Joyce A McClane,
Purchasing Manager, CPPB

QUESTIONS RECEIVED IN THE DIVISION OF PURCHASES & SUPPLIES
For City of Flint Employee/Retiree Healthcare Consulting and Benefit Administration

PROPOSAL# 22000704

1. Can you please provide benefit designs and current costs for Active/Pre/Post 65 health plans and ancillary benefits for all employees under the City of Flint employee benefits programs? What is your overall Per Employee Per Year (PEPY) costs regarding medical and pharmacy benefits?

   Response: See attached.

2. Please share the "winning proposal (RFP) from the previous contract. (Incumbent)

   Response: Inquiries regarding the winning proposal (RFP) from the previous contract (Incumbent) must be requested from the City of Flint Legal Department. Please refer to the website link: https://www.cityofflint.com/legal-2/foia/

3. What are the goals of the health benefits program for the City of Flint?

   Response: The City of Flint (City) is seeking proposals from vendors ("V e n d o r") who offer the oversight and dissemination of healthcare services for the city's active and retiree base. The Vendor must have demonstrated experience in managing a municipal active and retiree healthcare programs *within the state of Michigan*, which must include provision and oversight of healthcare services for Pre-65 and Medicare-eligible retirees. Currently, the city must seek ways to save on both active and retiree healthcare. Previous litigation activities restricted cost-saving measures for the city in its provision of healthcare to its retirees. The city is looking to maintain a satisfactory level of quality of care for both active employees and retirees that will allow for cost saving measure, if available.

4. What cost containment strategies does the City of Flint use in their health benefits program?

   Response: The City benefits were restructured under a state emergency manager who increased deductible, copays, and prescription copays. Further changes to medical and prescription coverage must be negotiated through the collective bargaining process.

5. Has the City of Flint ever received increased benefits, decreased costs, additional free services, or new free programs over the course of 1-3 years consecutive? (high performance health plans). Have the employee benefits program costs for the City of Flint ever been reduced by 30-40%?

   Response: The City of Flint is always seeking benefit plans that will provide the maximum return for the money spent including plans that will provide additional benefits at a lower cost per employee. The City made available Total Hurley plan to active employee insurance plan during fiscal year 2021. Hospitalization and prescription deductible and copays for active employees are negotiated through collective bargaining agreements. Retiree hospital and prescription coverage and copays were developed through a court ordered litigation settlement for retiree groups.

6. What is more important to the City of Flint, advisor experience delivering high performance health plans which deliver best-in-class benefits for all employees and reduces overall costs annually while giving additional dividends to be used at your discretion or a firm working with 5 other municipalities, where the costs go up every year and they deliver the status-quo?

   Response: The City of Flint is seeking high performance health plans with lower costs while delivering the best-in-class benefits for all employees. We are seeking those vendors who can provide cost savings annually. Failure to meet our objectives may require us to see out vendors who can provide the necessary cost savings.

CITY OF FLINT

BENEFIT ELECTION FORM FOR RETIREES – Non Lit. NEW RETIREES – Retired On or After 07/01/2014

RETIREE INFORMATION		☐ CHECK BOX IF ANY OF THE INFORMATION BELOW HAS CHANGED		
Name		Social Security #		☐ Male ☐ Female
Address (number & street)		City	State	ZIP Code
Date of Birth	Primary Phone ( )	Marital Status ☐ Single ☐ Married ☐ Divorced	Medicare Eligibility (provide copy of card(s)) ☐ Part A ☐ Part B ☐ Part A & B	

If Medicare Eligible a Medicare Advantage Enrollment Form Will Also Need to Be Completed

LIST THE DEPENDENTS YOU WISH TO HAVE COVERED BELOW – USE AN ADDITIONAL PAGE, IF NEEDED

NAME	BIRTH DATE	GENDER	RELATIONSHIP	SSN	ADD/DROP CHANGE COVERAGE	OTHER COVERAGE? YES or NO

COVERAGE	OPTIONS	MONTHLY CONTRIBUTION					
1. MEDICAL AND PRESCRIPTION DRUG PLAN (EFFECTIVE JULY 1, 2020)							
	Circle the option of your choice below:	**MONTHLY CONTRIBUTION**					
		One Person Non-Medicare	2 Person Non-Medicare	Family Non-Medicare	Medicare Per Person	Members Enrolled In Medicare	
Select the option and coverage level of your choice. A completed carrier form is required if you are making any changes.	• Blue Cross Blue Shield	$481.94	$1,304.52	$1,445.81	$0.00		$_____ Monthly Contribution
	• Health Alliance Plan (HAP)	$357.16	$776.53	$885.60	$0.00	_____	
	• McLaren	$0.00	$0.00	$0.00	N/A		
	• Waive – No Coverage	$0.00	$0.00	$0.00	$0.00		

To calculate your Monthly Contribution, add the rate for Non-Medicare coverage and the rate for Medicare coverage. Please note that the Medicare rate is calculated by the amount in the "Medicare Per Person" column times the number of family members enrolled in Medicare.

Example #1: Coverage with BCBS. Retiree is not enrolled in Medicare and the Spouse is not enrolled in Medicare – Coverage level is "2 Person Non-Medicare" The total Monthly Contribution would be $1,304.52.

Example #2: Coverage with BCBS. Retiree is not enrolled in Medicare and the Spouse is enrolled in Medicare – Coverage level is "One Person Non-Medicare" in the amount of $481.94 PLUS "Medicare Per Person" in the amount of $0.00. The total Monthly Contribution would be $481.94.

Example #3: Coverage with BCBS. Retiree is not enrolled in Medicare and the Spouse and Child are enrolled in Medicare – Coverage level is "One Person Non-Medicare" in the amount of $481.94 PLUS "Medicare Per Person" times 2 in the amount of $0.00 ($0.00 per Medicare member). The total Monthly Contribution would be $481.94.

2. YOUR SIGNATURE

The following actions are prohibited:

- Attempting to submit a claim for benefits which includes attempting to fill a prescription for a person who is not eligible under this plan
- Attempting to file a claim for a participant for services which were not rendered for drugs or other items which were not provided
- Providing false or misleading information in connection with enrollment in the plan
- Providing any false or misleading information to the plan

I understand that if I partake in the actions listed above, such actions, or the knowledge of such actions taken by another, constitute fraud and will result in termination of all coverage under this plan in accordance with applicable law and insurance company policy/procedure.

I understand that I cannot change these benefit elections unless I notify Meadowbrook Insurance Agency **within 30 days** after I experience a qualifying change in status (such as marriage, divorce, death of a spouse or a child, birth or adoption of a child) and the insurance carrier approves such a change. I agree to pay the amount necessary to satisfy the required contribution I am expected to pay toward the cost of coverage. This agreement is subject to the terms of the City's contribution plan as amended from time to time, and shall be governed by and construed in accordance with applicable laws. This benefit election form revokes any prior benefit election relating to such plan. My signature below acknowledges my elections for this plan year beginning July 1, 2020.

Any qualifying change in status and requests for cancellation of coverage must be reported to Meadowbrook Insurance Agency. All changes or cancellations will take place on the first of the month following Meadowbrook Insurance Agency receipt of the written request and documentation supporting such change. Should I fail to inform Meadowbrook Insurance Agency, I understand that I will be required to wait until the next Open Enrollment. I further agree that any paperwork required to support a change in status will be supplied to Meadowbrook Insurance Agency at the earliest point in time that it becomes available.

Date:_____ Signature: _____

CITY OF FLINT
BENEFIT ELECTION FORM FOR RETIREES - LITIGANT Retired On or Before 4/25/12

RETIREE INFORMATION — ☐ CHECK BOX IF ANY OF THE INFORMATION BELOW HAS CHANGED

Name		Social Security #	☐ Male ☐ Female
Address (number & street)	City	State	ZIP Code
Date of Birth / Primary Phone ( )	Marital Status ☐ Single ☐ Married ☐ Divorced		Medicare Eligibility (provide copy of card(s)) ☐ Part A ☐ Part B ☐ Part A & B

If Medicare Eligible a Medicare Advantage Enrollment Form Will Also Need to Be Completed

LIST THE DEPENDENTS YOU WISH TO HAVE COVERED BELOW – USE AN ADDITIONAL PAGE, IF NEEDED

NAME	BIRTH DATE	GENDER	RELATIONSHIP	SSN		ADD/DROP CHANGE COVERAGE	OTHER COVERAGE? YES or NO

COVERAGE	OPTIONS	MONTHLY CONTRIBUTION					
1. MEDICAL AND PRESCRIPTION DRUG PLAN Effective July 1, 2020							
	Circle the option of your choice below:	**MONTHLY CONTRIBUTION**					
		One Person Non-Medicare	2 Person Non-Medicare	Family Non-Medicare	Medicare Per Person 2020	Members Enrolled In Medicare	
Select the option and coverage level of your choice. A completed carrier form is required if you are making any changes.	• Blue Cross Blue Shield	$124.00	$297.59	$371.99	$124.00		$_____ Monthly Contribution
	• Health Alliance Plan (HAP)	0.00	$0.00	$0.00	$0.00	_____	
	• McLaren	$68.15	$163.55	$204.44	N/A		
	• Waive – No Coverage	$0.00	$0.00	$0.00	$0.00		

To calculate your Monthly Contribution, add the rate for Non-Medicare coverage and the rate for Medicare coverage. Please note that the Medicare rate is calculated by the amount in the "Medicare Per Person" column times the number of family members enrolled in Medicare.

Example #1: Coverage with BCBS. Retiree is not enrolled in Medicare and the Spouse is not enrolled in Medicare – Coverage level is "2 Person Non-Medicare" The total Monthly Contribution would be $297.59.

Example #2: Coverage with BCBS. Retiree is not enrolled in Medicare and the Spouse is enrolled in Medicare – Coverage level is "One Person Non-Medicare" in the amount of $124.00 PLUS "Medicare Per Person" in the amount of $124.00. The total Monthly Contribution would be $248.00.

Example #3: Coverage with BCBS. Retiree is not enrolled in Medicare and the Spouse and Child are enrolled in Medicare – Coverage level is "One Person Non-Medicare" in the amount of $124.00 PLUS "Medicare Per Person" times 2 in the amount of $248.00 ($124.00 per Medicare member). The total Monthly Contribution would be $372.00.

2. YOUR SIGNATURE

The following actions are prohibited:

- Attempting to submit a claim for benefits which includes attempting to fill a prescription for a person who is not eligible under this plan
- Attempting to file a claim for a participant for services which were not rendered for drugs or other items which were not provided
- Providing false or misleading information in connection with enrollment in the plan
- Providing any false or misleading information to the plan

I understand that if I partake in the actions listed above, such actions, or the knowledge of such actions taken by another, constitute fraud and will result in termination of all coverage under this plan in accordance with applicable law and insurance company policy/procedure.

I understand that I cannot change these benefit elections unless I notify Meadowbrook Insurance Group **within 30 days** after I experience a qualifying change in status (such as marriage, divorce, death of a spouse or a child, birth or adoption of a child) and the insurance carrier approves such a change. I agree to pay the amount necessary to satisfy the required contribution I am expected to pay toward the cost of coverage. This agreement is subject to the terms of the City's contribution plan as amended from time to time, and shall be governed by and construed in accordance with applicable laws. This benefit election form revokes any prior benefit election relating to such plan. My signature below acknowledges my elections for this plan year beginning July 1, 2020.

Any qualifying change in status and requests for cancellation of coverage must be reported to Meadowbrook Insurance Group. All changes or cancellations will take place on the first of the month following Cornerstone's receipt of the written request and documentation supporting such change. Should I fail to inform Meadowbrook Insurance Group, I understand that I will be required to wait until the next Open Enrollment. I further agree that any paperwork required to support a change in status will be supplied to Meadowbrook Insurance Group at the earliest point in time that it becomes available.

Date: _____ Signature: _____ Coverage Effective Date: _____ Vision: Yes/No

Highlights of Medical/Prescription Drug Plan Options

	HAP HMO	McLaren POS	Blue Cross Blue Shield Community
How Benefits are Provided	Primary Care Physician (PCP) directed benefits	PCP (Option A) and self-referred (Option B)	Participating providers (In-Network) and Out of
Deductible (calendar year)	$500 single/$1,000 family	Option A $500 single/$1,000 family	In-Network: $500 single/$1,000 family
4th quarter carry-forward (deductible met in last quarter of calendar year applied to the following year deductible)	Not Applicable	No	Yes
Coinsurance (Plan pays/employee pays)	80%/20%	Option A: 80%/20%	In-Network: 80%/20%
Coinsurance Maximum (calendar year)	$1,500 single/$3,000 family	Option A: $2,000 single/$4,000 family	In-Network: $1,500 single/$3,000 family
Preventive Care	100%, no deductible or copay	Option A: 100%, no deductible or copay	In-Network: 100%, no deductible or
Office Visit copay (Primary Care/Specialist)	$25/$50	Option A: $30/$30	In-Network: $30/$30
Emergency Room copay	$150	$100	$100
Rx copay (generic/brand on formulary/brand not on formulary)	Your copayment is the same as the Rx copayment plan in which you were enrolled prior to August 1, 2012. See Note below.	$10/$25/$50 30-day supply 1 copay for 90-day supply at Retail Pharmacy (contact McLaren) or, 2 copays for mail order	Your copayment is the same as the Rx copayment plan in which you were enrolled prior to August 1, 2012. See Note below.
Drug Management Programs	Some drugs require Prior Authorization, Step Therapy, Quantity Limits; mandatory Specialty Pharmacy	Some drugs require Prior Authorization, Step Therapy, Quantity Limits	Some drugs require Prior Authorization, Step Therapy, Quantity Limits
Annual Maximum Out of Pocket	$6,350 single/$12,700 family – includes deductibles, copays, and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if any.	Option A: $6,350 single/$12,700 family – includes deductibles, copays, and coinsurance amounts for all covered services – including cost- sharing amounts for prescription drugs, if any.	In-Network: $6,350 single/ $12,700 family – includes deductibles, copays, and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if any.

The benefits described above apply only to a retiree and/or eligible dependents who are not enrolled in Medicare. Coverage for persons enrolled in Medicare is provided under a Medicare Advantage plan from Blue Cross Blue Shield of Michigan or Health Alliance Plan.

Note: Please understand that your decision to change plans is an irrevocable one. For example, if you are currently enrolled in the Blue Cross Blue Shield medical plan with a $2 Rx copay and you decide to change to the HAP plan with the $20 generic/$40 preferred brand/ $60 non-preferred brand drug copay plan, you cannot go back to the BCBSM plan with $2 Rx copay at the next open enrollment.

INSURANCE COMPANY CONTACT INFORMATION

MEDICAL AND PRESCRIPTION DRUG PLAN
Health Alliance Plan HMO

800-422-4641
www.hap.org

McLaren Health Plan

888-327-0671
www.mclarenhealthplan.org

Blue Cross Blue Shield of Michigan (BCBSM)
(Prescription Drug, and non-Medicare medical)

800-356-6118
www.bcbsm.com
Blue Card program: 1-800-810-BLUE (2583)

VISION PLAN
MECA Vision

800-875-6322

For Additional Benefit Information
City of Flint Human Resource administration company Meadowbrook Insurance Agency

Meadowbrook Insurance Agency
City of Flint Retiree
Phone: 248-204-6100
Monday-Friday, 8:30 am–3:00 pm
Email:flintretiree@meadowbrook.com
FAX: 248-603-8435
26255 American Drive
Southfield, MI 48034

Blue Cross Blue Shield of Michigan

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

CITY OF FLINT
0070003040491 - 06H8M
Effective Date: 07/01/2020

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

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

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

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

ADM PLANYR JUL;ASCMOD 8054 MED;CB ASC;CB-AMB-XMHP ASC;CB-ECM-IN$1.5KA;CB-ECM-ON $3K A;CB-ET $100 ASC;CB-MTC $30 ASC;CB-OPMIN 6350 A;CB-OV $30 ASC;CB-XMHP ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD $1K-ON ASC;CBD $500-IN ASC;CBOPMON 12.7K A;DC 26-ME ASC;MHP-E;PDRX ASC;PDTTC104080RXCM;SD ASC

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

Eligibility Information

Members	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26
Sponsored dependents	• Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.

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

Benefits	In-network	Out-of-network
Deductible	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $30 copay for office visits and office consultations • $30 copay for medical online visits • $30 copay for chiropractic and osteopathic manipulative therapy • $100 copay for emergency room visits • $30 copay for urgent care visits	• $100 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 50% of approved amount for mental health care and substance use disorder treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 50% of approved amount for mental health care and substance use disorder treatment • 40% of approved amount for most other covered services
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays, mental health and substance use disorder services, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$1,500 for one member, $3,000 for the family (when two or more members are covered under your contract) each calendar year	$3,000 for one member, $6,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.

ADM PLANYR JUL;ASCMOD 8054 MED;CB ASC;CB-AMB-XMHP ASC;CB-ECM-IN$1.5KA;CB-ECM-ON $3K A;CB-ET $100 ASC;CB-MTC $30 ASC;CB-OPMIN 6350 A;CB-OV $30 ASC;CB-XMHP ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD $1K-ON ASC;CBD $500-IN ASC;CBOPMON 12.7K A;DC 26-ME ASC;MHP-E;PDRX ASC;PDTTC104080RXCM;SD ASC

Benefits	In-network	Out-of-network
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	$6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

ADM PLANYR JUL;ASCMOD 8054 MED;CB ASC;CB-AMB-XMHP ASC;CB-ECM-IN$1.5KA;CB-ECM-ON $3K A;CB-ET $100 ASC;CB-MTC $30 ASC;CB-OPMIN 6350 A;CB-OV $30 ASC;CB-XMHP ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD $1K-ON ASC;CBD $500-IN ASC;CBOPMON 12.7K A;DC 26-ME ASC;MHP-E;PDRX ASC;PDTTC104080RXCM;SD ASC

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Benefits	In-network	Out-of-network
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	$30 copay per office visit	60% after out-of-network deductible
Online visits - by physician must be medically necessary **Note:** Online visits by a vendor are not covered.	$30 copay per online visit	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	$30 copay per office consultation	60% after out-of-network deductible
Urgent care visits - must be medically necessary	$30 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$100 copay per visit (copay waived if admitted or for an accidental injury)	$100 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible

ADM PLANYR JUL;ASCMOD 8054 MED;CB ASC;CB-AMB-XMHP ASC;CB-ECM-IN$1.5KA;CB-ECM-ON $3K A;CB-ET $100 ASC;CB-MTC $30 ASC;CB-OPMIN 6350 A;CB-OV $30 ASC;CB-XMHP ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD $1K-ON ASC;CBD $500-IN ASC;CBOPMON 12.7K A;DC 26-ME ASC;MHP-E;PDRX ASC;PDTTC104080RXCM;SD ASC

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

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Benefits	In-network	Out-of-network
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	80% after in-network deductible Unlimited days	60% after out-of-network deductible
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	80% after in-network deductible Limited to a maximum of 120 days per member per calendar year	80% after in-network deductible
Hospice care	100% (no deductible or copay/coinsurance) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% (no deductible or copay/coinsurance)
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor	80% after in-network deductible	80% after in-network deductible

ADM PLANYR JUL;ASCMOD 8054 MED;CB ASC;CB-AMB-XMHP ASC;CB-ECM-IN$1.5KA;CB-ECM-ON $3K A;CB-ET $100 ASC;CB-MTC $30 ASC;CB-OPMIN 6350 A;CB-OV $30 ASC;CB-XMHP ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD $1K-ON ASC;CBD $500-IN ASC;CBOPMON 12.7K A;DC 26-ME ASC;MHP-E;PDRX ASC;PDTTC104080RXCM;SD ASC

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

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	80% after in-network deductible	60% after out-of-network deductible
Voluntary abortions	80% after in-network deductible	60% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Note: We do not pay for treatment for tobacco addictions.

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	50% after in-network deductible	50% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized • subject to medical criteria	Not covered	Not covered
Outpatient mental health care: • Facility and clinic	50% after in-network deductible	50% after in-network deductible in participating facilities **only**
• Online visits **Note:** Online visits by a vendor are not covered.	$30 copay per online visit	50% after out-of-network deductible
• Physician's office	50% (no deductible)	50% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	50% after in-network deductible	50% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

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

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	80% after in-network deductible	80% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$30 copay per visit	60% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
Durable medical equipment **Note:** DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

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BCBSM Preferred RX Program

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. AllianceRx Walgreens Prime will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay $10 copay	You pay $10 copay	You pay $10 copay	You pay $10 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $20 copay	No coverage	No coverage
	84 to 90-day period	You pay $20 copay	You pay $20 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay $40 copay	You pay $40 copay	You pay $40 copay	You pay $40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $80 copay	No coverage	No coverage
	84 to 90-day period	You pay $80 copay	You pay $80 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay $80 copay	You pay $80 copay	You pay $80 copay	You pay $80 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $160 copay	No coverage	No coverage
	84 to 90-day period	You pay $160 copay	You pay $160 copay	No coverage	No coverage

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Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs. * BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	No coverage	100% of approved amount	75% of approved amount
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

ADM PLANYR JUL;ASCMOD 8054 MED;CB ASC;CB-AMB-XMHP ASC;CB-ECM-IN$1.5KA;CB-ECM-ON $3K A;CB-ET $100 ASC;CB-MTC $30 ASC;CB-OPMIN 6350 A;CB-OV $30 ASC;CB-XMHP ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD $1K-ON ASC;CBD $500-IN ASC;CBOPMON 12.7K A;DC 26-ME ASC;MHP-E;PDRX ASC;PDTTC104080RXCM;SD ASC

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

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

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.
Drug interchange and generic copay/coinsurance waiver	BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits
AA002739 / XR000450 **HMO**

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$500 Individual; $1,000 Family	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	20%	N/A	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	$1,000 Individual; $2,000 Family	N/A	These values do not accumulate: premiums, balance-billed charges, deductibles, services with 50% coinsurance, copays, and health care this plan doesn't cover.
Annual Out-of-Pocket Maximum	$6,350 Individual; $12,700 Family	N/A	These values do not accumulate: premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$25 Copay - Deductible does not apply	N/A	
Telehealth Visit	$25 Copay - Deductible does not apply	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	$50 Copay - Deductible does not apply	N/A	
Audiology Office Visit	$50 Copay - Deductible does not apply	N/A	One routine hearing exam per benefit period at no cost share.
Eye Exam Office Visit	$50 Copay - Deductible does not apply	N/A	One routine eye exam per benefit period at no cost share.
Chiropractic Services	$50 Copay - Deductible does not apply	N/A	Manipulation of the spine for subluxation only; Up to 20 visits per benefit period.
Allergy Treatment	20% Coinsurance after deductible	N/A	
Allergy Injections	20% Coinsurance after deductible	N/A	
Laboratory & Pathology	20% Coinsurance after deductible	N/A	Some services require preauthorization.
Imaging MRI, CT & PET Scans	20% Coinsurance after deductible	N/A	Services require preauthorization.
Radiology (X-ray)	20% Coinsurance after deductible	N/A	Some services require preauthorization.
Radiation Therapy & Chemotherapy	20% Coinsurance after deductible	N/A	
Dialysis	20% Coinsurance after deductible	N/A	
Outpatient Surgical Services			
Outpatient Surgery	20% Coinsurance after deductible	N/A	
Ambulatory Surgical Center	20% Coinsurance after deductible	N/A	
Professional Surgical and Related Services	20% Coinsurance after deductible	N/A	
Emergency/Urgent Care			
Urgent Care	$75 Copay - Deductible does not apply		
Emergency Room Care	$150 Copay - Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	$100 Copay - Deductible does not apply		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	20% Coinsurance after deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	20% Coinsurance after deductible	N/A	
Bariatric Surgery and Related Services	20% Coinsurance after deductible	N/A	One procedure per lifetime
Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services
Postnatal Office Visits	$50 Copay - Deductible does not apply	N/A	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	

Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	$25 Copay - Deductible does not apply	N/A	
Other Services			
Home Health Care	20% Coinsurance after deductible	N/A	Does not include Rehabilitation Services; Up to 60 visits per benefit period.
Hospice Care	20% Coinsurance after deductible	N/A	Up to 210 days per lifetime.
Skilled Nursing Care	20% Coinsurance after deductible	N/A	Covered for authorized services; Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	20% Coinsurance after deductible	N/A	Covered for approved equipment only.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	20% Coinsurance after deductible	N/A	May be rendered at home; Up to 60 combined visits per benefit period.
Habilitation Services	20% Coinsurance after deductible	N/A	Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only. See Outpatient Mental Health for ABA cost sharing amount.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy.
Infertility Services	50% Coinsurance after deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	20% Coinsurance after deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$20 Copay 30 day supply, $40 Copay 90 day supply		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply.
Non-Preferred Generic Drugs	$20 Copay 30 day supply, $40 Copay 90 day supply		
Preferred Brand Drugs	$40 Copay 30 day supply, $80 Copay 90 day supply		
Non-Preferred Brand Drugs	$60 Copay 30 day supply, $120 Copay 90 day supply		
Preferred Specialty Drugs	$60 Copay 30 day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	$60 Copay 30 day supply at specialty pharmacy only		

- Elective hospital admissions require that HAP be notified prior to the admission. HAP must be notified within 48 hours of any emergency hospital admission. Failure to notify HAP could result in a reduction of benefits or nonpayment.
- Students away at school are covered for acute illness and injury related services according to HAP criteria.
- In case of conflict between this summary and your HMO Subscriber Contract and Riders, the terms and conditions of the HMO Subscriber Contract and Riders will govern.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.

McLaren HEALTH PLAN COMMUNITY

CITY OF FLINT
190065 POS PLAN 2
2020 POS Summary of Benefits

	Option A Benefit	Option B Benefit
	Option A benefits provide the highest level of coverage. In most cases, to receive Option A benefits a Member must obtain services from a Participating Provider and obtain any necessary Preauthorization from MHP Community.	Option B benefits allow the member to receive covered services from a non-Participating Provider. Member cost sharing is higher and provider balance billing may apply. Many services require Preauthorization from MHP Community in order for them to be covered. If the service is noted to be Not Covered, there is no Option B benefit.
Deductibles, Co-payments and Dollar Maximums		
Annual Deductible	$500/$1000	$3000/$6000
Coinsurance	After deductible 20% coinsurance	After deductible 30% coinsurance
Coinsurance Annual Out-of-Pocket Maximum	$2000/$4000	$3000/$6000
Total Annual Out-of-Pocket Maximum	$7350/$14700	Unlimited
Physician Office Visits		
Physician Office Visits	$30 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Specialist Office Visit	$30 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Preventive Services		
Preventive Services as defined by the US Preventive Services Task Force. Examples of Preventive Services: • Well child visits • Certain Immunizations • Certain assessments and screenings for children and for adults • Breast cancer screening	No member cost sharing	After deductible 30% coinsurance Provider balance bill may apply
Emergency Care		
Hospital Emergency Room	$100 co-pay - no deductible (Copayment waived if admitted)	$100 co-pay - no deductible Provider balance bill may apply (Copayment waived if admitted)
Urgent Care Center	$50 co-pay - no deductible	$50 co-pay - no deductible Provider balance bill may apply
Physician's Office	$30 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Medically Necessary Ambulance Services - Ground and Air	After deductible 20% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Hospital Services		
Inpatient Hospital Services Semi-private room; surgery and related services; anesthesia, laboratory and radiology; chemotherapy, inhalation therapy; hemodialysis; physical, speech and occupational therapy; transplant services; maternity care (hospital only); physician services including consultation	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Outpatient Hospital Services Outpatient surgery and nuclear medicine	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Outpatient MRI, MRA, CAT, and PET scans	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Diagnostic and Therapeutic Services and Tests		
Laboratory Tests (Note: Preventive Laboratory Tests are covered under Preventive Services above)	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Diagnostic X-ray	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply

McLaren HEALTH PLAN COMMUNITY

CITY OF FLINT
190065 POS PLAN 2
2020 POS Summary of Benefits

	Option A Benefit	Option B Benefit
	Option A benefits provide the highest level of coverage. In most cases, to receive Option A benefits a Member must obtain services from a Participating Provider and obtain any necessary Preauthorization from MHP Community.	Option B benefits allow the member to receive covered services from a non-Participating Provider. Member cost sharing is higher and provider balance billing may apply. Many services require Preauthorization from MHP Community in order for them to be covered. If the service is noted to be Not Covered, there is no Option B benefit.
Special Surgical Procedures		
Surgical fees for: Bariatric surgery, reduction mammoplasty, blepharoplasty of upper eyelids, panniculectomy, surgical treatment of male gynecomastia, procedures to correct obstructive sleep apnea	After deductible 50% coinsurance	Not Covered
Alternatives to Hospital Care		
Skilled Nursing Care	After deductible 20% coinsurance Benefit maximum: 60 days per year	Not Covered
Home Health Care	After deductible 20% coinsurance Benefit maximum: 60 visits per episode per year	Not Covered
Hospice Care	After deductible covered at 100%	Not Covered
Mental Health and Substance Abuse Services		
Inpatient Mental Health (including Partial Hospitalization and Residential Mental Health Treatment)	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Inpatient Substance Abuse Treatment (including Intensive Inpatient, Partial Hospitalization, and Residential Treatment)	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Outpatient Mental Health	$30 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Outpatient Substance Abuse Services	$30 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Other Services		
Outpatient Rehabilitation Services – Physical, Occupational and Speech Therapies	After deductible 20% coinsurance Benefit maximum: 60 visits per condition per year	After deductible 30% coinsurance Provider balance bill may apply Benefit maximum: 60 visits per condition per year
Outpatient Habilitative Services - Physical and Occupational Therapy, Applied Behavioral Analysis (ABA) for treatment of Autism Spectrum Disorder and Speech Therapies	After deductible 20% coinsurance Benefit maximum: 30 visits per year for all services except ABA for treatment of Autism	After deductible 30% coinsurance Provider balance bill may apply Benefit maximum: 30 visits per year for all services except ABA for treatment of Autism
Chiropractic Spinal Manipulation/Treatment	0% coinsurance - no deductible Benefit maximum: $1000 per person per year	0% coinsurance - no deductible Provider balance bill may apply Benefit maximum: $1000 per person per year
Durable Medical Equipment	After deductible 20% coinsurance	Not Covered
Prosthetics, Orthotics and Corrective Appliances	After deductible 20% coinsurance	Not Covered
Infertility Treatment and Counseling	After deductible 50% coinsurance	Not Covered
Voluntary Termination of Pregnancy	Not Covered	Not Covered
Reproductive Care and Family Planning Services and Genetic Testing	$30 co-pay - no deductible	Not Covered
Oral Surgery	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Temporomandibular Joint Syndrome (TMJ) Treatment (surgical fees)	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Orthognathic Surgery (surgical fees)	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Antineoplastic Drugs	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Pain Management	$30 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply

McLaren
HEALTH PLAN COMMUNITY

CITY OF FLINT
190065 POS PLAN 2
2020 POS Summary of Benefits

	Retail	Mail Order
Prescription Drugs		
Generic	$10 co-pay	$20 co-pay
Formulary	Brand: $25 co-pay	Brand: $50 co-pay
	Brand - Generic Available: $25 co-pay plus difference in cost between Brand and Generic	Brand - Generic Available: $50 co-pay plus difference in cost between Brand and Generic
Non-Formulary*	$50 co-pay	$100 co-pay
Specialty**	$50 co-pay	

***Prior Authorization or Step Therapy required.**

****Specialty Drugs must be filled at an MHP Community Preferred Specialty Pharmacy. Specialty Drugs are limited to a 30-day supply.**

This Summary of Benefits is intended only to highlight the benefits provided by McLaren Health Plan Community and should not be relied upon to fully determine coverage. This health plan may not cover all health care expenses. Please refer to the McLaren Health Plan Community Certificate of Coverage for a complete listing of covered services, limitations and exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Certificate issued to the enrolling group, the Certificate will prevail. For answers to questions about information that appears in the summary, call Customer Service at (888) 327-0671.

This proposal is contingent upon:

* Employer contribution of at least 50% of the single rate.
* The benefits or service requirements requested and/or quoted do not change prior to or after the effective date.
* No changes in federal, state or other applicable legislation or regulation requiring changes to this proposal.
* The accuracy of the information provided regarding current benefit options, rate ratios and census data.
* MHP Community's right to adjust the SIC assignments as well as the rates in this proposal.
* State regulatory approval of rates.

***PENDING DIFS APPROVAL**

CITY OF FLINT RETIREE

VISION PLAN HIGHLIGHTS

Updated 05/11

Mutual Eye Claim Audits, Inc.
P.O. Box 17190
Indianapolis, In 46217
1-800-875-6322 * 317-862-2500

YOUR MECA VISION PLAN MAKES A VISIBLE DIFFERENCE:

Access to any Provider across the Nation allowing Freedom of Choice

Access to an extensive Network of Providers
- Ophthalmologists
- Optometrists
- Opticians
- National Chains
- Providers who offer 1 hour service

Access to eye exams that can detect systemic health problems

Access to an excellent vision plan that discounts your eye exam and lenses

Access to a non-automated customer service department Monday through Friday, 8:00am-4:30pm.

ELIGIBILITY

You are eligible for vision care benefits described herein provided you are a retired employee who has completed at least one year. Per the rules and regulations a retiree must have enrolled in the vision plan. A retiree and their dependents, which have been retired for at least one year, will be eligible on the next birth month of the retiree following one year of retirement. Spouses are eligible provided he/she is not legally separated and enrolled in the plan. Unmarried dependent children under 19 years of age and adult dependents age 19-23 years old who are unmarried and full time students are eligible to be enrolled in the plan.

BENEFIT FREQUENCY

Adults	Once every 24 consecutive months.
Children under age 19	Once every 12 consecutive months.
Full time students age 19-23	Once every 24 consecutive months.
Physically or mentally disabled	Once every 24 consecutive months.

MATERIALS

Glasses or contacts are once every benefit period. Contacts are in lieu of ALL benefits including exam.

3-STAR NETWORK FEE SCHEDULE

	Patient allowance	Patient pays
Exam	50% Co-payment	50% Co-payment
Lenses*		
Single	50% Co-payment	50% Co-payment
Bifocal	50% Co-payment	50% Co-payment
Trifocal	50% Co-payment	50% Co-payment
Standard Progressive	50% Co-payment	50% Co-payment
Frame* Up to $33.00	Paid in Full	-0-
Over $33.00 up to $130.00	45% of retail price	55% of retail price
Over $130.00	20% of retail price	80% of retail price
Contacts and Exam	$60.00	Balance
Conventional Lenses	15% Discount	85% of retail price
UV Coating	-0-	$12.00
Tint (Solid & Gradient)	-0-	$12.00
Standard Scratch-Resistance	-0-	$15.00
Standard Polycarbonate	-0-	$35.00
Standard Anti-Reflective	-0-	$45.00
Other Add-ons and Services (20% discount)	-0-	80% of materials

*Purchases of additional eyewear are discounted at 25%.

2-STAR NETWORK FEE SCHEDULE

	Patient allowance	Patient pays
Exam	50% Co-payment	50% Co-payment
Lenses*		
Single	50% Co-payment	50% Co-payment
Bifocal	50% Co-payment	50% Co-payment
Trifocal	50% Co-payment	50% Co-payment
Standard Progressive	50% Co-payment	50% Co-payment
Frame* Up to $22.50	Paid in Full	-0-
Over $22.50 up to $130.00	20% of retail price	80% of retail price
Contacts and Exam	$60.00	Balance
Conventional Lenses	15% Discount	85% of Balance
Extras*		
UV Coating	-0-	80% of services
Tint (Solid & Gradient)	-0-	80% of services
Standard Scratch-Resistance	-0-	80% of services
Standard Polycarbonate	-0-	80% of services
Standard Anti-Reflective	-0-	80% of services
Other Add-ons and Services	-0-	80% of services

1-STAR FEE SCHEDULE

	Patient allowance	Patient pays
Exam		
M.D.	50% Co-payment	50% Co-payment
O.D.	50% Co-payment	50% Co-payment
Lenses*		
Single	50% Co-payment	50% Co-payment
Bifocal	50% Co-payment	50% Co-payment
Trifocal	50% Co-payment	50% Co-payment
Standard Progressive	$52.50	Balance
Frame*	$18.00	Balance
Contacts and Exam	$60.00	Balance
Extras*		
UV Coating	-0-	Balance
Tint (Solid & Gradient)	-0-	Balance
Standard Scratch-Resistance	-0-	Balance
Standard Polycarbonate	-0-	Balance
Standard Anti-Reflective	-0-	Balance
Other Add-ons and Services	-0-	Balance

OUT-OF-NETWORK SCHEDULE

	Patient allowance	Patient pays
Exam		
M.D.	$36.00	Balance
O.D.	$25.00	Balance
Lenses*		
Single	$30.00	Balance
Bifocal	$42.50	Balance
Trifocal	$52.50	Balance
Standard Progressive	$52.50	Balance
Frame*	$18.00	Balance
Contacts and Exam	$60.00	Balance
Extras*		
UV Coating	-0-	Balance
Tint (Solid & Gradient)	-0-	Balance
Standard Scratch-Resistance	-0-	Balance
Standard Polycarbonate	-0-	Balance
Standard Anti-Reflective	-0-	Balance
Other Add-ons and Services	-0-	Balance

HOW TO USE YOUR BENEFITS

MECA Network Providers

1. Schedule an appointment with your provider
   - Verify Provider is a MECA participant to receive maximum benefits
   - Give Provider the Employees Social Security Number, Patients name and date of birth. Inform them of your employment with the City of Flint.
2. Upon receiving services, MECA and your Provider will do the rest.
   - The Provider fill out form and send to MECA
   - Pay the Provider for service not covered by this Plan*

If You Select a Out-Of-Network Provider

1. Call MECA to verify your eligibility status.
2. Submit an itemized receipt or the doctor's generic claim form with your employer's name, the social security number, address and patient information listed on the receipt.
3. Make an appointment with the doctor of your choice.
   - After the examination, pay the required fees for services rendered.
   - Submit the completed claim form, or itemized receipts with all required charges. MECA will then reimburse the employee.

Reimbursement for approved claims will be mailed to you within 30 days after receiving a properly executed claim form. You will be reimbursed per the authorized schedule for out-of-network providers.

- Contact MECA at 1-800-875-6322 for complete eligibility and benefit information.

PLAN EXCLUSIONS AND LIMITATIONS

The vision plan is designed to cover your vision requirements rather than cosmetic purposes. An additional charge may be made if you select any of the following:

1. Additional charges for oversize, tinted, coated lenses or any "extra" added to the lens.
2. Additional charges for blended, progressive or executive lenses.
3. The cost of a frame or contact lenses in excess of the plan allowance.
4. More than one pair of glasses or contact lenses.
5. Charges over the standard 65mm single vision, D 25 & 28 bifocals and 7x25 & 7x28 trifocals.
6. Glasses that do not require a prescription.
7. Medical or surgical treatment of the eye and/or medication for the eye.
8. Special procedures, such as vision training, sub-normal vision aids or non-prescription lenses.
9. Services or materials provided as a result of any Workman's Compensation Law.
10. Exams and/or materials ordered:
    a) Before coverage begins or after termination;
    b) or services obtained without cost.

CITY OF FLINT

BENEFIT ELECTION FORM FOR RETIREES – Non Lit. DHNG3 Retired 06/26/2012-06/30/2014

RETIREE INFORMATION		☐ CHECK BOX IF ANY OF THE INFORMATION BELOW HAS CHANGED	
Name		Social Security #	☐ Male ☐ Female
Address (number & street)		City	State / ZIP Code
Date of Birth	Primary Phone ( )	Marital Status ☐ Single ☐ Married ☐ Divorced	Medicare Eligibility (provide copy of card(s)) ☐ Part A ☐ Part B ☐ Part A & B

If Medicare Eligible a Medicare Advantage Enrollment Form Will Also Need to Be Completed

LIST THE DEPENDENTS YOU WISH TO HAVE COVERED BELOW – USE AN ADDITIONAL PAGE, IF NEEDED

NAME	BIRTH DATE	GENDER	RELATIONSHIP	SSN	ADD/DROP CHANGE COVERAGE	OTHER COVERAGE? YES or NO

1. MEDICAL AND PRESCRIPTION DRUG PLAN (EFFECTIVE JULY 1, 2020)

COVERAGE	OPTIONS	MONTHLY CONTRIBUTION					
	Circle the option of your choice below:	One Person Non-Medicare	2 Person Non-Medicare	Family Non-Medicare	Medicare Per Person	Members Enrolled In Medicare	
Select the option and coverage level of your choice. A completed carrier form is required if you are making any changes.	• Blue Cross Blue Shield	$92.76	$222.61	$278.26	$0.00		$_____ Monthly Contribution
	• Health Alliance Plan (HAP)	$89.39	$186.95	$243.80	$0.00	_____	
	• McLaren	$119.60	$284.94	$318.84	N/A		
	• Waive – No Coverage	$0.00	$0.00	$0.00	$0.00		

To calculate your Monthly Contribution, add the rate for Non-Medicare coverage and the rate for Medicare coverage. Please note that the Medicare rate is calculated by the amount in the "Medicare Per Person" column times the number of family members enrolled in Medicare.

Example #1: Coverage with BCBS. Retiree is not enrolled in Medicare and the Spouse is not enrolled in Medicare – Coverage level is "2 Person Non-Medicare" The total Monthly Contribution would be $222.61.

Example #2: Coverage with BCBS. Retiree is not enrolled in Medicare and the Spouse is enrolled in Medicare – Coverage level is "One Person Non-Medicare" in the amount of $92.76 PLUS "Medicare Per Person" in the amount of $0.00. The total Monthly Contribution would be $92.76.

Example #3: Coverage with BCBS. Retiree is not enrolled in Medicare and the Spouse and Child are enrolled in Medicare – Coverage level is "One Person Non-Medicare" in the amount of $92.76 PLUS "Medicare Per Person" times 2 in the amount of $0.00 ($0.00 per Medicare member). The total Monthly Contribution would be $92.76.

2. YOUR SIGNATURE

The following actions are prohibited:

- Attempting to submit a claim for benefits which includes attempting to fill a prescription for a person who is not eligible under this plan
- Attempting to file a claim for a participant for services which were not rendered for drugs or other items which were not provided
- Providing false or misleading information in connection with enrollment in the plan
- Providing any false or misleading information to the plan

I understand that if I partake in the actions listed above, such actions, or the knowledge of such actions taken by another, constitute fraud and will result in termination of all coverage under this plan in accordance with applicable law and insurance company policy/procedure.

I understand that I cannot change these benefit elections unless I notify Meadowbrook Insurance Agency **within 30 days** after I experience a qualifying change in status (such as marriage, divorce, death of a spouse or a child, birth or adoption of a child) and the insurance carrier approves such a change. I agree to pay the amount necessary to satisfy the required contribution I am expected to pay toward the cost of coverage. This agreement is subject to the terms of the City's contribution plan as amended from time to time, and shall be governed by and construed in accordance with applicable laws. This benefit election form revokes any prior benefit election relating to such plan. My signature below acknowledges my elections for this plan year beginning July 1, 2020.

Any qualifying change in status and requests for cancellation of coverage must be reported to Meadowbrook Insurance Agency. All changes or cancellations will take place on the first of the month following Meadowbrook's receipt of the written request and documentation supporting such change. Should I fail to inform Meadowbrook Insurance Agency, I understand that I will be required to wait until the next Open Enrollment. I further agree that any paperwork required to support a change in status will be supplied to Meadowbrook Insurance Agency at the earliest point in time that it becomes available.

Date: _____ Signature: _____

Highlights of Medical/Prescription Drug Plan Options

	HAP HMO	McLaren POS	Blue Cross Blue Shield Community Blue PPO
How Benefits are Provided	Primary Care Physician (PCP) directed benefits	PCP (Option A) and self-referred (Option B)	Participating providers (In-Network) and Out of Network
Deductible (calendar year)	$1,000 single/$2,000 family	Option A $1,000 single/$2,000	In-Network: $1,000 single/$2,000 family
4th quarter carry-forward (deductible met in last quarter of calendar year applied to the following year deductible)	Not Applicable	family No	Yes
Coinsurance (Plan pays/employee pays)	80%/20%	Option A: 80%/20%	In-Network: 80%/20%
Coinsurance Maximum (calendar year)	$3,000 single/$6,000 family	Option A: $2,000 single/$4,000 family	In-Network: $2,500 single/$5,000 family
Preventive Care	100%, no deductible or copay	Option A: 100%, no deductible or copay	In-Network: 100%, no deductible or copay
Office Visit copay (Primary Care/Specialist)	$25/$50	Option A: $30/$30	In-Network: $30/$30
Emergency Room copay	$150	$100	$100
Rx copay (generic/brand on formulary/brand not on formulary)	Your copayment is the same as the Rx copayment plan in which you were enrolled prior to August 1, 2012. See Note below.	$10/$25/$50 30 day supply 1 copay for 90 day supply at Retail Pharmacy (contact McLaren) or, 2 copays for mail order	Your copayment is the same as the Rx copayment plan in which you were enrolled prior to August 1, 2012. See Note below.
Drug Management Programs	Some drugs require Prior Authorization, Step Therapy, Quantity Limits; mandatory Specialty Pharmacy	Some drugs require Prior Authorization, Step Therapy, Quantity Limits	Some drugs require Prior Authorization, Step Therapy, Quantity Limits
Annual Maximum Out of Pocket	$6,350 single/$12,700 family – includes deductibles, copays, and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if any.	Option A: $6,350 single/$12,700 family – includes deductibles, copays, and coinsurance amounts for all covered services – including cost- sharing amounts for prescription drugs, if any.	In-Network: $6,350 single/ $12,700 family – includes deductibles, copays, and coinsurance amounts for all covered services – including cost-sharing amounts for prescription drugs, if any.

The benefits described above apply only to a retiree and/or eligible dependents who are not enrolled in Medicare. Coverage for persons enrolled in Medicare is provided under a Medicare Advantage plan from Blue Cross Blue Shield of Michigan or Health Alliance Plan.

Note: Please understand that your decision to change plans is an irrevocable one. For example, if you are currently enrolled in the Blue Cross Blue Shield medical plan with a $2 Rx copay and you decide to change to the HAP plan with the $20 generic/$40 preferred brand/$60 non-preferred brand drug copay plan, you cannot go back to the BCBSM plan with $2 Rx copay at the next open enrollment.

INSURANCE COMPANY CONTACT INFORMATION

MEDICAL AND PRESCRIPTION DRUG PLAN

Health Alliance Plan HMO — 800-422-4641
www.hap.org

McLaren Health Plan — 888-327-0671
www.mclarenhealthplan.org

Blue Cross Blue Shield of Michigan (BCBSM)
(Prescription Drug, and non-Medicare medical) — 800-356-6118
www.bcbsm.com
Blue Card program: 1-800-810-BLUE (2583)

VISION PLAN

MECA Vision — 800-875-6322

For Additional Benefit Information

City of Flint Human Resource Administration
Company Meadowbrook Insurance Agency

Meadowbrook Insurance Agency
City of Flint Retiree
Phone: 248-204-6100
Monday-Friday, 8:30 am – 3:00 pm
Email: flintretiree@meadowbrook.com
FAX: 248-603-8435
26255 American Drive
Southfield, MI 48034

Blue Cross Blue Shield of Michigan

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

CITY OF FLINT
0070003040492 - 06H8K
Effective Date: 07/01/2020

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

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

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.**

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

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

ADM PLANYR JUL;ASCMOD 8281 MED;CB ASC;CB-AMB-XMHP ASC;CB-ECM-IN$2.5KA;CB-ECM-ON $5K A;CB-ET $100 ASC;CB-MTC $30 ASC;CB-OV $30 ASC;CB-XMHP ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD $1K-IN ASC;CBD $2K-ON ASC;CBOPM$13700;CBOPMIN6850 ASC;DC 26-ME ASC;MHP-E;PDRX ASC;PDTTC104080RXCM;SD ASC

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

Eligibility Information

Members	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26
Sponsored dependents	• Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.

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

Benefits	In-network	Out-of-network
Deductible	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.	$2,000 for one member, $4,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $30 copay for office visits and office consultations • $30 copay for medical online visits • $30 copay for chiropractic and osteopathic manipulative therapy • $100 copay for emergency room visits • $30 copay for urgent care visits	• $100 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 50% of approved amount for private duty nursing care • 50% of approved amount for mental health care and substance use disorder treatment • 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office)	• 50% of approved amount for private duty nursing care • 50% of approved amount for mental health care and substance use disorder treatment • 40% of approved amount for most other covered services
Annual coinsurance maximums - applies to coinsurance amounts for all covered services but does not apply to deductibles, flat-dollar copays, mental health and substance use disorder coinsurance, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$2,500 for one member, $5,000 for the family (when two or more members are covered under your contract) each calendar year	$5,000 for one member, $10,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.

ADM PLANYR JUL;ASCMOD 8281 MED;CB ASC;CB-AMB-XMHP ASC;CB-ECM-IN$2.5KA;CB-ECM-ON $5K A;CB-ET $100 ASC;CB-MTC $30 ASC;CB-OV $30 ASC;CB-XMHP ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD $1K-IN ASC;CBD $2K-ON ASC;CBOPM$13700;CBOPMIN6850 ASC;DC 26-ME ASC;MHP-E;PDRX ASC;PDTTC104080RXCM;SD ASC

Benefits	In-network	Out-of-network
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	$6,850 for one member, $13,700 for the family (when two or more members are covered under your contract) each calendar year	$13,700 for one member, $27,400 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

ADM PLANYR JUL;ASCMOD 8281 MED;CB ASC;CB-AMB-XMHP ASC;CB-ECM-IN$2.5KA;CB-ECM-ON $5K A;CB-ET $100 ASC;CB-MTC $30 ASC;CB-OV $30 ASC;CB-XMHP ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD $1K-IN ASC;CBD $2K-ON ASC;CBOPM$13700;CBOPMIN6850 ASC;DC 26-ME ASC;MHP-E;PDRX ASC;PDTTC104080RXCM;SD ASC

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Benefits	In-network	Out-of-network
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	$30 copay per office visit	60% after out-of-network deductible
Online visits - by physician must be medically necessary **Note:** Online visits by a vendor are not covered.	$30 copay per online visit	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	$30 copay per office consultation	60% after out-of-network deductible
Urgent care visits - must be medically necessary	$30 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$100 copay per visit (copay waived if admitted or for an accidental injury)	$100 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible

ADM PLANYR JUL;ASCMOD 8281 MED;CB ASC;CB-AMB-XMHP ASC;CB-ECM-IN$2.5KA;CB-ECM-ON $5K A;CB-ET $100 ASC;CB-MTC $30 ASC;CB-OV $30 ASC;CB-XMHP ASC;CBC 20%-IN ASC;CBC 40%-ON ASC;CBD $1K-IN ASC;CBD $2K-ON ASC;CBOPM$13700;CBOPMIN6850 ASC;DC 26-ME ASC;MHP-E;PDRX ASC;PDTTC104080RXCM;SD ASC

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

Benefits	In-network	Out-of-network
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	80% after in-network deductible	60% after out-of-network deductible
Note: Nonemergency services must be rendered in a **participating** hospital.	Unlimited days	
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a **participating** skilled nursing facility	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor	80% after in-network deductible	80% after in-network deductible

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Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	80% after in-network deductible	60% after out-of-network deductible
Voluntary abortions	80% after in-network deductible	60% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Note: We do not pay for treatment for tobacco addictions.

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	50% after in-network deductible	50% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • treatment **must** be preauthorized • subject to medical criteria	Not covered	Not covered
Outpatient mental health care: • Facility and clinic	50% after in-network deductible	50% after in-network deductible in participating facilities **only**
• Online visits **Note:** Online visits by a vendor are not covered.	$30 copay per online visit	50% after out-of-network deductible
• Physician's office	50% (no deductible)	50% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	50% after in-network deductible	50% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

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

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization **Note:** Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	80% after in-network deductible	80% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$30 copay per visit	60% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member per calendar year	
Durable medical equipment **Note:** DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

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BCBSM Preferred RX Program

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. AllianceRx Walgreens Prime will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay $10 copay	You pay $10 copay	You pay $10 copay	You pay $10 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $20 copay	No coverage	No coverage
	84 to 90-day period	You pay $20 copay	You pay $20 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay $40 copay	You pay $40 copay	You pay $40 copay	You pay $40 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $80 copay	No coverage	No coverage
	84 to 90-day period	You pay $80 copay	You pay $80 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay $80 copay	You pay $80 copay	You pay $80 copay	You pay $80 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $160 copay	No coverage	No coverage
	84 to 90-day period	You pay $160 copay	You pay $160 copay	No coverage	No coverage

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Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs. * BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	No coverage	100% of approved amount	75% of approved amount
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug

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

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.
Drug interchange and generic copay/coinsurance waiver	BCBSM's drug interchange and generic copay/coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/coinsurance. In select cases BCBSM may waive the initial copay/coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits
AA002736 **HMO**

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,000 Individual; $2,000 Family	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	20%	N/A	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	$3,000 Individual; $6,000 Family	N/A	These values do not accumulate: premiums, balance-billed charges, deductibles, services with 50% coinsurance, copays, and health care this plan doesn't cover.
Annual Out-of-Pocket Maximum	$6,850 Individual; $13,700 Family	N/A	These values do not accumulate: premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$25 Copay - Deductible does not apply	N/A	
Telehealth Visit	$25 Copay - Deductible does not apply	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	$50 Copay - Deductible does not apply	N/A	
Audiology Office Visit	$50 Copay - Deductible does not apply	N/A	One routine hearing exam per benefit period at no cost share.
Eye Exam Office Visit	$50 Copay - Deductible does not apply	N/A	One routine eye exam per benefit period at no cost share.
Chiropractic Services	$50 Copay - Deductible does not apply	N/A	Manipulation of the spine for subluxation only; Up to 20 visits per benefit period.
Allergy Treatment	20% Coinsurance after deductible	N/A	
Allergy Injections	20% Coinsurance after deductible	N/A	
Laboratory & Pathology	20% Coinsurance after deductible	N/A	Some services require preauthorization.
Imaging MRI, CT & PET Scans	20% Coinsurance after deductible	N/A	Services require preauthorization.
Radiology (X-ray)	20% Coinsurance after deductible	N/A	Some services require preauthorization.
Radiation Therapy & Chemotherapy	20% Coinsurance after deductible	N/A	
Dialysis	20% Coinsurance after deductible	N/A	
Outpatient Surgical Services			
Outpatient Surgery	20% Coinsurance after deductible	N/A	
Ambulatory Surgical Center	20% Coinsurance after deductible	N/A	
Professional Surgical and Related Services	20% Coinsurance after deductible	N/A	
Emergency/Urgent Care			
Urgent Care	$75 Copay - Deductible does not apply		
Emergency Room Care	$150 Copay - Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	$100 Copay - Deductible does not apply		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	20% Coinsurance after deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	20% Coinsurance after deductible	N/A	
Bariatric Surgery and Related Services	20% Coinsurance after deductible	N/A	One procedure per lifetime
Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services
Postnatal Office Visits	$50 Copay - Deductible does not apply	N/A	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	

Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	$25 Copay - Deductible does not apply	N/A	
Other Services			
Home Health Care	20% Coinsurance after deductible	N/A	Does not include Rehabilitation Services; Up to 60 visits per benefit period.
Hospice Care	20% Coinsurance after deductible	N/A	Up to 210 days per lifetime.
Skilled Nursing Care	20% Coinsurance after deductible	N/A	Covered for authorized services; Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	20% Coinsurance after deductible	N/A	Covered for approved equipment only.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	20% Coinsurance after deductible	N/A	May be rendered at home; Up to 60 combined visits per benefit period.
Habilitation Services	20% Coinsurance after deductible	N/A	Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only. See Outpatient Mental Health for ABA cost sharing amount.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy.
Infertility Services	50% Coinsurance after deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	20% Coinsurance after deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$20 Copay 30 day supply, $40 Copay 90 day supply		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply.
Non-Preferred Generic Drugs	$20 Copay 30 day supply, $40 Copay 90 day supply		
Preferred Brand Drugs	$40 Copay 30 day supply, $80 Copay 90 day supply		
Non-Preferred Brand Drugs	$60 Copay 30 day supply, $120 Copay 90 day supply		
Preferred Specialty Drugs	$60 Copay 30 day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	$60 Copay 30 day supply at specialty pharmacy only		

- Elective hospital admissions require that HAP be notified prior to the admission. HAP must be notified within 48 hours of any emergency hospital admission. Failure to notify HAP could result in a reduction of benefits or nonpayment.
- Students away at school are covered for acute illness and injury related services according to HAP criteria.
- In case of conflict between this summary and your HMO Subscriber Contract and Riders, the terms and conditions of the HMO Subscriber Contract and Riders will govern.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.

McLaren HEALTH PLAN COMMUNITY

CITY OF FLINT
190065 POS PLAN 1
2020 POS Summary of Benefits

	Option A Benefit	Option B Benefit
	Option A benefits provide the highest level of coverage. In most cases, to receive Option A benefits a Member must obtain services from a Participating Provider and obtain any necessary Preauthorization from MHP Community.	Option B benefits allow the member to receive covered services from a non-Participating Provider. Member cost sharing is higher and provider balance billing may apply. Many services require Preauthorization from MHP Community in order for them to be covered. If the service is noted to be Not Covered, there is no Option B benefit.
Deductibles, Co-payments and Dollar Maximums		
Annual Deductible	$1000/$2000	$3000/$6000
Coinsurance	After deductible 20% coinsurance	After deductible 30% coinsurance
Coinsurance Annual Out-of-Pocket Maximum	$2000/$4000	$3000/$6000
Total Annual Out-of-Pocket Maximum	$7350/$14700	Unlimited
Physician Office Visits		
Physician Office Visits	$30 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Specialist Office Visit	$30 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Preventive Services		
Preventive Services as defined by the US Preventive Services Task Force. Examples of Preventive Services: • Well child visits • Certain Immunizations • Certain assessments and screenings for children and for adults • Breast cancer screening	No member cost sharing	After deductible 30% coinsurance Provider balance bill may apply
Emergency Care		
Hospital Emergency Room	$100 co-pay - no deductible (Copayment waived if admitted)	$100 co-pay - no deductible Provider balance bill may apply (Copayment waived if admitted)
Urgent Care Center	$50 co-pay - no deductible	$50 co-pay - no deductible Provider balance bill may apply
Physician's Office	$30 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Medically Necessary Ambulance Services - Ground and Air	After deductible 20% coinsurance	After deductible 20% coinsurance Provider balance bill may apply
Hospital Services		
Inpatient Hospital Services Semi-private room; surgery and related services; anesthesia, laboratory and radiology; chemotherapy, inhalation therapy; hemodialysis; physical, speech and occupational therapy; transplant services; maternity care (hospital only); physician services including consultation	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Outpatient Hospital Services Outpatient surgery and nuclear medicine	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Outpatient MRI, MRA, CAT, and PET scans	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Diagnostic and Therapeutic Services and Tests		
Laboratory Tests (Note: Preventive Laboratory Tests are covered under Preventive Services above)	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Diagnostic X-ray	After deductible 0% coinsurance	After deductible 30% coinsurance Provider balance bill may apply

McLaren
HEALTH PLAN COMMUNITY

CITY OF FLINT
190065 POS PLAN 1
2020 POS Summary of Benefits

	Option A Benefit	Option B Benefit
	Option A benefits provide the highest level of coverage. In most cases, to receive Option A benefits a Member must obtain services from a Participating Provider and obtain any necessary Preauthorization from MHP Community.	Option B benefits allow the member to receive covered services from a non-Participating Provider. Member cost sharing is higher and provider balance billing may apply. Many services require Preauthorization from MHP Community in order for them to be covered. If the service is noted to be Not Covered, there is no Option B benefit.
Special Surgical Procedures		
Surgical fees for: Bariatric surgery, reduction mammoplasty, blepharoplasty of upper eyelids, panniculectomy, surgical treatment of male gynecomastia, procedures to correct obstructive sleep apnea	After deductible 50% coinsurance	Not Covered
Alternatives to Hospital Care		
Skilled Nursing Care	After deductible 20% coinsurance Benefit maximum: 60 days per year	Not Covered
Home Health Care	After deductible 20% coinsurance Benefit maximum: 60 visits per episode per year	Not Covered
Hospice Care	After deductible covered at 100%	Not Covered
Mental Health and Substance Abuse Services		
Inpatient Mental Health (including Partial Hospitalization and Residential Mental Health Treatment)	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Inpatient Substance Abuse Treatment (including Intensive Inpatient, Partial Hospitalization, and Residential Treatment)	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Outpatient Mental Health	$30 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Outpatient Substance Abuse Services	$30 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply
Other Services		
Outpatient Rehabilitation Services – Physical, Occupational and Speech Therapies	After deductible 20% coinsurance Benefit maximum: 60 visits per condition per year	After deductible 30% coinsurance Provider balance bill may apply Benefit maximum: 60 visits per condition per year
Outpatient Habilitative Services - Physical and Occupational Therapy, Applied Behavioral Analysis (ABA) for treatment of Autism Spectrum Disorder and Speech Therapies	After deductible 20% coinsurance Benefit maximum: 30 visits per year for all services except ABA for treatment of Autism	After deductible 30% coinsurance Provider balance bill may apply Benefit maximum: 30 visits per year for all services except ABA for treatment of Autism
Chiropractic Spinal Manipulation/Treatment	0% coinsurance - no deductible Benefit maximum: $1000 per person per year	0% coinsurance - no deductible Provider balance bill may apply Benefit maximum: $1000 per person per year
Durable Medical Equipment	After deductible 20% coinsurance	Not Covered
Prosthetics, Orthotics and Corrective Appliances	After deductible 20% coinsurance	Not Covered
Infertility Treatment and Counseling	After deductible 50% coinsurance	Not Covered
Voluntary Termination of Pregnancy	Not Covered	Not Covered
Reproductive Care and Family Planning Services and Genetic Testing	$30 co-pay - no deductible	Not Covered
Oral Surgery	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Temporomandibular Joint Syndrome (TMJ) Treatment (surgical fees)	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Orthognathic Surgery (surgical fees)	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Antineoplastic Drugs	After deductible 20% coinsurance	After deductible 30% coinsurance Provider balance bill may apply
Pain Management	$30 co-pay - no deductible	After deductible 30% coinsurance Provider balance bill may apply

McLaren
HEALTH PLAN COMMUNITY

CITY OF FLINT
190065 POS PLAN 1
2020 POS Summary of Benefits

	Retail	Mail Order
Prescription Drugs		
Generic	$10 co-pay	$20 co-pay
Formulary	Brand: $25 co-pay	Brand: $50 co-pay
	Brand - Generic Available: $25 co-pay plus difference in cost between Brand and Generic	Brand - Generic Available: $50 co-pay plus difference in cost between Brand and Generic
Non-Formulary*	$50 co-pay	$100 co-pay
Specialty**	$50 co-pay	

***Prior Authorization or Step Therapy required.**

****Specialty Drugs must be filled at an MHP Community Preferred Specialty Pharmacy. Specialty Drugs are limited to a 30-day supply.**

This Summary of Benefits is intended only to highlight the benefits provided by McLaren Health Plan Community and should not be relied upon to fully determine coverage. This health plan may not cover all health care expenses. Please refer to the McLaren Health Plan Community Certificate of Coverage for a complete listing of covered services, limitations and exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Certificate issued to the enrolling group, the Certificate will prevail. For answers to questions about information that appears in the summary, call Customer Service at (888) 327-0671.

This proposal is contingent upon:

* Employer contribution of at least 50% of the single rate.
* The benefits or service requirements requested and/or quoted do not change prior to or after the effective date.
* No changes in federal, state or other applicable legislation or regulation requiring changes to this proposal.
* The accuracy of the information provided regarding current benefit options, rate ratios and census data.
* MHP Community's right to adjust the SIC assignments as well as the rates in this proposal.
* State regulatory approval of rates.

***PENDING DIFS APPROVAL**

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

MHP Community:

- 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 MHP Community's Compliance Officer.

If you believe that MHP Community 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 MHP Community's Compliance Officer, G-3245 Beecher Rd., Flint, MI 48532, call: 866-866-2135, TTY 711, Fax: 877-733-5788, or Email mhpcompliance@mclaren.org.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, MHP Community's Compliance Officer is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-327-0671 (TTY: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 0671-327-888-1 (رقم هاتف الصم والبكم: 711).

Svriac/Assyrian:
(TTY: 711) 0671-327-888-1

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-327-0671（TTY：711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-327-0671 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-327-0671 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-327-0671 (TTY: 711)번으로 전화해 주십시오.

Bengali: লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-888-327-0671 (TTY: 711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-327-0671 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-327-0671 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-327-0671 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-327-0671（TTY:711）まで、お電話にてご連絡ください。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-327-0671 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-327-0671 (TTY-Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-327-0671 (TTY: 711).

CITY OF FLINT RETIREE

VISION PLAN HIGHLIGHTS

Updated 05/11

MECA

Mutual Eye Claim Audits, Inc.
P.O. Box 17190
Indianapolis, In 46217
1-800-875-6322 * 317-862-2500

YOUR MECA VISION PLAN MAKES A VISIBLE DIFFERENCE:

Access to any Provider across the Nation allowing Freedom of Choice

Access to an extensive Network of Providers
- Ophthalmologists
- Optometrists
- Opticians
- National Chains
- Providers who offer 1 hour service

Access to eye exams that can detect systemic health problems

Access to an excellent vision plan that discounts your eye exam and lenses

Access to a non-automated customer service department Monday through Friday, 8:00am-4:30pm.

ELIGIBILITY

You are eligible for vision care benefits described herein provided you are a retired employee who has completed at least one year. Per the rules and regulations a retiree must have enrolled in the vision plan. A retiree and their dependents, which have been retired for at least one year, will be eligible on the next birth month of the retiree following one year of retirement. Spouses are eligible provided he/she is not legally separated and enrolled in the plan. Unmarried dependent children under 19 years of age and adult dependents age 19-23 years old who are unmarried and full time students are eligible to be enrolled in the plan.

BENEFIT FREQUENCY

Adults	Once every 24 consecutive months.
Children under age 19	Once every 12 consecutive months.
Full time students age 19-23	Once every 24 consecutive months.
Physically or mentally disabled	Once every 24 consecutive months.

MATERIALS

Glasses or contacts are once every benefit period. Contacts are in lieu of **ALL** benefits including exam.

3-STAR NETWORK FEE SCHEDULE

	Patient allowance	Patient pays
Exam	50% Co-payment	50% Co-payment
Lenses*		
Single	50% Co-payment	50% Co-payment
Bifocal	50% Co-payment	50% Co-payment
Trifocal	50% Co-payment	50% Co-payment
Standard Progressive	50% Co-payment	50% Co-payment
Frame* Up to $33.00	Paid in Full	-0-
Over $33.00 up to $130.00	45% of retail price	55% of retail price
Over $130.00	20% of retail price	80% of retail price
Contacts and Exam	$60.00	Balance
Conventional Lenses	15% Discount	85% of retail price
Extras* (discounted)		
UV Coating	-0-	$12.00
Tint (Solid & Gradient)	-0-	$12.00
Standard Scratch-Resistance	-0-	$15.00
Standard Polycarbonate	-0-	$35.00
Standard Anti-Reflective	-0-	$45.00
Other Add-ons and Services (20% discount)	-0-	80% of materials

*Purchases of additional eyewear are discounted at 25%.

2-STAR NETWORK FEE SCHEDULE

	Patient allowance	Patient pays
Exam	50% Co-payment	50% Co-payment
Lenses*		
Single	50% Co-payment	50% Co-payment
Bifocal	50% Co-payment	50% Co-payment
Trifocal	50% Co-payment	50% Co-payment
Standard Progressive	50% Co-payment	50% Co-payment
Frame* Up to $22.50	Paid in Full	-0-
Over $22.50 up to $130.00	20% of retail price	80% of retail price
Contacts and Exam	$60.00	Balance
Conventional Lenses	15% Discount	85% of Balance
Extras*		
UV Coating	-0-	80% of services
Tint (Solid & Gradient)	-0-	80% of services
Standard Scratch-Resistance	-0-	80% of services
Standard Polycarbonate	-0-	80% of services
Standard Anti-Reflective	-0-	80% of services
Other Add-ons and Services	-0-	80% of services

1-STAR FEE SCHEDULE

	Patient allowance	Patient pays
Exam		
M.D.	50% Co-payment	50% Co-payment
O.D.	50% Co-payment	50% Co-payment
Lenses*		
Single	50% Co-payment	50% Co-payment
Bifocal	50% Co-payment	50% Co-payment
Trifocal	50% Co-payment	50% Co-payment
Standard Progressive	$52.50	Balance
Frame*	$18.00	Balance
Contacts and Exam	$60.00	Balance
Extras*		
UV Coating	-0-	Balance
Tint (Solid & Gradient)	-0-	Balance
Standard Scratch-Resistance	-0-	Balance
Standard Polycarbonate	-0-	Balance
Standard Anti-Reflective	-0-	Balance
Other Add-ons and Services	-0-	Balance

OUT-OF-NETWORK SCHEDULE

	Patient allowance	Patient pays
Exam		
M.D.	$36.00	Balance
O.D.	$25.00	Balance
Lenses*		
Single	$30.00	Balance
Bifocal	$42.50	Balance
Trifocal	$52.50	Balance
Standard Progressive	$52.50	Balance
Frame*	$18.00	Balance
Contacts and Exam	$60.00	Balance
Extras*		
UV Coating	-0-	Balance
Tint (Solid & Gradient)	-0-	Balance
Standard Scratch-Resistance	-0-	Balance
Standard Polycarbonate	-0-	Balance
Standard Anti-Reflective	-0-	Balance
Other Add-ons and Services	-0-	Balance

HOW TO USE YOUR BENEFITS

MECA Network Providers

1. Schedule an appointment with your provider
   - Verify Provider is a MECA participant to receive maximum benefits
   - Give Provider the Employees Social Security Number, Patients name and date of birth. Inform them of your employment with the City of Flint.
2. Upon receiving services, MECA and your Provider will do the rest.
   - The Provider fill out form and send to MECA
   - Pay the Provider for service not covered by this Plan*

If You Select a Out-Of-Network Provider

1. Call MECA to verify your eligibility status.
2. Submit an itemized receipt or the doctor's generic claim form with your employer's name, the social security number, address and patient information listed on the receipt.
3. Make an appointment with the doctor of your choice.
   - After the examination, pay the required fees for services rendered.
   - Submit the completed claim form, or itemized receipts with all required charges. MECA will then reimburse the employee.

Reimbursement for approved claims will be mailed to you within 30 days after receiving a properly executed claim form. You will be reimbursed per the authorized schedule for out-of-network providers.

- Contact MECA at 1-800-875-6322 for complete eligibility and benefit information.

PLAN EXCLUSIONS AND LIMITATIONS

The vision plan is designed to cover your vision requirements rather than cosmetic purposes. An additional charge may be made if you select any of the following:

1. Additional charges for oversize, tinted, coated lenses or any "extra" added to the lens.
2. Additional charges for blended, progressive or executive lenses.
3. The cost of a frame or contact lenses in excess of the plan allowance.
4. More than one pair of glasses or contact lenses.
5. Charges over the standard 65mm single vision, D 25 & 28 bifocals and 7x25 & 7x28 trifocals.
6. Glasses that do not require a prescription.
7. Medical or surgical treatment of the eye and/or medication for the eye.
8. Special procedures, such as vision training, sub-normal vision aids or non-prescription lenses.
9. Services or materials provided as a result of any Workman's Compensation Law.
10. Exams and/or materials ordered:
    a) Before coverage begins or after termination;
    b) or services obtained without cost.

CITY OF FLINT

BENEFIT ELECTION FORM RETIREES – Non Lit. DHG3 Retired 06/26/2012-06/30/2014

RETIREE INFORMATION		☐ CHECK BOX IF ANY OF THE INFORMATION BELOW HAS CHANGED		
Name		Social Security #		☐ Male ☐ Female
Address (number & street)		City	State	ZIP Code
Date of Birth	Primary Phone ( )	Marital Status ☐ Single ☐ Married ☐ Divorced	Medicare Eligibility (provide copy of card(s)) ☐ Part A ☐ Part B ☐ Part A & B	

If Medicare Eligible a Medicare Advantage Enrollment Form Will Also Need to Be Completed

LIST THE DEPENDENTS YOU WISH TO HAVE COVERED BELOW – USE AN ADDITIONAL PAGE, IF NEEDED

NAME	BIRTH DATE	GENDER	RELATIONSHIP	SSN	ADD/DROP CHANGE COVERAGE	OTHER COVERAGE? YES or NO

COVERAGE	OPTIONS	MONTHLY CONTRIBUTION					
1. MEDICAL AND PRESCRIPTION DRUG PLAN (EFFECTIVE JULY 1, 2020)							
	Circle the option of your choice below:	**MONTHLY CONTRIBUTION**					
		One Person Non-Medicare	2 Person Non-Medicare	Family Non-Medicare	Medicare Per Person	Members Enrolled In Medicare	
Select the option and coverage level of your choice. A completed carrier form is required if you are making any changes.	• Blue Cross Blue Shield	$294.52	$878.81	$1,035.49	$0.00		$_____ Monthly Contribution
	• Health Alliance Plan (HAP)	$124.43	$260.21	$339.35	$0.00	_____	
	• McLaren	$40.91	$259.64	$74.84	N/A		
	• Waive – No Coverage	$0.00	$0.00	$0.00	$0.00		

To calculate your Monthly Contribution, add the rate for Non-Medicare coverage and the rate for Medicare coverage. Please note that the Medicare rate is calculated by the amount in the "Medicare Per Person" column times the number of family members enrolled in Medicare.

Example #1: Coverage with BCBS. Retiree is not enrolled in Medicare and the Spouse is not enrolled in Medicare – Coverage level is "2 Person Non-Medicare" The total Monthly Contribution would be $878.81.

Example #2: Coverage with BCBS. Retiree is not enrolled in Medicare and the Spouse is enrolled in Medicare – Coverage level is "One Person Non-Medicare" in the amount of $294.52 PLUS "Medicare Per Person" in the amount of $0.00. The total Monthly Contribution would be $294.52.

Example #3: Coverage with BCBS. Retiree is not enrolled in Medicare and the Spouse and Child are enrolled in Medicare – Coverage level is "One Person Non-Medicare" in the amount of $294.52 PLUS "Medicare Per Person" times 2 in the amount of $0.00 ($0.00 per Medicare member). The total Monthly Contribution would be $294.52.

2. YOUR SIGNATURE

The following actions are prohibited:

- Attempting to submit a claim for benefits which includes attempting to fill a prescription for a person who is not eligible under this plan
- Attempting to file a claim for a participant for services which were not rendered for drugs or other items which were not provided
- Providing false or misleading information in connection with enrollment in the plan
- Providing any false or misleading information to the plan

I understand that if I partake in the actions listed above, such actions, or the knowledge of such actions taken by another, constitute fraud and will result in termination of all coverage under this plan in accordance with applicable law and insurance company policy/procedure.

I understand that I cannot change these benefit elections unless I notify Meadowbrook Insurance Agency **within 30 days** after I experience a qualifying change in status (such as marriage, divorce, death of a spouse or a child, birth or adoption of a child) and the insurance carrier approves such a change. I agree to pay the amount necessary to satisfy the required contribution I am expected to pay toward the cost of coverage. This agreement is subject to the terms of the City's contribution plan as amended from time to time, and shall be governed by and construed in accordance with applicable laws. This benefit election form revokes any prior benefit election relating to such plan. My signature below acknowledges my elections for this plan year beginning July 1, 2020.

Any qualifying change in status and requests for cancellation of coverage must be reported to Meadowbrook Insurance Agency. All changes or cancellations will take place on the first of the month following Cornerstone's receipt of the written request and documentation supporting such change. Should I fail to inform Meadowbrook Insurance Agency, I understand that I will be required to wait until the next Open Enrollment. I further agree that any paperwork required to support a change in status will be supplied to Meadowbrook Insurance Agency at the earliest point in time that it becomes available.

Date:_____ Signature: _____

City of Flint
Per Pay Employee Contributions
for plan year July 1, 2020 – June 30, 2021

	Blue Cross Blue Shield	Health Alliance Plan (HAP)	McLaren	Total Hurley
Single	$41.84	$36.03	$55.24	$38.32
Two Person	$100.42	$75.35	$131.61	$76.64
Family	$125.52	$98.26	$147.27	$118.79

	Dental - $1,000 Max Plan		Vision	
Single	$6.68		$.85	
Two Person	$13.36		$1.56	
Family	$23.37		$2.04	

City of Flint Per Pay Employee Contributions for plan year July 1, 2020 – June 30, 2021				
	Blue Cross Blue Shield	Health Alliance Plan (HAP)	McLaren	Total Hurley
Single	$41.84	$36.03	$55.24	$38.32
Two Person	$100.42	$75.35	$131.61	$76.64
Family	$125.52	$98.26	$147.27	$118.79

	Dental - $1,000 Max Plan		Vision	
Single	$6.68		$.85	
Two Person	$13.36		$1.56	
Family	$23.37		$2.04	

Blue Cross Blue Shield of Michigan

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

CITY OF FLINT
007000304
Effective Date: 07/01/2019

Dental Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Network access information
With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.[1]

Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 438,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**

[1]Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
[2]A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.

Blue Par SelectSM arrangement- Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services - members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com.**

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Eligibility information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Unmarried** dependent children: related to you by birth, marriage, legal adoption or legal guardianship, eligible for dental coverage through the last day of the month the dependent turns age 26, provided all eligibility requirements are met

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Deductible	None
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	None (covered at 100%)
• Class II services	10%
• Class III services	50%
• Class IV services	50%
Dollar maximums • Annual maximum for Class I, II and III services	$1,000 per member
• Lifetime maximum for Class IV services	$1,000 per member

Benefits	Coverage

Class I services

Benefits	Coverage
Oral exams	100% of approved amount twice in a 12 month period
A set (up to 4 films) of bitewing x-rays	100% of approved amount twice in a 12 month period
Dental prophylaxis (teeth cleaning)	100% of approved amount twice in a 12 month period or four (4) times in a twelve (12) month period if the patient has documented history of periodontal treatment/surgery
Pit and fissure sealants - for members age 19 and younger	100% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Palliative (emergency) treatment	100% of approved amount
Fluoride treatment - for members age 26 and younger unless medically necessary	100% of approved amount **Note:** Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members under age 19	100% of approved amount **Note:** Once per quadrant per lifetime

Class II services

Benefits	Coverage
Panoramic or full-mouth x-rays	90% of approved amount **Note:** Once every 60 months
Fillings - permanent (adult) teeth	90% of approved amount **Note:** Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	90% of approved amount **Note:** Replacement fillings covered after 12 months or more after initial filling
Onlays, inlays, crowns and veneer restorations - permanent teeth - for members age 12 and older	90% of approved amount **Note:** Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	90% of approved amount **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery, except simply extractions	90% of approved amount
Root canal treatment - permanent tooth	90% of approved amount **Note:** Once every 12 months for tooth with one or more canals
Scaling and root planing	90% of approved amount **Note:** Once every 24 months per quadrant
Limited occlusal adjustments	90% of approved amount **Note:** Limited occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	90% of approved amount **Note:** Once every 12 months
General anesthesia or IV sedation	90% of approved amount **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	90% of approved amount **Note:** Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	90% of approved amount **Note:** Once per arch in any 36 consecutive months
Tissue conditioning	90% of approved amount **Note:** Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount **Note:** Once every 60 months

Benefits	Coverage
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount **Note:** Once every 60 months after original was delivered
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount **Note:** Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	50% of approved amount
Minor treatment to control harmful habits	50% of approved amount
Interceptive and comprehensive orthodontic treatment	50% of approved amount
Post-treatment stabilization	50% of approved amount
Cephalometric film (skull) and diagnostic photos	50% of approved amount

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

CITY OF FLINT

Community Blue PPO℠ ASC

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

Note to ASC groups: Before completing this template, please reference the disclaimer on the attached cover page.

Coverage Period: Beginning on or after 07/01/2019

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?	$1,000 Individual/ $2,000 Family	$2,000 Individual/ $4,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	$6,850 Individual/ $13,700 Family	$13,700 Individual/ $27,400 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been 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	$30 copay/office visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$30 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% 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/prescription for retail 30-day supply; $20 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network.
	Preferred brand-name drugs	$40 copay/prescription for retail 30-day supply; $80 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
	Non preferred brand-name drugs	$80 copay/prescription for retail 30-day supply; $160 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay/visit; deductible does not apply	$100 copay/visit; deductible does not apply	Copay waived if admitted or for an accidental injury.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Mileage limits apply
	Urgent care	$30 copay/visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	50% coinsurance for Mental Health; 50% coinsurance for substance use disorder	50% coinsurance for Mental Health; 50% coinsurance for substance use disorder	Your cost share may be different for services performed in an office setting
	Inpatient services	50% coinsurance	50% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	Prenatal: No Charge; deductible does not apply Postnatal: No Charge; deductible does not apply	Prenatal: 40% coinsurance Postnatal: 40% coinsurance	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Preauthorization is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	20% coinsurance for Applied Behavioral Analysis; 20% coinsurance for Physical, Speech and Occupational Therapy	20% coinsurance for Applied Behavioral Analysis; 40% coinsurance for Physical, Speech and Occupational Therapy	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)	
	Skilled nursing care	20% coinsurance	20% coinsurance	Preauthorization is required. Limited to 120 days per member per calendar year
	Durable medical equipment	20% coinsurance	20% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge; deductible does not apply	No Charge; deductible does not apply	Preauthorization is required. Visit limits apply.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

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

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

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

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

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

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

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

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

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

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

Language Access Services: **See Addendum**

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

About these Coverage Examples:

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

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

The plan's overall deductible	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$90
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,950**

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

The plan's overall deductible	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,000
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,260**

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

The plan's overall deductible	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$90
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

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

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

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

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

[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

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

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

Health Alliance Plan

Coverage for: Individual + Family | Plan Type: HMO Value Plus
AA002736 XR001508

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-422-4641 or visit http://www.hap.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-422-4641 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** individual / **$2,000** family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency Services, Urgent care, Emergency Medical Transportation, Preventive services, Office Visits, Chiropractic, Pharmacy	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?	**$6,850** individual/ **$13,700** 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.hap.org or call 1-800-422-4641 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plans network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	Written referrals are not required for specialist visits within the member's assigned network for selected services. Referrals or oral approvals are required in other instances. Further information on the referral process can be found at www.hap.org.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copay; deductible does not apply	Not Covered	
	Specialist visit	$50 Copay; deductible does not apply	Not Covered	
	Other practitioner office visit	PCP Visit: $25 Copay; deductible does not apply Telehealth Visit: $25 Copay; deductible does not apply Specialist Visit: $50 Copay; deductible does not apply Chiropractic Visit: $50 Copay; deductible does not apply	Not Covered	Telehealth: Through our contracted telehealth services provider. Chiropractic: Manipulation of the spine for subluxation only; Up to 20 visits per benefit period.
	Preventive care/screening/ immunization	No Charge; deductible does not apply	Not Covered	Coverage information available at www.hap.org. You may have to pay for services that aren't preventive services. Ask your provider if the services needed are preventive services. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance after deductible	Not Covered	Some services require preauthorization
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after deductible	Not Covered	Services require preauthorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hap.org	Preferred Generic drugs	$20 Copay / prescription (retail); deductible does not apply	Not Covered	Costs shown apply to a 30-day supply of drugs. A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Applies to all Generic and Brand type drugs.
	Non-preferred Generic drugs	$20 Copay / prescription (retail); deductible does not apply	Not Covered	
	Preferred Brand drugs	$40 Copay / prescription (retail); deductible does not apply	Not Covered	
	Non-preferred Brand drugs	$60 Copay / prescription (retail); deductible does not apply	Not Covered	
	Preferred Specialty drugs	$60 Copay / prescription (retail); deductible does not apply	Not Covered	All Specialty type drugs are not available at 90 day or mail order.
	Non-preferred Specialty drugs	$60 Copay / prescription (retail); deductible does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center(ASC))	20% Coinsurance after deductible	Not Covered	Some services require preauthorization
	Physician/surgeon fees	20% Coinsurance after deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 Copay; deductible does not apply	$150 Copay; deductible does not apply	Copay will be waived if admitted
	Emergency medical transportation	$100 Copay; deductible does not apply	$100 Copay; deductible does not apply	Emergency transport only
	Urgent care	$75 Copay; deductible does not apply	$75 Copay; deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after deductible	Not Covered	Services require preauthorization
	Physician/surgeon fees	20% Coinsurance after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay; deductible does not apply	Not Covered	Some services require preauthorization. Services can be accessed by calling 1-800-444-5755
	Inpatient services	20% Coinsurance after deductible	Not Covered	Services require preauthorization. Services can be accessed by calling 1-800-444-5755.
If you are pregnant	Office visits	$50 Copay; deductible does not apply	Not Covered	Prenatal covered under Preventive Services.
	Childbirth/delivery professional services	20% Coinsurance after deductible	Not Covered	
	Childbirth/delivery facility services	20% Coinsurance after deductible	Not Covered	Some services require preauthorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after deductible	Not Covered	Up to 60 consecutive days per illness or injury beginning with the first visit; Does not include Rehabilitation Services.
	Rehabilitation services	20% Coinsurance after deductible	Not Covered	May be rendered at home; Up to 60 combined visits per benefit period
	Habilitation services	20% Coinsurance after deductible	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only. See Outpatient Mental Health for ABA cost sharing amount.
	Skilled nursing care	20% Coinsurance after deductible	Not Covered	Covered for authorized services; Up to 100 days per benefit period.
	Durable medical equipment	20% Coinsurance after deductible	Not Covered	Covered for approved equipment only; Coverage for approved equipment only
	Hospice services	20% Coinsurance after deductible	Not Covered	Up to 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	$50 Copay; deductible does not apply	Not Covered	One routine eye exam per benefit period at no cost share
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency Care Outside the U.S.
- Private Duty Nursing
- Routine Foot Care
- Vision Hardware
- Voluntary Termination of Pregnancy

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

- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Routine Eye Care (Adult)
- Weight Loss Programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-800-422-4641 you may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or http://www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact the plan at 1-800-422-4641; you may also contact the Department of Insurance and Financial Services, Healthcare Appeals Section, Office of General Counsel, 611 Ottawa, 3rd Floor, P.O.Box 30220, Lansing, MI 48909-7720, http://michigan.gov/difs; call 1-877-999-6442 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Financial and Insurance Regulation, P.O.Box 30220, Lansing, MI 48909, phone 1-877-999-6442, website: http://michigan.gov/difs or e-mail difs-HICAP@michigan.gov.

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

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

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$980
Coinsurance	$2,001
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,041**

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

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,440
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,867**

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

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$255
Copayments	$450
Coinsurance	$63
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$768**

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

Language Assistance

We want you to easily get the information you need. To request assistance in a language other than English. call (800) 422-4641 (TTY: 711).

VINI RE: Nëse flisni shqip. ju ofrohen shërbime ndihme gjuhësore falas. Telefononi numrin (800) 422-4641 ose TTY: 711.

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية مجانًا. اتصل بالرقم 422-4641 (800) أو خدمة الهاتف النصي: 711.

নজর দিন: আপনি বাংলা ভাষায় কথা বললে. ভাষা সহায়তার পরিষেবা বিনামূল্যে আপনার জন্য উপলব্ধ। (800) 422-4641 বা TTY: 711 নম্বরে কল করুন।

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

HINWEIS: Wenn Sie Deutsch sprechen. stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufnummer: (800) 422-4641 oder TTY: 711.

ATTENZIONE: In caso la lingua parlata sia l'italiano. sono disponibili servizi di assistenza linguistica gratuiti.
Chiamare il numero (800) 422-4641 (TTY: 711).

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

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-422-4641 번 또는 TTY: 711 번으로 연락해 주십시오.

UWAGA: jeżeli mówisz po polsku. możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 422-4641 lub TTY: 711.

ВНИМАНИЕ! Если ваш родной язык русский. вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь по номеру (800) 422-4641 (телетайп: 711).

NAPOMENA: Ako govorite hrvatski/srpski. dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte (800) 422-4641 ili tekstualni telefon za osobe oštećena sluha: 711.

ATENCIÓN: si habla español. los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Llame al (800) 422-4641. los usuarios TTY deben llamar al 711.

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. اتصل بالرقم (800) 422-4641 أو خدمة الهاتف النصي TTY: 711.

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo. may makukuha kang mga serbisyong tulong sa wika na walang bayad. Tumawag sa (800) 422-4641 o TTY: 711.

CHÚ Ý: Nếu quý vị nói tiếng Việt. chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi (800) 422-4641 hoặc TTY: 711.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage call 1-888-327-0671. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.McLarenHealthPlan.com or call 1-888-327-0671 to request a copy.

Important Questions	Option A Answers	Option B Answers	Why This Matters:
What is the overall deductible?	$1,000/individual $2,000/family	$3,000/individual $6,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	No	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	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,350/individual $14,700/family	Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges and health care this plan doesn't cover.		Even though you pay these expenses they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See McLarenHealthPlan.org or call 1-888-327-0671 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 (a "participating provider". You will pay the most if you use a non-participating 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 participating provider might use a non-participating 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. Note, however, that some services require plan preauthorization in order to be covered.

* For more information about limitations and exceptions, see the plan or policy document.

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
		Option A – Participating Providers (You will pay the least)	Option B – Non-Participating Providers (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	$30/visit Deductible does not apply.	30% coinsurance plus balance bill	None
	Specialist visit	$30/visit Deductible does not apply.	30% coinsurance plus balance bill	Plan preauthorization for some services is required. See Section 8.05.01 of your Certificate of Coverage.
	Preventive care/screening/ immunization	No charge Deductible does not apply.	30% coinsurance plus balance bill	Plan preauthorization for some services is required. See Section 8.05.01 of your Certificate of Coverage. 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	30% coinsurance plus balance bill	Plan preauthorization is required for genetic testing. See Section 8.05.01 of your Certificate of Coverage.
	Imaging (CT/PET scans, MRIs)	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	Plan preauthorization is required. See Section 8.05.01 of your Certificate of Coverage.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.MclarenHealthPlan.org	Generic drugs (Tier 1)	Retail - $10/prescription (up to a 90-day supply for 1 copay) Mail order – $40/prescription (90-day supply) Deductible does not apply.		Preauthorization is required for some drugs. See the plan formulary at http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx.
	Formulary brand drugs (Tier 2)	Retail - $25/prescription (34-day supply) Mail order - $100/prescription (90-day supply) Deductible does not apply.		
	Non-formulary brand drugs (Tier 3)	Retail - $50/prescription (34-day supply) Mail order - $160/prescription (90-day supply) Deductible does not apply.		
	Specialty drugs (Tier 4)	Retail - $80/prescription (34-day supply) Mail order – not covered Deductible does not apply.		

* For more information about limitations and exceptions, see the plan or policy document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Option A – Participating Providers (You will pay the least)	Option B – Non-Participating Providers (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	Plan preauthorization for some services is required. See Section 8.05.01 of your Certificate of Coverage.
	Physician/surgeon fees	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	
If you need immediate medical attention	Emergency room care	$100/visit Deductible does not apply. Copay waived if admitted.	$100/visit plus balance bill Deductible does not apply. Copay waived if admitted.	You may be responsible for a balance-bill when services are obtained by non-participating providers.
	Emergency medical transportation	20% coinsurance Up to $2,000/$4,000	20% coinsurance plus balance bill	
	Urgent care	$50/visit Deductible does not apply.	$50/visit plus balance bill Deductible does not apply.	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	Plan preauthorization is required for the service to be covered (with the exception of Maternity Care). See Section 8.05.01 of your Certificate of Coverage.
	Physician/surgeon fees	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30/visit Deductible does not apply.	30% coinsurance plus balance bill	None
	Inpatient services	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	Plan preauthorization for some services is required. See Section 8.05.01 of your Certificate of Coverage.
If you are pregnant	Office visits	No Charge Deductible does not apply.	30% coinsurance plus balance bill	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	
	Childbirth/delivery facility services	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	
If you need help recovering or have other special health needs	Home health care	20% coinsurance Up to $2,000/$4,000	Not covered	Limited to 60 days per episode per calendar year.
	Rehabilitation services	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	Plan preauthorization is required. See Section 8.05.01 of your Certificate of Coverage. Physical and Occupational Therapy Disorder and Speech Therapy Treatment for Treatment other than for Autism Spectrum: 60 visits/year for each.

* For more information about limitations and exceptions, see the plan or policy document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Option A – Participating Providers (You will pay the least)	Option B – Non-Participating Providers (You will pay the most)	
If you need help recovering or have other special health needs	Habilitation services	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	Plan preauthorization is required. See Section 8.05.01 of your Certificate of Coverage. 30 visits per year for all services except ABA for treatment of Autism.
	Skilled nursing care	20% coinsurance Up to $2,000/$4,000	Not covered	Plan preauthorization is required. See Section 8.05.01 of your Certificate of Coverage. 60 visits/year.
	Durable medical equipment	20% coinsurance Up to $2,000/$4,000	Not covered	Durable medical equipment that costs $3,000 or more requires plan preauthorization. See Section 8.05.01 of your Certificate of Coverage.
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	$30-Copay	Not covered	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S. Private Duty Nursing
- Private Duty Nursing
- 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 (if rider purchased)
- Infertility Treatment

* For more information about limitations and exceptions, see the plan or policy document.

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: your state insurance department at the Michigan Health Insurance Consumers Assistance Program (HICAP) at (877) 999-6442 or DIFS-HICAP@Michigan.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: McLaren Health Plan Community, G-3245 Beecher Rd., Flint, MI 48532, Attn: Member Appeals, or call (888) 327-0671. You may also contact the Department of Insurance and Financial Services (DIFS) at (877) 999-6442. Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumers Assistance Program (HICAP) at (877) 999-6442 or DIFS-HICAP@Michigan.gov.

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

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

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al [1-888-327-0671] [TTY 711]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-888-327-0671] [TTY 711]
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** [1-888-327-0671] [TTY 711]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [1-888-327-0671] [TTY 711]

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

* For more information about limitations and exceptions, see the plan or policy document.

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	**$1,000**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$12,739**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$1,825
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,985**

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$935
Coinsurance	$346
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,336**

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

The plan's overall deductible	**$1,000**
Specialist copayment	**$30**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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

Total Example Cost	**$1,991**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$859
Copayments	$390
Coinsurance	$215
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,464**

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

National Vision Administrators, L.L.C.

Your NVA Vision Benefit Summary

City of Flint
Effective 07/01/2019
Group Number# 3098

Schedule of Vision Benefits

Benefit Frequency	Participating Provider	Non-Participating Provider
Examination Under 19 Once Every Plan Year 19 & over Once Every Two Plan Years	▪ Covered 100% After $10 copay	Reimbursed Amount ▪ Up to $50 (OD) ▪ Up to $62 (MD)
Lenses Under 19 Once Every Plan Year 19 & over Once Every Two Plan Years	Standard Glass or Plastic	
▪ Single Vision ▪ Bifocal ▪ Trifocal ▪ Lenticular	▪ Covered 100% After $10 copay	▪ Up to $50 ▪ Up to $75 ▪ Up to $95 ▪ Up to $95
▪ Standard Progressives	▪ Covered 100%	▪ N/A
Frame Under 19 Once Every Plan Year 19 & over Once Every Two Plan Years	Retail Allowance ▪ Up to $130② (20% discount off balance)*	▪ Up to $45
Contact Lenses Under 19 Once Every Plan Year 19 & over Once Every Two Plan Years	In lieu of Lenses & Frame	In lieu of Lenses & Frame
Elective Contact Lenses①	▪ Up to $130 Retail③ (15% discount (Conventional) or 10% discount (Disposable) off balance)**	▪ Up to $100
Medically Necessary***	▪ Covered 100%	▪ Up to $210

How Your Vision Care Program Works

Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses and a frame or contact lenses once every two plan years. Eligible dependents under age 19 are entitled to receive a vision examination and one (1) pair of lenses and a frame or contact lenses once every plan year.

For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, simply present your NVA identification card to the provider or indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care professional, please visit our website at www.e-nva.com or download our mobile app by searching NVA Vision, or contact NVA's Customer Service Department toll-free at 1.800.672.7723 (TDD line 1-888-820-2990) or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 3098000001 or the group number on the identification card and enter in your search parameters. It's that easy!

*Does not apply to Wal-Mart / Sam's Club locations or for certain proprietary brands.
**Does not apply to Wal-Mart/Sam's Club, Contact Fill (NVA Mail Order) or certain locations at: Target, Sears, Pearle, & K-Mart and may be prohibited by some manufacturers.
***Pre-approval from NVA required.

①Additional professional services related to contact lenses (also known as fitting fees) would be included in the contact lens allowance shown above.
②Includes frames up to $52 Every Day Low Price-price point at Walmart/Sam's Club locations.
③$91 Every Day Low Price-price point for contact lenses at Walmart/Sam's Club locations

Due to their everyday low prices (EDLP) the amounts listed below may not be applicable at Wal-Mart/Sam's Club.
Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- $40 Anti-Reflective Coating (Standard)
- $30 Blended Bifocal (Segment)
- $40 Blue Light Blocker (Standard)
- $60 Blue Light Blocker (Premium)
- $150 Blue Light Blocker (Ultra)
- $12 Fashion Gradient
- $20 Glass Photogrey (Single Vision)
- $30 Glass Photogrey (Multi-Focal)
- $55 High Index
- $25 Polycarbonate (Single Vision)
- $30 Polycarbonate (Multi-Focal)
- $75 Polarized
- $100 Progressive Lenses (Premium)
- $10 Scratch-Resistant Coating (Standard)
- $10 Solid Tint
- $65 Transitions Single Vision (Standard)
- $70 Transitions Multi-Focal (Standard)
- $12 Ultraviolet Coating

For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price. Fixed prices are available in-network only. Discounts are not insured benefits. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Get a Better View

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations*:* The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Hearing Discount: You will receive up to 30-60% off retail at participating provider locations through EPIC Hearing.

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

Your NVA EyeEssential® Plan Discount – In Network Only

Service	Participating Provider	Lens Options
	Member Cost:	
Eye Examination:	Retail Less $10	$12 Solid Tint/ Gradient Tint
		$50 Standard Progressive Lenses
Contact Lens Fitting:	Retail Less 10%	$75 Polarized Lenses
		$65 Transitions Single Vision Standard
		$70 Transitions Multi-Focal Standard
Lenses:	Glass or Plastic	$15 Standard Scratch Coating
Single Vision	$35.00	$12 UV Coating
Bifocal	$55.00	$35 Polycarbonate
Trifocal or Lenticular	$70.00	$45 Standard Anti-Reflective
Frame:	Retail Less 35%	
Contact Lenses*:	**Member Cost:**	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U and C) price.

Wal-Mart / Sam's Club Stores: Due to their everyday low prices (EDLP) Wal-Mart / Sam's Club stores do not provide additional discounts.

At NVA, We Work Only for Our Clients.

National Vision Administrators, L.L.C. ▫ PO Box 2187 ▫ Clifton, NJ 07015
Web: www.e-nva.com ▫ Toll-Free: 1.800.672.7723

This document is intended as a program overview only and is not a certified document of the individual plan parameters.

TOTAL HURLEY
A Partnership For Better Healthcare

OCCUPATIONAL EYEWEAR NETWORK, INC

Vision Plan Program (Included With Medical)

Total Hurley, A Partnership For Better Healthcare, is a health plan provided by Hurley Medical Center and administered by Total Health Care USA.

ITEM:	MEMBER PAYS:
Comprehensive Eye Exam	0%
Contact Lens Fitting Fee	Retail
FRAMES	
Frames (Up to $80.00 Retail)	Retail
Frames (Over $80.00 Retail)	Retail, less 30%, less $24.00
LENSES (CR-39 or Glass)	
Single Vision	$0
Bifocal	$0
Trifocal	$0
CONTACT LENSES	
Elective	Retail, less $80.00
Medically Necessary	Retail, less $140.00

Options available to eligible Total Health Care USA Commercial Groups Members:

ITEM:	MEMBER PAYS:
Polycarbonate Lenses	$30.00
Hi Index	$60.00
Progressive – Standard	$50.00
Progressive – Midrange	$80.00
Progressive – Premium	$125.00
Solid Tint	$10.00
Gradient Tint	$12.00
Oversize Lenses	$0
UV Coating	$15.00
Scratch Coat	$15.00
AR Coating – Standard	$40.00
AR Coating – Premium	$55.00
AR Coating – Hydrophobics	$79.00
Photochromic Lenses	$20.00
Transition Lenses	$70.00
Polarized Lenses	$70.00

AUTHORIZATION:

- Please call OEN customer service toll-free number at (877) 799-0220 to verify eligibility.

NOTES:

- For any item not listed above: Give a 20% discount off retail pricing.
- Progressive Upgrade: Bill Plan for trifocal reimbursement.
- Utilize optical lab of choice for lens fabrication.
- Contact lens benefit is in lieu of eyeglass benefit.
- A prior authorization is required for medically necessary contact lenses.

ELIGIBILITY – All eligible Members are entitled to:

- Examination – every calendar year.
- Frames and Lenses, or Contacts – every two calendar years.

EXCLUSIONS – No payment will be made for the following:

- Eyeglasses for Members not requiring corrective lenses.
- Charges for any service or materials not covered by this program.
- Medical or surgical treatment.
- Services provided or glasses ordered before Member is eligible for coverage or after termination of coverage.
- Replacement of lost lenses or frames, unless Member meets all eligibility requirements.
- Replacement of scratched lenses.
- Prescription safety glasses.

Blue Cross Blue Shield of Michigan

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

CITY OF FLINT
007000304
Effective Date: 07/01/2019

Dental Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Network access information
With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.[1]

Blue Dental PPO network- Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 438,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**

[1]Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
[2]A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.

Blue Par SelectSM arrangement- Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services - members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com.**

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Eligibility information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Unmarried** dependent children: related to you by birth, marriage, legal adoption or legal guardianship, eligible for dental coverage through the last day of the month the dependent turns age 26, provided all eligibility requirements are met

Member's responsibility (deductible, coinsurance and dollar maximums)

Benefits	Coverage
Deductible	None
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	None (covered at 100%)
• Class II services	10%
• Class III services	50%
• Class IV services	50%
Dollar maximums • Annual maximum for Class I, II and III services	$1,000 per member
• Lifetime maximum for Class IV services	$1,000 per member

Benefits	Coverage

Class I services

Benefits	Coverage
Oral exams	100% of approved amount twice in a 12 month period
A set (up to 4 films) of bitewing x-rays	100% of approved amount twice in a 12 month period
Dental prophylaxis (teeth cleaning)	100% of approved amount twice in a 12 month period or four (4) times in a twelve (12) month period if the patient has documented history of periodontal treatment/surgery
Pit and fissure sealants - for members age 19 and younger	100% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Palliative (emergency) treatment	100% of approved amount
Fluoride treatment - for members age 26 and younger unless medically necessary	100% of approved amount **Note:** Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members under age 19	100% of approved amount **Note:** Once per quadrant per lifetime

Class II services

Benefits	Coverage
Panoramic or full-mouth x-rays	90% of approved amount **Note:** Once every 60 months
Fillings - permanent (adult) teeth	90% of approved amount **Note:** Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	90% of approved amount **Note:** Replacement fillings covered after 12 months or more after initial filling
Onlays, inlays, crowns and veneer restorations - permanent teeth - for members age 12 and older	90% of approved amount **Note:** Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	90% of approved amount **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery, except simply extractions	90% of approved amount
Root canal treatment - permanent tooth	90% of approved amount **Note:** Once every 12 months for tooth with one or more canals
Scaling and root planing	90% of approved amount **Note:** Once every 24 months per quadrant
Limited occlusal adjustments	90% of approved amount **Note: Limited** occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	90% of approved amount **Note:** Once every 12 months
General anesthesia or IV sedation	90% of approved amount **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	90% of approved amount **Note:** Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	90% of approved amount **Note:** Once per arch in any 36 consecutive months
Tissue conditioning	90% of approved amount **Note:** Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount **Note:** Once every 60 months

Benefits	Coverage
Bridges (fixed partial dentures) - for members age 16 and older	50% of approved amount **Note:** Once every 60 months after original was delivered
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	50% of approved amount **Note:** Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	50% of approved amount
Minor treatment to control harmful habits	50% of approved amount
Interceptive and comprehensive orthodontic treatment	50% of approved amount
Post-treatment stabilization	50% of approved amount
Cephalometric film (skull) and diagnostic photos	50% of approved amount

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

CITY OF FLINT

Community Blue PPO℠ ASC

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

Note to ASC groups: Before completing this template, please reference the disclaimer on the attached cover page.

Coverage Period: Beginning on or after 07/01/2019

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?	$1,000 Individual/ $2,000 Family	$2,000 Individual/ $4,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	$6,850 Individual/ $13,700 Family	$13,700 Individual/ $27,400 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been 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	$30 copay/office visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$30 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% 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/prescription for retail 30-day supply; $20 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network.
	Preferred brand-name drugs	$40 copay/prescription for retail 30-day supply; $80 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
	Non preferred brand-name drugs	$80 copay/prescription for retail 30-day supply; $160 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% of the approved amount; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay/visit; deductible does not apply	$100 copay/visit; deductible does not apply	Copay waived if admitted or for an accidental injury.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Mileage limits apply
	Urgent care	$30 copay/visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	50% coinsurance for Mental Health; 50% coinsurance for substance use disorder	50% coinsurance for Mental Health; 50% coinsurance for substance use disorder	Your cost share may be different for services performed in an office setting
	Inpatient services	50% coinsurance	50% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	Prenatal: No Charge; deductible does not apply Postnatal: No Charge; deductible does not apply	Prenatal: 40% coinsurance Postnatal: 40% coinsurance	Maternity care may include services described elsewhere in the SBC (i.e. tests) and cost share may apply. Cost sharing does not apply to certain maternity services considered to be preventive.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Preauthorization is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical, Speech and Occupational Therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	20% coinsurance for Applied Behavioral Analysis; 20% coinsurance for Physical, Speech and Occupational Therapy	20% coinsurance for Applied Behavioral Analysis; 40% coinsurance for Physical, Speech and Occupational Therapy	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)	
	Skilled nursing care	20% coinsurance	20% coinsurance	Preauthorization is required. Limited to 120 days per member per calendar year
	Durable medical equipment	20% coinsurance	20% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge; deductible does not apply	No Charge; deductible does not apply	Preauthorization is required. Visit limits apply.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

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

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

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

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

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

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

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

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

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

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

Language Access Services: **See Addendum**

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

About these Coverage Examples:

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

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

The plan's overall deductible	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$90
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,950**

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

The plan's overall deductible	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,000
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,260**

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

The plan's overall deductible	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$90
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Important disclosure

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

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

Health Alliance Plan

Coverage for: Individual + Family | Plan Type: HMO Value Plus
AA002736 XR001508

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-422-4641 or visit http://www.hap.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-422-4641 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** individual / **$2,000** family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency Services, Urgent care, Emergency Medical Transportation, Preventive services, Office Visits, Chiropractic, Pharmacy	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?	**$6,850** individual/ **$13,700** 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.hap.org or call 1-800-422-4641 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plans network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	Written referrals are not required for specialist visits within the member's assigned network for selected services. Referrals or oral approvals are required in other instances. Further information on the referral process can be found at www.hap.org.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copay; deductible does not apply	Not Covered	
	Specialist visit	$50 Copay; deductible does not apply	Not Covered	
	Other practitioner office visit	PCP Visit: $25 Copay; deductible does not apply Telehealth Visit: $25 Copay; deductible does not apply Specialist Visit: $50 Copay; deductible does not apply Chiropractic Visit: $50 Copay; deductible does not apply	Not Covered	Telehealth: Through our contracted telehealth services provider. Chiropractic: Manipulation of the spine for subluxation only; Up to 20 visits per benefit period.
	Preventive care/screening/ immunization	No Charge; deductible does not apply	Not Covered	Coverage information available at www.hap.org. You may have to pay for services that aren't preventive services. Ask your provider if the services needed are preventive services. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance after deductible	Not Covered	Some services require preauthorization
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after deductible	Not Covered	Services require preauthorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hap.org	Preferred Generic drugs	$20 Copay / prescription (retail); deductible does not apply	Not Covered	Costs shown apply to a 30-day supply of drugs. A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Applies to all Generic and Brand type drugs.
	Non-preferred Generic drugs	$20 Copay / prescription (retail); deductible does not apply	Not Covered	
	Preferred Brand drugs	$40 Copay / prescription (retail); deductible does not apply	Not Covered	
	Non-preferred Brand drugs	$60 Copay / prescription (retail); deductible does not apply	Not Covered	
	Preferred Specialty drugs	$60 Copay / prescription (retail); deductible does not apply	Not Covered	All Specialty type drugs are not available at 90 day or mail order.
	Non-preferred Specialty drugs	$60 Copay / prescription (retail); deductible does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center(ASC))	20% Coinsurance after deductible	Not Covered	Some services require preauthorization
	Physician/surgeon fees	20% Coinsurance after deductible	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 Copay; deductible does not apply	$150 Copay; deductible does not apply	Copay will be waived if admitted
	Emergency medical transportation	$100 Copay; deductible does not apply	$100 Copay; deductible does not apply	Emergency transport only
	Urgent care	$75 Copay; deductible does not apply	$75 Copay; deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after deductible	Not Covered	Services require preauthorization
	Physician/surgeon fees	20% Coinsurance after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay; deductible does not apply	Not Covered	Some services require preauthorization. Services can be accessed by calling 1-800-444-5755
	Inpatient services	20% Coinsurance after deductible	Not Covered	Services require preauthorization. Services can be accessed by calling 1-800-444-5755.
If you are pregnant	Office visits	$50 Copay; deductible does not apply	Not Covered	Prenatal covered under Preventive Services.
	Childbirth/delivery professional services	20% Coinsurance after deductible	Not Covered	
	Childbirth/delivery facility services	20% Coinsurance after deductible	Not Covered	Some services require preauthorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after deductible	Not Covered	Up to 60 consecutive days per illness or injury beginning with the first visit; Does not include Rehabilitation Services.
	Rehabilitation services	20% Coinsurance after deductible	Not Covered	May be rendered at home; Up to 60 combined visits per benefit period
	Habilitation services	20% Coinsurance after deductible	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only. See Outpatient Mental Health for ABA cost sharing amount.
	Skilled nursing care	20% Coinsurance after deductible	Not Covered	Covered for authorized services; Up to 100 days per benefit period.
	Durable medical equipment	20% Coinsurance after deductible	Not Covered	Covered for approved equipment only; Coverage for approved equipment only
	Hospice services	20% Coinsurance after deductible	Not Covered	Up to 210 days per lifetime.
If your child needs dental or eye care	Children's eye exam	$50 Copay; deductible does not apply	Not Covered	One routine eye exam per benefit period at no cost share
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency Care Outside the U.S.
- Private Duty Nursing
- Routine Foot Care
- Vision Hardware
- Voluntary Termination of Pregnancy

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

- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Routine Eye Care (Adult)
- Weight Loss Programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-800-422-4641 you may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or http://www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact the plan at 1-800-422-4641; you may also contact the Department of Insurance and Financial Services, Healthcare Appeals Section, Office of General Counsel, 611 Ottawa, 3rd Floor, P.O.Box 30220, Lansing, MI 48909-7720, http://michigan.gov/difs; call 1-877-999-6442 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Financial and Insurance Regulation, P.O.Box 30220, Lansing, MI 48909, phone 1-877-999-6442, website: http://michigan.gov/difs or e-mail difs-HICAP@michigan.gov.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet Minimum Value Standards? Yes

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

Language Access Services:

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$980
Coinsurance	$2,001
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,041**

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

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,440
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,867**

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

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$255
Copayments	$450
Coinsurance	$63
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$768**

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

Language Assistance

We want you to easily get the information you need. To request assistance in a language other than English. call (800) 422-4641 (TTY: 711).

VINI RE: Nëse flisni shqip. ju ofrohen shërbime ndihme gjuhësore falas. Telefononi numrin (800) 422-4641 ose TTY: 711.

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية مجانًا. اتصل بالرقم 422-4641 (800) أو خدمة الهاتف النصي: 711.

নজর দিন: আপনি বাংলা ভাষায় কথা বললে. ভাষা সহায়তার পরিষেবা বিনামূল্যে আপনার জন্য উপলব্ধ। (800) 422-4641 বা TTY: 711 নম্বরে কল করুন।

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

HINWEIS: Wenn Sie Deutsch sprechen. stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufnummer: (800) 422-4641 oder TTY: 711.

ATTENZIONE: In caso la lingua parlata sia l'italiano. sono disponibili servizi di assistenza linguistica gratuiti.
Chiamare il numero (800) 422-4641 (TTY: 711).

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

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-422-4641 번 또는 TTY: 711 번으로 연락해 주십시오.

UWAGA: jeżeli mówisz po polsku. możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 422-4641 lub TTY: 711.

ВНИМАНИЕ! Если ваш родной язык русский. вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь по номеру (800) 422-4641 (телетайп: 711).

NAPOMENA: Ako govorite hrvatski/srpski. dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte (800) 422-4641 ili tekstualni telefon za osobe oštećena sluha: 711.

ATENCIÓN: si habla español. los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Llame al (800) 422-4641. los usuarios TTY deben llamar al 711.

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية مجانًا. اتصل بالرقم 422-4641 (800) أو خدمة الهاتف النصي: 711.

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo. may makukuha kang mga serbisyong tulong sa wika na walang bayad. Tumawag sa (800) 422-4641 o TTY: 711.

CHÚ Ý: Nếu quý vị nói tiếng Việt. chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi (800) 422-4641 hoặc TTY: 711.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage call 1-888-327-0671. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.McLarenHealthPlan.com or call 1-888-327-0671 to request a copy.

Important Questions	Option A Answers	Option B Answers	Why This Matters:
What is the overall deductible?	$1,000/individual $2,000/family	$3,000/individual $6,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	No	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	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,350/individual $14,700/family	Unlimited	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges and health care this plan doesn't cover.		Even though you pay these expenses they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See McLarenHealthPlan.org or call 1-888-327-0671 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 (a "participating provider". You will pay the most if you use a non-participating 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 participating provider might use a non-participating 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. Note, however, that some services require plan preauthorization in order to be covered.

* For more information about limitations and exceptions, see the plan or policy document.

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
		Option A – Participating Providers (You will pay the least)	Option B – Non-Participating Providers (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	$30/visit Deductible does not apply.	30% coinsurance plus balance bill	None
	Specialist visit	$30/visit Deductible does not apply.	30% coinsurance plus balance bill	Plan preauthorization for some services is required. See Section 8.05.01 of your Certificate of Coverage.
	Preventive care/screening/ immunization	No charge Deductible does not apply.	30% coinsurance plus balance bill	Plan preauthorization for some services is required. See Section 8.05.01 of your Certificate of Coverage. 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	30% coinsurance plus balance bill	Plan preauthorization is required for genetic testing. See Section 8.05.01 of your Certificate of Coverage.
	Imaging (CT/PET scans, MRIs)	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	Plan preauthorization is required. See Section 8.05.01 of your Certificate of Coverage.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.MclarenHealthPlan.org	Generic drugs (Tier 1)	Retail - $10/prescription (up to a 90-day supply for 1 copay) Mail order – $40/prescription (90-day supply) Deductible does not apply.		Preauthorization is required for some drugs. See the plan formulary at http://www.mclarenhealthplan.org/community-member/marketplace-mhp.aspx.
	Formulary brand drugs (Tier 2)	Retail - $25/prescription (34-day supply) Mail order - $100/prescription (90-day supply) Deductible does not apply.		
	Non-formulary brand drugs (Tier 3)	Retail - $50/prescription (34-day supply) Mail order - $160/prescription (90-day supply) Deductible does not apply.		
	Specialty drugs (Tier 4)	Retail - $80/prescription (34-day supply) Mail order – not covered Deductible does not apply.		

* For more information about limitations and exceptions, see the plan or policy document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Option A – Participating Providers (You will pay the least)	Option B – Non-Participating Providers (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	Plan preauthorization for some services is required. See Section 8.05.01 of your Certificate of Coverage.
	Physician/surgeon fees	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	
If you need immediate medical attention	Emergency room care	$100/visit Deductible does not apply. Copay waived if admitted.	$100/visit plus balance bill Deductible does not apply. Copay waived if admitted.	You may be responsible for a balance-bill when services are obtained by non-participating providers.
	Emergency medical transportation	20% coinsurance Up to $2,000/$4,000	20% coinsurance plus balance bill	
	Urgent care	$50/visit Deductible does not apply.	$50/visit plus balance bill Deductible does not apply.	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	Plan preauthorization is required for the service to be covered (with the exception of Maternity Care). See Section 8.05.01 of your Certificate of Coverage.
	Physician/surgeon fees	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30/visit Deductible does not apply.	30% coinsurance plus balance bill	None
	Inpatient services	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	Plan preauthorization for some services is required. See Section 8.05.01 of your Certificate of Coverage.
If you are pregnant	Office visits	No Charge Deductible does not apply.	30% coinsurance plus balance bill	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	
	Childbirth/delivery facility services	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	
If you need help recovering or have other special health needs	Home health care	20% coinsurance Up to $2,000/$4,000	Not covered	Limited to 60 days per episode per calendar year.
	Rehabilitation services	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	Plan preauthorization is required. See Section 8.05.01 of your Certificate of Coverage. Physical and Occupational Therapy Disorder and Speech Therapy Treatment for Treatment other than for Autism Spectrum: 60 visits/year for each.

* For more information about limitations and exceptions, see the plan or policy document.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Option A – Participating Providers (You will pay the least)	Option B – Non-Participating Providers (You will pay the most)	
If you need help recovering or have other special health needs	Habilitation services	20% coinsurance Up to $2,000/$4,000	30% coinsurance plus balance bill	Plan preauthorization is required. See Section 8.05.01 of your Certificate of Coverage. 30 visits per year for all services except ABA for treatment of Autism.
	Skilled nursing care	20% coinsurance Up to $2,000/$4,000	Not covered	Plan preauthorization is required. See Section 8.05.01 of your Certificate of Coverage. 60 visits/year.
	Durable medical equipment	20% coinsurance Up to $2,000/$4,000	Not covered	Durable medical equipment that costs $3,000 or more requires plan preauthorization. See Section 8.05.01 of your Certificate of Coverage.
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	$30-Copay	Not covered	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S. Private Duty Nursing
- Private Duty Nursing
- 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 (if rider purchased)
- Infertility Treatment

* For more information about limitations and exceptions, see the plan or policy document.

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: your state insurance department at the Michigan Health Insurance Consumers Assistance Program (HICAP) at (877) 999-6442 or DIFS-HICAP@Michigan.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: McLaren Health Plan Community, G-3245 Beecher Rd., Flint, MI 48532, Attn: Member Appeals, or call (888) 327-0671. You may also contact the Department of Insurance and Financial Services (DIFS) at (877) 999-6442. Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumers Assistance Program (HICAP) at (877) 999-6442 or DIFS-HICAP@Michigan.gov.

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

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

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al [1-888-327-0671] [TTY 711]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-888-327-0671] [TTY 711]
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** [1-888-327-0671] [TTY 711]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [1-888-327-0671] [TTY 711]

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

* For more information about limitations and exceptions, see the plan or policy document.

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	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$12,739**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$100
Coinsurance	$1,825
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,985**

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

The plan's overall deductible	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$935
Coinsurance	$346
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,336**

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

The plan's overall deductible	$1,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$1,991**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$859
Copayments	$390
Coinsurance	$215
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,464**

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

National Vision Administrators, L.L.C.

Your NVA Vision Benefit Summary

City of Flint
Effective 07/01/2019
Group Number# 3098

Schedule of Vision Benefits

Benefit Frequency	Participating Provider	Non-Participating Provider
Examination Under 19 Once Every Plan Year 19 & over Once Every Two Plan Years	▪ Covered 100% After $10 copay	Reimbursed Amount ▪ Up to $50 (OD) ▪ Up to $62 (MD)
Lenses Under 19 Once Every Plan Year 19 & over Once Every Two Plan Years	Standard Glass or Plastic	
▪ Single Vision ▪ Bifocal ▪ Trifocal ▪ Lenticular	▪ Covered 100% After $10 copay	▪ Up to $50 ▪ Up to $75 ▪ Up to $95 ▪ Up to $95
▪ Standard Progressives	▪ Covered 100%	▪ N/A
Frame Under 19 Once Every Plan Year 19 & over Once Every Two Plan Years	Retail Allowance ▪ Up to $130② (20% discount off balance)*	▪ Up to $45
Contact Lenses Under 19 Once Every Plan Year 19 & over Once Every Two Plan Years	In lieu of Lenses & Frame	In lieu of Lenses & Frame
Elective Contact Lenses①	▪ Up to $130 Retail③ (15% discount (Conventional) or 10% discount (Disposable) off balance)**	▪ Up to $100
Medically Necessary***	▪ Covered 100%	▪ Up to $210

How Your Vision Care Program Works

Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses and a frame or contact lenses once every two plan years. Eligible dependents under age 19 are entitled to receive a vision examination and one (1) pair of lenses and a frame or contact lenses once every plan year.

For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, simply present your NVA identification card to the provider or indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care professional, please visit our website at www.e-nva.com or download our mobile app by searching NVA Vision, or contact NVA's Customer Service Department toll-free at 1.800.672.7723 (TDD line 1-888-820-2990) or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 3098000001 or the group number on the identification card and enter in your search parameters. It's that easy!

*Does not apply to Wal-Mart / Sam's Club locations or for certain proprietary brands.
**Does not apply to Wal-Mart/Sam's Club, Contact Fill (NVA Mail Order) or certain locations at: Target, Sears, Pearle, & K-Mart and may be prohibited by some manufacturers.
***Pre-approval from NVA required.

①Additional professional services related to contact lenses (also known as fitting fees) would be included in the contact lens allowance shown above.
②Includes frames up to $52 Every Day Low Price-price point at Walmart/Sam's Club locations.
③$91 Every Day Low Price-price point for contact lenses at Walmart/Sam's Club locations

Due to their everyday low prices (EDLP) the amounts listed below may not be applicable at Wal-Mart/Sam's Club.
Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- $40 Anti-Reflective Coating (Standard)
- $30 Blended Bifocal (Segment)
- $40 Blue Light Blocker (Standard)
- $60 Blue Light Blocker (Premium)
- $150 Blue Light Blocker (Ultra)
- $12 Fashion Gradient
- $20 Glass Photogrey (Single Vision)
- $30 Glass Photogrey (Multi-Focal)
- $55 High Index
- $25 Polycarbonate (Single Vision)
- $30 Polycarbonate (Multi-Focal)
- $75 Polarized
- $100 Progressive Lenses (Premium)
- $10 Scratch-Resistant Coating (Standard)
- $10 Solid Tint
- $65 Transitions Single Vision (Standard)
- $70 Transitions Multi-Focal (Standard)
- $12 Ultraviolet Coating

For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price. Fixed prices are available in-network only. Discounts are not insured benefits. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Get a Better View

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations: The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Hearing Discount: You will receive up to 30-60% off retail at participating provider locations through EPIC Hearing.

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order, however, you may get even better pricing on contact lenses through Contact Fill.

Your NVA EyeEssential® Plan Discount – In Network Only

Service	Participating Provider	Lens Options
	Member Cost:	
Eye Examination:	Retail Less $10	$12 Solid Tint/ Gradient Tint
		$50 Standard Progressive Lenses
Contact Lens Fitting:	Retail Less 10%	$75 Polarized Lenses
		$65 Transitions Single Vision Standard
Lenses:	Glass or Plastic	$70 Transitions Multi-Focal Standard
Single Vision	$35.00	$15 Standard Scratch Coating
Bifocal	$55.00	$12 UV Coating
Trifocal or Lenticular	$70.00	$35 Polycarbonate
		$45 Standard Anti-Reflective
Frame:	Retail Less 35%	
Contact Lenses*:	**Member Cost:**	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U and C) price.

Wal-Mart / Sam's Club Stores: Due to their everyday low prices (EDLP) Wal-Mart / Sam's Club stores do not provide additional discounts.

At NVA, We Work Only for Our Clients.

National Vision Administrators, L.L.C. ▫ PO Box 2187 ▫ Clifton, NJ 07015
Web: www.e-nva.com ▫ Toll-Free: 1.800.672.7723

TOTAL HURLEY
A Partnership For Better Healthcare

OCCUPATIONAL EYEWEAR NETWORK, INC

Vision Plan Program (Included With Medical)

Total Hurley, A Partnership For Better Healthcare, is a health plan provided by Hurley Medical Center and administered by Total Health Care USA.

ITEM:	MEMBER PAYS:
Comprehensive Eye Exam	0%
Contact Lens Fitting Fee	Retail
FRAMES	
Frames (Up to $80.00 Retail)	Retail
Frames (Over $80.00 Retail)	Retail, less 30%, less $24.00
LENSES (CR-39 or Glass)	
Single Vision	$0
Bifocal	$0
Trifocal	$0
CONTACT LENSES	
Elective	Retail, less $80.00
Medically Necessary	Retail, less $140.00

Options available to eligible Total Health Care USA Commercial Groups Members:

ITEM:	MEMBER PAYS:
Polycarbonate Lenses	$30.00
Hi Index	$60.00
Progressive – Standard	$50.00
Progressive – Midrange	$80.00
Progressive – Premium	$125.00
Solid Tint	$10.00
Gradient Tint	$12.00
Oversize Lenses	$0
UV Coating	$15.00
Scratch Coat	$15.00
AR Coating – Standard	$40.00
AR Coating – Premium	$55.00
AR Coating – Hydrophobics	$79.00
Photochromic Lenses	$20.00
Transition Lenses	$70.00
Polarized Lenses	$70.00

AUTHORIZATION:

- Please call OEN customer service toll-free number at (877) 799-0220 to verify eligibility.

NOTES:

- For any item not listed above: Give a 20% discount off retail pricing.
- Progressive Upgrade: Bill Plan for trifocal reimbursement.
- Utilize optical lab of choice for lens fabrication.
- Contact lens benefit is in lieu of eyeglass benefit.
- A prior authorization is required for medically necessary contact lenses.

ELIGIBILITY – All eligible Members are entitled to:

- Examination – every calendar year.
- Frames and Lenses, or Contacts – every two calendar years.

EXCLUSIONS – No payment will be made for the following:

- Eyeglasses for Members not requiring corrective lenses.
- Charges for any service or materials not covered by this program.
- Medical or surgical treatment.
- Services provided or glasses ordered before Member is eligible for coverage or after termination of coverage.
- Replacement of lost lenses or frames, unless Member meets all eligibility requirements.
- Replacement of scratched lenses.
- Prescription safety glasses.

TOTAL HURLEY

Total Hurley HMO Basic $1,000 Ded - 20% Co-Ins

BENEFIT INFORMATION	
BENEFIT PERIOD: Calendar year	
Medical Deductible	$1,000 Annual per Member $2,000 Annual per Family
Coinsurance	20%
Combined Out-of-Pocket Maximum	$1,700 per Member $3,400 per Family
PHYSICIAN/PREVENTIVE SERVICES	
Primary Care Visit	$20 Co-Pay
Specialty Care	$40 Co-Pay
Preventive Care/Screening/Immunizations	100% Coverage
Prenatal and Postnatal Care	100% Coverage
Well Baby Visits	100% Coverage
Allergy Injections	100% Coverage
Allergy Testing	100% Coverage
Chiropractic Care (Limited to 30 visits per calendar year in combination with PT/OT)	Member pays Coinsurance after Deductible
PT/OT (Limited to 30 visits per calendar year in combination with Chiropractic Care)	Member pays Coinsurance after Deductible
Rehabilitative & Habilitative Devices	Member pays Coinsurance after Deductible
Rehabilitative Speech Therapy (30 visits per calendar year)	Member pays Coinsurance after Deductible
Diabetes Education	100% Coverage
Dietician Services (Nutritional Counseling)	100% Coverage
Family Planning	100% Coverage
Habilitation Services	Member pays Coinsurance after Deductible
Infertility Testing (Underlying causes only)	Member pays Coinsurance after Deductible
Mammograms	100% Coverage
Weight Loss Programs	100% Coverage
INPATIENT SERVICES	
Inpatient Stay	Member pays Coinsurance after Deductible
Inpatient Physician & Surgical Services	Member pays Coinsurance after Deductible
Bariatric Surgery (One procedure per lifetime)	Member pays Coinsurance after Deductible
Delivery & All Inpatient Services for Maternity Care	Member pays Coinsurance after Deductible
Reconstructive Surgery	Member pays Coinsurance after Deductible
Transplant	Member pays Coinsurance after Deductible
OUTPATIENT SERVICES	
Outpatient Surgery Physician/Surgical Services	Member pays Coinsurance after Deductible
Outpatient Facility Fee	Member pays Coinsurance after Deductible
Outpatient Rehabilitation Services (Includes Cardio/Pulmonary Rehab)	Member pays Coinsurance after Deductible
Chemotherapy	Member pays Coinsurance after Deductible
Dialysis	Member pays Coinsurance after Deductible
Imaging (CT/PET Scans, MRIs)	Member pays Coinsurance after Deductible
Infusion Therapy	Member pays Coinsurance after Deductible
Laboratory Outpatient & Professional Services	Member pays Coinsurance after Deductible
Radiation Therapy	Member pays Coinsurance after Deductible
Temporomandibular Joint Disorders	50% Coverage
X-Rays & Diagnostic Imaging	Member pays Coinsurance after Deductible
EMERGENCY/AFTER HOURS MEDICAL SERVICES	
Emergency Room	$150 Co-Pay
Urgent Care	$40 Co-Pay
Ambulance Services (When medically necessary)	$75 Co-Pay

Total Hurley HMO Basic $1,000 Ded - 20% Co-Ins

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES	
Mental/Behavioral Health Outpatient Services	$40 Co-Pay
Mental/Behavioral Health Inpatient Services	Member pays Coinsurance after Deductible
Substance Abuse Outpatient	$40 Co-Pay
Substance Abuse Inpatient	Member pays Coinsurance after Deductible
OTHER SERVICES	
Home Health Care	Member pays Coinsurance after Deductible
Skilled Nursing Facility (Limited to 45 days per calendar year)	Member pays Coinsurance after Deductible
Hospice Services	Member pays Coinsurance after Deductible
DURABLE MEDICAL EQUIPMENT/PROSTHETIC DEVICES	
DME	100% Coverage by Plan's DME Provider
Prosthetic Devices	Member pays Coinsurance after Deductible
HEARING SERVICES	
Hearing Exam	100% Coverage
Hearing Aids	Plan pays a max $600 per ear every 3 years
VISION SERVICES	
Routine Eye Exam (Adult & Pediatric)	100% Coverage
Eye Glasses for Adults	100% Coverage on selected lenses & frames
Eye Glasses for Children	100% Coverage on selected lenses & frames
TELEMEDICINE	
Teladoc	100% Coverage
PHARMACY	
Generic Drugs	$10 Copay
Preferred Brand Name Drugs	$40 Copay
Non-Preferred Brand Name Drugs	$60 Copay
Specialty Drugs	25% Coinsurance
90-day supply Medications available through Plan's Mail Order Pharmacy	2 times the monthly copay

The Benefits described above are intended to be only a Summary Description. For details, please review the Certificate of Coverage Agreement.