2020

Enrollment Guide

Comfort Keepers
a sodexo brand

Medical Carrier Contact	Vision Carrier Contact	Dental Carrier Contact
United Healthcare – HMO	Beam/VSP	Beam
Member Service	Member Services	Member Services
(866) 414-1959	(800) 877-7195	(800) 648-1179
Policy # 01F5710	**Policy # MI02183**	**Policy # MI02183**
www.myhuc.com	www.vsp.com	www.beam.dental

Karl J. Ruth Jr • kruth@ajmassoc.com • (248) 778-6070 • www.ajmassoc.com

Dear Employee:

At Comfort Keepers we value your service and contributions and we care about the health of you and your family members. Our goal for the upcoming benefit plan year is to provide you with options, based on your healthcare needs, as well as access to participating network medical doctors and hospitals and to provide coverage for the most frequently used services such as office visits and prescription drugs. Therefore, we have worked diligently with our Benefits Administrator, AJM Associates, Inc., to develop medical, prescription drug plans and ancillary coverage that incorporate National and Local network access while providing popular options at an affordable price.

You will have the opportunity, each year, during open enrollment to review you benefit plan options and to make any necessary changes for the upcoming benefit plan year. At this time, you can change your benefit elections or add / delete eligible dependents under the plan. Your elections will be effective **January 1, 2020 through December 31, 2020.** This Enrollment Guide is your regular full-time employee benefits manual. The purpose of this guide is to give you information and answer questions regarding your **2020** benefit package. Your benefits are an important part of your total compensation, so we invite you to familiarize yourself with the details of these plans and encourage you to seek clarification when necessary.

HOW TO ENROLL

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

HOW TO MAKE CHANGES

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. See **Open Enrollment** in this Enrollment Guide for details regarding IRS approved Qualifying Life Events.

We are excited and proud of this year's employee benefit offering and feel it is among the most competitive in our industry. As we continue to review employee satisfaction surveys, we intend to respond with further benefit package offering and refinements. Please feel free to contact Karl Ruth from our benefits administration company, Karl J. Ruth Jr., at AJM Associates, Inc. (248) 778-6070 with any questions or concerns you may have.

Open enrollment is the time of year when you can make any necessary changes to your current health election. The elections that you choose may be changed only at the next Open Enrollment Period, unless you have a Qualified Change of Status which would allow a Special Open Enrollment.

In accordance with federal regulations, the benefits you choose in your benefits package will remain in effect through the next plan year. However, you may be allowed to make changes in certain benefits if you have a **Qualified Change of Status Event**. Examples of qualified change of status events are listed below:

- Change in Status
- Change in employee's legal marital status
- Change in number of dependents
- Change in employment status (including change in work site location)
- Dependent satisfies (or ceases to satisfy) eligibility requirements
- Change in residence
- Commencement or termination of adoption proceedings
- Significant Cost Increase
- Significant Curtailment of Coverage
- Change in Coverage of Spouse or Dependent Under Other Employer's Plan
- FMLA Leave*
- COBRA Event
- Judgment, Decree, or Court Order
- Medicare or Medicaid Entitlement
- Employee/dependent loss of Medicaid or Children's Health Insurance Program (CHIP) or employee/dependent entitlement for a premium assistance program through Medicaid or CHIP. Please note that these qualifying events have a special 60 day enrollment period rather than the typical 30 day enrollment period.

Note that there are certain limitations and/or exclusions within <u>each</u> qualifying event. For more information please contact AJM Associates, Inc at (248) 778-6070.

The Internal Revenue Service requires that the change in benefits must be consistent with the change of status. If you have a change, you must complete a new Enrollment Form within 30 days of the event. These forms are available from Human Resources. **Changes made after 30 days will not be accepted.**

Notice of HIPAA Special Open Enrollment Rights – If you are declining enrollment for yourself or your dependents (including your spouse) because other health insurance coverage, you may in the future be able to enroll yourself or your dependents in these plans if you request enrollment within 30 days after your other coverage ends. In addition, if you acquire a new dependent, because of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself, your spouse and your newly acquired dependents if you request enrollment within 30 days after the marriage, birth, adoption and placement for adoption.

PLEASE LET US KNOW ABOUT:

Weddings	Within 30 days of marriage
New Babies	Within 30 days of birth
Adoptions	Within 30 days of the date of petition or adoption
Change of Name or Address	Immediately
Death	Within 30 days
Divorce	Within30 days
Military Service	Within 30 days of induction or when dependent is discharged
Dependent Children	Any change in status of dependent children
65th Birthday	When you or your dependent become eligible for Medicare.

This is intended as an easy-to-read-summary. It is not a contract. For complete detail of benefits, limitations and exclusions please see your benefits contract.

Women's Health and Cancer Rights Act of 1998

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

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

Newborn's and Mothers' Health Protection Act

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

Genetic Information Nondiscrimination Act of 2008

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of disease or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members. Genetic information cannot be requested, required or purchased for underwriting purposes or before enrollment, participants and covered dependents cannot be required to undergo a genetic test, and genetic information cannot be used to adjust premiums or contributions for the group. However, a plan is permitted to use the minimum necessary amount of genetic testing results to decide about claim payment.

Notice of HIPAA Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. A copy of the HIPPA Privacy Notice is included within this enrollment guide.

Tell Us When You're Medicare Eligible

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

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

The Children's Health Insurance Program Reauthorization

Act of 2009 added the following two special enrollment opportunities.

- The employee or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated because of loss of eligibility; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

It is your responsibility to notify Human Resources within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. More information on CHIP is provided later in this guide.

Michelle's Law

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

Summary of Material Modification

The information in this guide applies to the Comfort Keepers Benefit Plan Information. This information meets the requirements for a Summary of Material Modification as required by the Employee Retirement Income Security Act (ERISA).

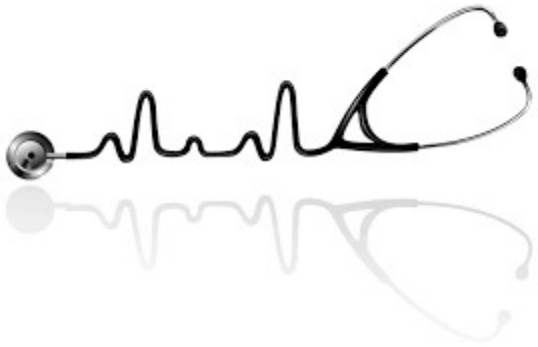
Summary of Benefits and Coverage (SBC)

For group health plan coverage, the regulations provide that, for disclosures with respect to participants and beneficiaries who enroll or re-enroll through an open enrollment period (including late enrollees and re-enrollees), the SBC must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the SBC must be provided beginning on the first day of the first plan year that begins on or after September 23, 2012.

Disclosure About The Benefit Enrollment Communications

The benefit enrollment communications (Enrollment Guide) contains only a summary of your benefits. We have worked to ensure the accuracy of these materials, but if there is any discrepancy between the benefits discussed in these materials and the official plan documents, the official plan documents will rule. Actual benefits will be paid in accordance with the carrier contracts and any amendments to those contracts in place at the time of the claim. Please refer to the carrier booklets for details regarding your coverage, including benefit limitation and exclusions. Comfort Keepers reserves the right to amend, modify or terminate any plan at any time and in any manner.

In addition, please be aware that information contained in these materials is based on the current understanding of the federal health care reform legislation signed into law in March 2010. The interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. Government. Therefore, we defer to the actual carrier contracts, processes, and the law itself as the governing documents.



MEDICAL INSURANCE COVERAGE

Deductibles and Out of Pocket Maximum reset on a Calendar Year Basis

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This is intended as an easy-to-read-summary. It is not a contract. For complete detail of benefits, limitations and exclusions please see your benefits contract.

UnitedHealthcare®

Benefit Summary

Choice HSA Silver 5000-1
Michigan - Choice
HSA - Plan BQRP

What is a benefit summary?

This is a summary of what the plan does and does not cover. This summary can also help you understand your share of the costs. It's always best to review your Certificate of Coverage (COC) and check your coverage before getting any health care services, when possible.

What are the benefits of the Choice Plan with an HSA?

Use our national network and an HSA to save money.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in our network. You can save money when you use the health savings account (HSA) and the network.

> **Save money by staying in our network.** If you don't use the network, you'll have to pay for all of the costs.

> **There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.** Consider a PCP; they can be helpful in managing your care.

> **Preventive care is covered 100% in our network.**

> **You can open a health savings account (HSA).** An HSA is a personal bank account to help you save and pay for your health care, and help you save on taxes.

Not enrolled yet? Learn more about this plan and search for network doctors or hospitals at **welcometouhc.com/choicehsa** or call **1-866-873-3903**, TTY **711**, 8 a.m. to 8 p.m. local time, Monday through Friday.

Are you a member?

Easily manage your benefits online at **myuhc.com®** and on the go with the **UnitedHealthcare Health4Me®** mobile app.

For questions, call the member phone number on your health plan ID card.

Benefits At-A-Glance

What you may pay for network care

This chart is a simple summary of the costs you may have to pay when you receive care in the network. It doesn't include all of the deductibles and co-payments you may have to pay. You can find more benefit details beginning on page 2.

Co-payment (Your cost for an office visit)	Individual Deductible (Your cost before the plan starts to pay)	Co-insurance (Your cost share after the deductible)
You have no co-payment.	$5,000	You have no co-insurance.

This Benefit Summary is to highlight your Benefits. Do not use this document to understand your exact coverage for certain conditions. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents are correct. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

UnitedHealthcare Community Plan, Inc.

Your Costs

In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Your cost if you use Network Benefits

Annual Deductible - Combined Medical and Pharmacy

What is an annual deductible?

The annual deductible is the amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. It does not include any amount that exceeds Allowed Amounts. The deductible may not apply to all Covered Health Care Services. You may have more than one type of deductible.

> All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.

Medical Deductible - Individual	$5,000 per year
Medical Deductible - Family	$10,000 per year
Dental - Pediatric Services Deductible - Individual	Included in your medical deductible.
Dental - Pediatric Services Deductible - Family	Included in your medical deductible.

Out-of-Pocket Limit - Combined Medical and Pharmacy

What is an out-of-pocket limit?

The Out-of-Pocket Limit is the maximum you pay per year. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year.

> Your co-pays, co-insurance and deductibles (including pharmacy) count towards meeting the out-of-pocket limit.

> All individual out-of-pocket limit amounts will count towards meeting the family out-of-pocket limit, but an individual will not have to pay more than the individual out-of-pocket limit amount.

Out-of-Pocket Limit - Individual	$5,500 per year
Out-of-Pocket Limit - Family	$11,000 per year

Your Costs

What is co-insurance?

Co-insurance is the amount you pay each time you receive certain Covered Health Care Services calculated as a percentage of the Allowed Amount (for example, 20%). You pay co-insurance plus any deductibles you owe. Co-insurance is not the same as a co-payment (or co-pay).

What is a co-payment?

A Co-payment is the amount you pay each time you receive certain Covered Health Care Services calculated as a set dollar amount (for example, $50). You are responsible for paying the lesser of the applicable Co-payment or the Allowed Amount. Please see the specific Covered Health Care Service to see if a co-payment applies and how much you have to pay.

What is Prior Authorization?

Prior Authorization is getting approval before you receive certain Covered Health Care Services. Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However there are some Benefits that you are responsible for obtaining authorization before you receive the services. Please see the specific Covered Health Care Service to find services that require you to obtain prior authorization. Service site review may be a component of the prior authorization process.

Want more information?

Find additional definitions in the glossary at justplainclear.com.

Your Costs

Following is a list of services that your plan covers in alphabetical order. In addition to your premium (monthly) payments paid by you or your employer, you are responsible for paying these costs.

Covered Health Care Services	Your cost if you use Network Benefits
Ambulance Services	
Emergency Ambulance:	You pay nothing, after the medical deductible has been met.
Non-Emergency Ambulance:	You pay nothing, after the medical deductible has been met. Prior Authorization is required for Non-Emergency Ambulance.
Antineoplastic Therapy	
	The amount you pay is based on where the covered health care service is provided.
Breast Cancer Diagnostic, Treatment and Rehabilitative Services	
	The amount you pay is based on where the covered health care service is provided.
Cellular and Gene Therapy	
Cellular or Gene Therapy services must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.
Clinical Trials	
	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.
Congenital Heart Disease (CHD) Surgeries	
	Benefits will be the same as stated under Hospital - Inpatient Stay.
Dental - Pediatric Services (Benefits covered up to age 19)	
Benefits provided by the National Options PPO 20 Network (INO-MAC).	
Dental - Pediatric Preventive Services	
Dental Prophylaxis (Cleanings) Limited to three times every 12 months.	You pay nothing, after the medical deductible has been met.
Fluoride Treatments	You pay nothing, after the medical deductible has been met.
Sealants (Protective Coating)	You pay nothing, after the medical deductible has been met.
Space Maintainers (Spacers)	You pay nothing, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Dental - Pediatric Diagnostic Services	
Evaluations (Check-up Exams) Limited to 2 times per 12 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	You pay nothing, after the medical deductible has been met.
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months for Bitewings and 1 time per 36 months for Panoramic radiograph image.	You pay nothing, after the medical deductible has been met.
Dental - Pediatric Basic Dental Services	
Endodontics (Root Canal Therapy)	20% co-insurance, after the medical deductible has been met.
Adjunctive Services Palliative (Emergency) Treatment: Covered as a separate Benefit only if no other services (other than the exam and radiographs) were done on the tooth during the visit. General Anesthesia: Covered only when clinically Necessary. Occlusal Guard: Limited to one guard every 12 months.	20% co-insurance, after the medical deductible has been met.
Oral Surgery	20% co-insurance, after the medical deductible has been met.
Periodontics Periodontal Surgery: Limited to one every 36 months per surgical area. Scaling and Root Planing: Limited to one time per quadrant every 24 months. Periodontal Maintenance: Limited to four times every 12 months in combination with prophylaxis.	20% co-insurance, after the medical deductible has been met.
Minor Restorative Services (Amalgam or Anterior Composite)	20% co-insurance, after the medical deductible has been met.
Simple Extractions (Simple tooth removal) Limited to one time per tooth per lifetime.	20% co-insurance, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Dental - Pediatric Major Restorative Services	
Crowns/Inlays/Onlays Limited to one time per tooth every 60 months.	50% co-insurance, after the medical deductible has been met.
Removable Dentures (Full denture/partial denture) Limited to a frequency of one every 60 months.	50% co-insurance, after the medical deductible has been met.
Bridges (Fixed partial dentures) Limited to one time every 60 months.	50% co-insurance, after the medical deductible has been met.
Implant Procedures Limited to one time every 60 months.	50% co-insurance, after the medical deductible has been met.
Dental - Pediatric Medically Necessary Orthodontics	
Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/ vertical (overjet/overbite) discrepancies.	50% co-insurance, after the medical deductible has been met. Prior Authorization is required for orthodontic treatment.
Dental Services - Accident Only	
	You pay nothing, after the medical deductible has been met.
Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care:	The amount you pay is based on where the covered health care service is provided.
Diabetes Self-Management Items:	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies and in the Outpatient Prescription Drug Rider.
Dietitian Services	
Limited to six visits per year.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required for certain services.
Durable Medical Equipment (DME), Orthotics and Supplies	
	You pay nothing, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Emergency Health Care Services - Outpatient	
	You pay nothing, after the medical deductible has been met. Notification is required if confined in an Out-of-Network Hospital.
Enteral Tube Feedings and Parenteral Nutrition - Outpatient or in the Home	
	You pay nothing, after the medical deductible has been met or as stated in the Outpatient Prescription Drug Rider. Prior Authorization is required.
Gender Dysphoria	
	The amount you pay is based on where the covered health care service is provided and in the Outpatient Prescription Drug Rider. Prior Authorization is required for certain services.
Habilitative Services	
Inpatient: Habilitative services received during an Inpatient Stay in an Inpatient Rehabilitative Facility are limited to 60 days per year.	The amount you pay is based on where the covered health care service is provided.
Outpatient: Outpatient therapies are limited per year as follows: 30 visits for any combination of physical therapy, occupational therapy and Manipulative treatments. 30 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive therapy. Please note there is no visit limits for physical, speech or occupational therapy relating to Autism Spectrum Disorder for Enrolled Dependent children through 18 years of age.	You pay nothing, after the medical deductible has been met.
Hearing Aids	
Limited to a single purchase per hearing impaired ear every 36 months. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase.	You pay nothing, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Home Health Care and Private Duty Nursing	
For the administration of intravenous infusion, you must receive services from a provider we identify.	You pay nothing, after the medical deductible has been met.
Hospice Care	
	You pay nothing, after the medical deductible has been met.
Hospital - Inpatient Stay	
	You pay nothing, after the medical deductible has been met.
Lab, X-Ray and Diagnostic - Outpatient	
Lab Testing - Outpatient:	
Limited to 18 Presumptive Drug Tests per year.	You pay nothing, after the medical deductible has been met.
Limited to 18 Definitive Drug Tests per year.	
X-Ray and Other Diagnostic Testing - Outpatient:	You pay nothing, after the medical deductible has been met.
Major Diagnostic and Imaging - Outpatient	
	You pay nothing, after the medical deductible has been met.
Mental Health Care and Substance - Related and Addictive Disorders Services	
Inpatient (including Residential Treatment):	You pay nothing, after the medical deductible has been met.
Outpatient:	You pay nothing, after the medical deductible has been met.
Partial Hospitalization/Intensive Outpatient Treatment:	You pay nothing, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Obesity - Weight Loss Surgery	
For Network Benefits, obesity - weight loss surgery must be received from a Designated Provider. Limited to one bariatric surgery per lifetime unless determined to be Medically Necessary to correct or reverse complications from a previous bariatric procedure.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.
Orthognathic Surgery	
	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.
Ostomy Supplies	
	You pay nothing, after the medical deductible has been met.
Pain-Evaluation and Treatment	
	The amount you pay is based on where the covered health care service is provided.
Pediatric Dental Anesthesia	
	The amount you pay is based on where the covered health care service is provided.
Pharmaceutical Products - Outpatient	
This includes medications given at a doctor's office, or in a Covered Person's home. It does not apply to outpatient Prescription Medications for which Benefits are described in the Outpatient Prescription Drug Rider.	You pay nothing, after the medical deductible has been met.
Physician Fees for Surgical and Medical Services	
	You pay nothing, after the medical deductible has been met.
Physician's Office Services - Sickness and Injury	
	You pay nothing for a primary care physician office visit, after the medical deductible has been met. You pay nothing for a specialist office visit, after the medical deductible has been met.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Pregnancy - Maternity Services	
	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.
Prescription Drug Benefits	
Prescription drug benefits are shown in the Prescription Drug benefit summary.	
Preventive Care Services	
Physician Office Services, Lab, X-Ray or other preventive tests.	You pay nothing. A deductible does not apply.
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a co-pay, co-insurance or deductible.	
Prosthetic Devices	
	You pay nothing, after the medical deductible has been met.
Reconstructive Procedures	
	The amount you pay is based on where the covered health care service is provided.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment	
Limited per year as follows: 30 visits for any combination of pulmonary rehabilitation therapy and cardiac rehabilitation therapy. 30 visits for any combination of physical therapy, occupational therapy and Manipulative treatments (includes osteopathic manipulations). 30 visits of speech therapy. 30 visits of post-cochlear implant aural therapy. 20 visits of cognitive rehabilitation therapy. Please note there are no visit limits for physical, speech or occupational therapy relating to Autism Spectrum Disorders for Enrolled Dependent children through 18 years of age.	You pay nothing, after the medical deductible has been met.

Your Costs

Covered Health Care Services	Your cost if you use Network Benefits
Scopic Procedures - Outpatient Diagnostic and Therapeutic	
Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy. Benefits that apply to certain preventive screenings are described under Preventive Care Services.	You pay nothing, after the medical deductible has been met.
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services	
Limited to 60 days per year.	You pay nothing, after the medical deductible has been met.
Surgery - Outpatient	
	You pay nothing, after the medical deductible has been met.
Temporomandibular Joint Services	
	The amount you pay is based on where the covered health care service is provided.
Therapeutic Treatments - Outpatient	
Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.	You pay nothing, after the medical deductible has been met.
Transplantation Services	
Network Benefits must be received from a Designated Provider.	The amount you pay is based on where the covered health care service is provided. Prior Authorization is required.
Urgent Care Center Services	
	You pay nothing, after the medical deductible has been met.

Additional co-pays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.

Covered Health Care Services	Your cost if you use Network Benefits
Virtual Visits	
Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.	You pay nothing, after the medical deductible has been met.

Covered Health Care Services	Your cost if you use Network Benefits
Vision - Pediatric Services (Benefits covered up to age 19)	
Find a listing of Spectera Eyecare Network Vision Care Providers at myuhcvision.com.	
Routine Vision Exam Limited to once every 12 months.	You pay nothing. A deductible does not apply.
Eyeglass Lenses Limited to once every 12 months.	You pay nothing, after the medical deductible has been met.
Lens Extras Limited to once every 12 months. Coverage includes polycarbonate lenses and standard scratch-resistant coating.	You pay nothing, after the medical deductible has been met.
Eyeglass Frames Limited to once every 12 months.	
Eyeglass frames with a retail cost up to $130.	You pay nothing, after the medical deductible has been met.
Eyeglass frames with a retail cost between $130 - 160.	You pay nothing, after the medical deductible has been met.
Eyeglass frames with a retail cost between $160 - 200.	You pay nothing, after the medical deductible has been met.
Eyeglass frames with a retail cost between $200 - 250.	You pay nothing, after the medical deductible has been met.
Eyeglass frames with a retail cost greater than $250.	You pay nothing, after the medical deductible has been met.
Contact Lenses/Necessary Contact Lenses You are eligible to choose only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If you choose more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service. Fitting and evaluation limited to once every 12 months. Limited to a 12 month supply. Find a complete list of covered contacts at myuhcvision.com.	You pay nothing, after the medical deductible has been met.
Low Vision Care Services Limited to once every 24 months.	You pay nothing for Low Vision Testing. A deductible does not apply. 25% co-insurance for Low Vision Therapy. A deductible does not apply.
Weight Loss Services	
	The amount you pay is based on where the covered health care service is provided.

Services your plan generally does NOT cover. It is recommended that you review your COC, Amendments and Riders for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Routine Foot Care

For Internal Use only:

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Item#	**Rev. Date**	
320-8771	1019_rev01	Base/Value HSA/Comb/Emb/45440/2018

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ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodiilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

UnitedHealthcare®

Benefit Summary

Outpatient Prescription Drug Products

Michigan Plan 623

Standard Drugs: 15/40/75/250

Your Co-payment and/or Co-insurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3 or Tier 4. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on **myuhc.com®** or calling the Customer Care number on your ID card.

Annual Drug Deductible - Network and Out-of-Network	
Individual Deductible	No Deductible
Family Deductible	No Deductible

Out-of-Pocket Drug Limit - Network	
Individual Out-of-Pocket Limit	See the Medical Benefit Summary for the total Individual Out-of-Pocket Limit that applies.
Family Out-of-Pocket Limit	See the Medical Benefit Summary for the total Family Out-of-Pocket Limit that applies.

Out-of-Pocket Limit does not apply to Out-of-Network Charges, Ancillary Charges and Coupons.

This summary of Benefits is intended only to highlight your Benefits for Outpatient Prescription Drug Products and should not be relied upon to determine coverage. Your plan may not cover all of your Outpatient Prescription Drug expenses. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the Outpatient Prescription Drug Rider or the Certificate of Coverage, the Outpatient Prescription Drug Rider and Certificate of Coverage shall prevail.

UnitedHealthcare Insurance Company

Tier Level	Up to 31-day supply			Up to 90-day supply
	Retail Network Pharmacy or Preferred Specialty Network Pharmacy	**Retail Non-Preferred Specialty Network Pharmacy**	**Retail Out-of-Network Pharmacy**	***Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy**
Tier 1 Prescription Drug Products	**$15**	**$30**	**$15**	**$37.50**
Tier 2 Prescription Drug Products	**$40**	**$80**	**$40**	**$100**
Tier 3 Prescription Drug Products	**$75**	**$150**	**$75**	**$187.50**
Tier 4 Prescription Drug Products	**$250**	**$500**	**$250**	**$625**

Benefit Plan Co-payment/Co-insurance - The amount you pay for Prescription Drug Products.

* Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the Out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at the Retail Network Pharmacy.

For Specialty Drugs from a Non-Preferred Pharmacy, you will be required to pay 2 times the Preferred Specialty Network Pharmacy Co-payment and/or 2 times the Preferred Specialty Network Pharmacy Co-insurance (up to 50% of the Prescription Drug Charge) based on the applicable Tier.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is Chemically Equivalent. When you choose the higher cost drug of the two, you will pay the difference between the higher cost drug and the lower cost drug in addition to your Co-payment and/or Co-insurance that applies to the lower cost drug. The Ancillary Charge may not apply to any Out of Pocket Limit.

Other Important Information about your Outpatient Prescription Drug Benefits

The amounts you are required to pay is based on the Prescription Drug Charge for Network Benefits and the Out-of-Network Reimbursement Rate for out-of-Network Benefits. For out-of-Network Benefits, you are responsible for the difference between the Out-of-Network Reimbursement Rate and the out-of-network Pharmacy's Usual and Customary Charge. We will not reimburse you for any non-covered drug product.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the applicable Co-payment and/or Co-insurance, the Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product or the Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the applicable Co-payment and/or Co-insurance or the Prescription Drug Charge for that Prescription Drug Product. See the Co-payments and/or Co-insurance stated in the Benefit Information table for amounts.

For a single Co-payment and/or Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com® or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

If you require certain Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you choose not to obtain your Prescription Drug Product from the Designated Pharmacy, you may opt-out of the Designated Pharmacy program by contacting us at myuhc.com® or the telephone number on your ID card. If you want to opt-out of the program and fill your Prescription Drug Product at a non-Designated Pharmacy but do not inform us, you will be responsible for the entire cost of the Prescription Drug Product and no Benefits will be paid. If you are directed to a Designated Pharmacy and you have informed us of your decision not to obtain your Prescription Drug Product from a Designated Pharmacy, you may be subject to the Out-of-Network Benefit for that Prescription Drug Product. For a Specialty Prescription Drug Product, if you choose to obtain your Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, you may be subject to the Non-Preferred Specialty Network Co-payment and/or Co-insurance.

You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy.

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy, you may opt-out of the Maintenance Medication Program by contacting us at myuhc.com® or the telephone number on your ID card. If you choose to opt out when directed to a Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy but do not inform us, you will be subject to the out-of-Network Benefit for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Certain PPACA Zero Cost Share Preventive Care Medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician are payable at 100% of the Prescription Drug Charge (without application of any Co-payment, Co-insurance, Annual Deductible, or Annual Drug Deductible) as required by applicable law. You may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication by contacting us at myuhc.com® or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com® or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

PHARMACY EXCLUSIONS

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

Exclusions

- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
- Experimental or Investigational or Unproven Services and medications; medications used for experimental treatments for specific diseases and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not apply to any off-label usage of a Prescription Drug Product, if all of the following conditions are met: The drug is approved by the U.S. Food and Drug Administration (FDA). The drug is prescribed by an allopathic or osteopathic Physician for the treatment of either of the following: a life-threatening condition, so long as the drug is Medically Necessary to treat that condition and the drug is on the Prescription Drug List or accessible through our Prescription Drug List procedures; a chronic and seriously debilitating condition, so long as the drug is Medically Necessary to treat that condition and the drug is on the Prescription Drug List or accessible through our Prescription Drug List procedures. The drug has been recognized for treatment for the condition for which it is prescribed by one of the following: The American Medical Association Drug Evaluations; The American Hospital Formulary Service Drug Information; The United States Pharmacopoeia Dispensing Information, Volume 1, Drug Information for the Health Care Professional; two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective, unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal. As used in this exclusion: “Chronic and seriously debilitating” means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration and that causes significant long-term morbidity. “Life-threatening” means a disease or condition where the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome where the end-point of clinical intervention is survival. "Off-label" means the use of a drug for clinical indications other than those stated in the labeling approved by the U.S. Food and Drug Administration (FDA).
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Medications used for cosmetic purposes.
- Prescription Drug Products when prescribed to treat infertility.
- Certain Prescription Drug Products for tobacco cessation that exceed the minimum number of drugs required to be covered under the Patient Protection and Affordable Care Act (PPACA) in order to comply with essential health benefits requirements.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. We may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter drugs covered under the PPACA Zero Cost Share Preventive Care Medications list.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury. This exclusion would not apply to formulas for enteral feedings administered via tube as described in Section 1 of the COC under Enteral Tube Feedings and Parenteral Nutrition - Outpatient or in the Home.

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注意事項：**日本語(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, निःशुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់អ្នក។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jiik'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jiik'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

Affordable Prescription Programs

Many drug store chains offer significant savings by utilizing their prescription drug programs. Drug store chains are using the strengths of their business to drive down the cost of health care and bring their customers the lowest prices on the products and services they need to stay healthy. Eligible drugs differ for each company and many of the drugs in these programs are generic. Generic drugs contain the same high quality active ingredients as their brand-name counterparts and are equally effective but cost significantly less. Generic medicines generally cost between 30 percent to 60 percent less than equivalent brand-name products.

Interested in saving money on prescriptions? Ask your doctor if a generic is available and is right for you.

Available Retail Programs May Include:

- $4 for up to a 30-day supply (Wal-mart,Kroger, Sam's Club)
- $10 for up to a 90-day supply (Wal-mart, Kroger, Sam's Club)
- $9.99 for up to a 30-day supply (Walgreens)
- $12 for up to a 90-day supply (Walgreens)
- Cash Back Rewards – Extracare Program (CVS/Pharmacy)

Get Free Antibiotics and Pre-Natal Vitamins at your Meijer Pharmacy!

The Meijer antibiotic pharmacy program covers leading, oral generic antibiotics with a special focus on the prescriptions most often filled for children. The following are **FREE** with your doctor's prescription, regardless of insurance or co-pay:

- Amoxicillin
- SMZ-TMP
- Ampicillin
- Cephalexin
- Ciprofloxacin
- Penicillin VK

The **FREE** pre-natal vitamin program features several leading brands of pre-natal vitamins. See a Meijer pharmacist for details.

Prescribed Metformin? Meijer offers **FREE** Metformin Immediate Release as prescribed by your doctor. See a Meijer pharmacist for details.

Please contact your local retail pharmacy or visit their website for current and specific drug coverage programs.

Did You Know?

- **Goodrx.com** provides prescription drug coupons, comparison shopping and a convenient mobile application to help you save on your prescription drug cost?
- **Rx Pharmacy Coupons. Com** (www.rxpharmacycoupons.com) provides script savings on your medications through the pharmacy manufactures and vendors? The Prescription Assistance Program, RxPharmacyCoupons, is partnered with companies that negotiate discounts directly with the pharmacies on over 20,000 name and generic brand drugs. Because their program is able to send such a high volume of cash-paying customers to pharmacies, they can provide group rate prescription discounts. These wholesale prices are passed directly on to patients.

How do I use the Prescription Discount Coupons?

1. Select a pharmacy: RxPharmacyCoupons is valid at over 68,000 network pharmacy locations nationwide. In most cases, your current pharmacy will be part of our network. Use their Pharmacy Locator Service if you need help finding a participating pharmacy.
2. Submit your prescription: Present your prescription to the pharmacist. If you need to transfer a prescription, bring your empty prescription bottle or label with you to the pharmacy.
3. Present RxPharmacyCoupons: Your coupon/card's unique code provides the pharmacist with the appropriately discounted prescription price. The price on the prescription is based on the pharmacy's contracted agreement with RxPharmacyCoupons and their partners.
4. You Save: Your savings will be clear once the pharmacist enters your filled prescription into the register.

DENTAL INSURANCE COVERAGE

Plan Year – January 1st – December 31st.

NOTES:

This is intended as an easy-to-read-summary. It is not a contract. For complete detail of benefits, limitations and exclusions please see your benefits contract.

DENTAL BENEFITS SUMMARY

Comfort Keepers

PLAN: SmartPremium 100/80/50/50-1000-1000

POLICY EFFECTIVE DATE: 01/01/20 **GROUP #:** MI02183

WHY BEAM

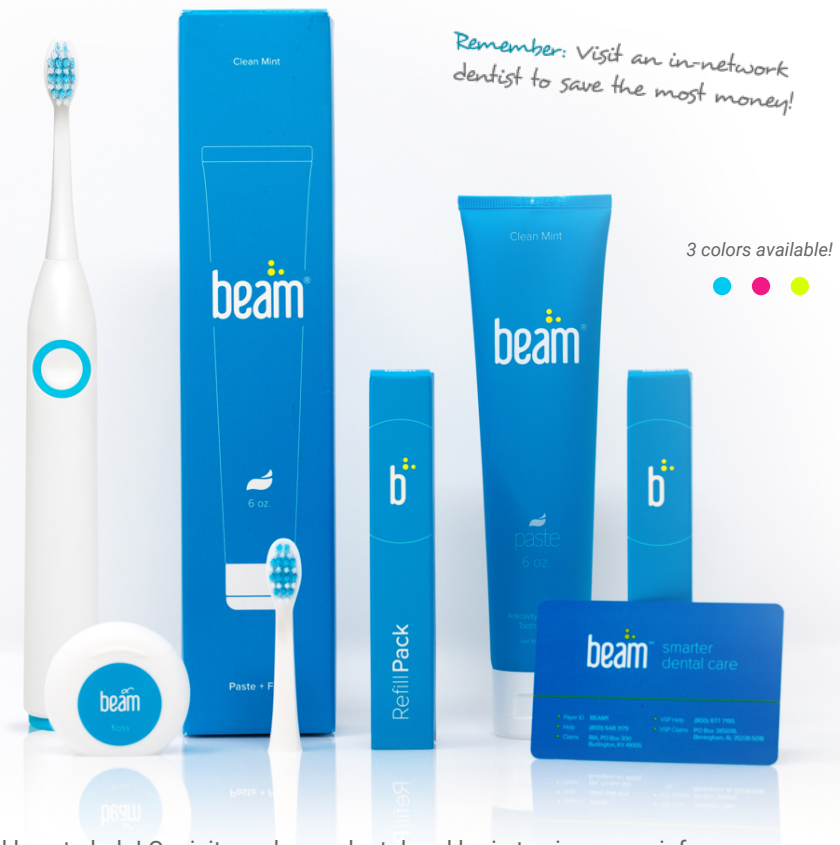
Beam is the future of group dental insurance for employers large and small. We're pairing innovative tech with personal service to deliver an insurance experience unlike any other.

- **No waiting period**
- **90th Percentile UCR OON**
- Digital implementation and admin
- **No downgrades on composites**
- Nationwide network (337,890 access points)
- Beam Perks included

BEAM PERKS INCLUDED

Everything needed for great dental care delivered right to member's doors every 6 months.

- **Beam Brush**
  Sonic powered, smart, electric toothbrush.
- **Replacement heads**
  Soft bristle brush heads made specifically for your brush.
- **Beam Paste**
  High-quality, custom formulated toothpaste.
- **Beam Floss**
  50 yards of high quality ribbon floss.



QUESTIONS?

If you have questions, call us at (800) 648-1179. We'd love to help! Or visit app.beam.dental and login to view more info. Please check your Certificate of Insurance for a description of coverage, limitations, and exclusions under the plan. Some Services require prior authorization.

PLAN COVERAGE

	IN-NETWORK (PPO FEE)	OUT-OF-NETWORK (90TH PERCENTILE UCR)
PREVENTIVE & DIAGNOSTIC **Diagnostic and preventive:** exams, cleanings, fluoride, space maintainers, x-rays, and sealants	100%	100%
BASIC **Minor restorative:** fillings **Prosthetic maintenance:** relines and repairs to bridges, implants, and dentures **Emergency palliative treatment:** to temporarily relieve pain	80%	80%
MAJOR **Major restorative:** crowns, inlays, and onlays **Endodontics:** root canals **Periodontics:** to treat gum disease **Prosthodontics:** dentures **Prosthetics:** bridges **Implants:** **Oral surgery:** extractions and dental surgery	50%	50%
ORTHODONTIA **Child Orthodontics:** braces with age limit of 19	50%	50%

PLAN MAXES

Annual maximum applies to diagnostic & preventive, basic services, and major services. Lifetime maximum applies to orthodontic services.
Annual Max based on Calendar Year.

ANNUAL MAX **Benefit Period:** Calendar Year	$1,000 /yr
ORTHO LIFETIME MAX	$1,000 /lifetime

PLAN DEDUCTIBLE

The deductible is waived for diagnostic & preventive services.

INDIVIDUAL	$50.00 /yr
FAMILY	$150.00 /yr

CLAIMS INFORMATION

Beam Insurance Administrators	Electronic payer ID	NEA ID	Fax number	Phone number	Claim form accepted
PO Box 75372 Cincinnati, OH 45275	BEAM1	BEAM1	(844) 688 - 4821	(800) 648 - 1179	ADA form 2006 or later

Beam Dental PPO Standard coverages, as of August 1, 2019

FREQUENCIES & LIMITATIONS

COVERAGE RULES

CODE	PROCEDURE	COVERED UNDER	FREQUENCY	NOTES
D1110	Prophylaxis	Preventive	Two per benefit period	Shared freq with D4910
D0120	Periodic oral exam	Preventive	Two per benefit period*	No shared freq with D0140
D0140	Limited oral exam	Emergency Palliative	Two per 12 months	Can do treatment on same day; no shared freq with D0120
D0150	Comprehensive oral exam	Preventive	One per 60 months*	Shared freq with D0160, D0180
D0210	Radiographs–FMX	Preventive	One per 60 months	Shared freq with D0330, D0274
D0220, 0230	Radiographs–periapical	Preventive	One set per 3 months	Should not exceed 4 images when done on same day as D0274; not covered on same day as D0210, D0330
D0270 - 0277	Radiographs–bitewings	Preventive	Every 6 months	Can perform 6 months after D0210
D0330	Radiographs–panoramic	Preventive	One per 60 months	Shared freq with D0210
D0431	Cancer screening	Preventive	One per benefit period	No age limit
D1206, 1208	Fluoride	Preventive	One per 12 months	Covered through age 16
D1351	Sealants	Preventive	One per 36 months	Covered through age 16, 1st & 2nd permanent molars
D1516, 1517	Space maintainers	Preventive	One per lifetime per arch	Covered through age 16
D2390 - 2394	Fillings	Minor Restorative	One per 24 months, per tooth	No downgrades on posterior composite
D3330	Root canal (N, X2)	Endodontics	One per lifetime, same tooth	
D4341, 4342	Periodontal root planing (N, P, X)	Periodontics	One per 24 months, per quadrant	Can perform all 4 quads in one day, shared freq with D1110
D4355	Full mouth debridement (N)	Periodontics	Once per lifetime	No exams on same day; healing period required
D4381	Localized antimicrobial delivery (P, H)	Periodontics	One per 24 months, per tooth	Can perform 6 weeks after D4341
D4910	Periodontal maintenance (H)	Periodontics	One per 3 months	Shared freq with D1110; covered 90 days after D4341; previous periodontal treatement required
D5110, 5120…	Dentures (N, X, A)	Major	One per 60 months	Paid on seat date, not prep date
D6010, 6056…	Implants (N, X)	Major	One per 60 months	Paid on seat date, not prep date; covered for single tooth replacement instead of 2 or 3 unit bridge; must abut natural tooth and not abut another implant
D2740, 2950…	Crowns (N, X, A)	Major	One per 60 months	No downgrades; build-up is covered separately
D7140	Simple extractions	Minor Restorative	No frequency restrictions	
D7210 - 7240	Extractions (N, X)	Oral Surgery	One per lifetime per tooth	
D7953	Bone replacement graft (N, X)	Oral Surgery	One per lifetime per tooth	Only covered in conjunction with an implant
D9110	Emergency palliative treatment (N)	Emergency Palliative	One per 12 months	Only medically necessary x-rays same day
D9223, 9243	General anesthesia (N)	Oral Surgery	No frequency restrictions	Only covered in conjunction with major oral surgery
D9310	Consultation	Preventive	One per 12 months per location*	Can do treatment same day; upon referral from dentist to specialist
D9944	Occlusal mouthguards (N)	Periodontics	One per 60 months	For bruxism only

Not covered: D0350, D0364, D0470, D1330, D2962, D3110, D3120, D8093, D9230, D9248

*For exams, there is a limit of 3 (D0120, D0150, D9310) per 12 months

FREQUENTLY ASKED QUESTIONS

Continuation of service?	Covered starting on patient's effective date
Coordination of benefits?	Standard – earlier effective date is primary
Wisdom tooth coverage?	Send to medical first, then covered by Beam
Frequency of ortho payments?	Monthly – submit claims for on-going treatment
Are prior extractions covered?	Yes – no missing tooth clause
Timely filling limit?	Yes – 12 months from date of service
Is pre-authorization mandatory?	No – but estimates recommended for $300+ services

REQUIRED DOCUMENTATION

N = Narrative of medical necessity

P = Perio charting

X = Dated, pre-op x-rays

X2 = Dated, pre-op and post-op x-rays

H = Periodontal history

A = Age of existing prosthetics, if possible

VISION INSURANCE COVERAGE

Plan Year – January 1st – December 31st.

NOTES:

VISION BENEFITS SUMMARY

VSP Choice Plan #1

CHOICE NETWORK: 31,000 preferred providers | 57,000 access points

Policy Effective Date: 01/01/20 **GROUP #:** MI02183

FREQUENCY

EXAMS	12 months
LENSES	12 months
FRAMES	24 months
CONTACTS (IN LIEU OF GLASSES)	12 months

COPAYMENTS

EXAM	$10
MATERIALS	$25
CONTACT LENS FITTING & EVALUATION	15% discount (not to exceed $60)

IN NETWORK ALLOWANCES

RETAIL FRAME VALUE[1,2,3]	$150 / 20% off coverage
ELECTIVE CONTACT LENSES	$150
COVERED LENS OPTIONS	Low Vision and Polycarbonate for Children

[1]Extra $20 Allowance on featured brands like bebe®, Calvin Klein, Flexon, Lacoste, Nike, Nine West and more. Featured frame brands and promotion subject to change.

[2]Frame allowance backed by a wholesale guarantee, meaning VSP fully covers more frames than retail allowance plans.

[3]Allowance may differ at Wal-Mart, Sams and Costco® Optical, however it is of equivalent value.

VALUE ADDED PROGRAMS

DIABETIC EYECARE PLUS PROGRAM	Included
HEARING AID DISCOUNTS	Included
EYE HEALTH MANAGEMENT	Included
DIABETIC EXAM REMINDER LETTERS	Included

OUT-OF-NETWORK ALLOWANCES

EXAMINATION, up to	$45
SINGLE VISION LENSES, up to	$30
BIFOCAL LENSES, up to	$50
TRIFOCAL LENSES, up to	$65
LENTICULAR LENSES, up to	$100
FRAME, up to	$70
ELECTIVE CONTACT LENSES, up to	$105
NECESSARY CONTACT LENSES, up to	$210

EXTRA DISCOUNTS & SAVINGS

LENS ENHANCEMENTS	Most popular are covered with a copay, saving 20-25% avg.
ADDITIONAL PAIRS OF GLASSES	20% off
SUNGLASSES	20% off
LASER VISION CORRECTION (LVC)	Average 15% discount

Important Notice from Comfort Keepers About Your Prescription Drug Coverage and Medicare

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

CMS Form 10182-CC

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

If you decide to join a Medicare drug plan, your current Comfort Keepers coverage may be affected based on Medicare Secondary Payor rules. Medicare eligible individuals can keep this coverage if they elect Part D and this plan will coordinate with Part D coverage.

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

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

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact Krista Kuligowski at (586) 231-0526 for further information or email at kristakuligowski@comfortkeepers.com. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Comfort Keepers changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage: Visit www.medicare.gov
Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Comfort Keepers

42621 Garfield Road, Suite 101B
Clinton Township, MI 48038
Krista Kuligowski
586-231-0526

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

January 1, 2018

This Notice of Privacy Practices applies to the following organizations.

Creative Care Partners, Inc. DBA Comfort Keepers 799

Krista Kuligowski • 586-231-0526 • kristakuligowski@comfortkeepers.com

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Krista Kuligowski 586-231-0526 .

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Comfort Keepers	45-2675830
5. Employer address	**6. Employer phone number**
42621 Garfield Road, Suite 101B	586-231-0526

7. City	8. State	9. ZIP code
Clinton Township	MICHIGAN	48038

10. Who can we contact about employee health coverage at this job?	
Krista Kuligowski	
11. Phone number (if different from above)	**12. Email address**
	kristakuligowski@comfortkeepers.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Each active, Full-Time employee, except any person employed on a temporary or seasonal basis.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse - Must be legally married. Verification may be required including, but not limited to, a marriage certificate. Dependent Child - Birth through age 25 (up to the end of the calendar year of the 26th birthday). Dependent Children must meet the IRS definition of a "Qualified Child".

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Phone (248) 778-6070 • Email: kruth@ajmassoc.com • Website: www.ajmassoc.com

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