2020

Enrollment Guide

Total Health Care
(for Medical HMO benefits questions/claims issues)

Member Services: (800) 826-2682

www.thcmi.com

Group #XG50541

HealthChoice of Michigan

(for inquires regarding the Wayne County Health Benefits Program)

(313) 961-3100
www.ccarei.com

Beam Dental

VSP Vision

(for inquires regarding Voluntary Dental & Voluntary Vision coverage)

(800) 648-1179
www.beam.dental
www.vsp.com

AJM Associates, Inc.

(for inquires regarding all lines of benefit coverage)

(248) 778-6070
www.ajmassoc.com

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

At M&M Home Care 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.

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 Total Health Care Medical plan. Your elections will be effective **January 1, 2020 through December 31, 2020.** This Enrollment Guide is your regular 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.

ELIGIBILITY

- Employees that work on average 30 hours or more per week during the calendar year are considered full-time employees and are eligible for the Employer Sponsored Medical Health Care Plan through **Total Health Care**. M&M Home Care pays up to $119.89 per month enrollment. Those employees that wish to enroll their eligible spouse or dependents will be responsible for the additional premium.
- Employees that work less than 30 hours per week and not eligible for the Employer Sponsored Medical Health Care Plan, may elect to enroll in the Wayne County program through **HealthChoice of Michigan**. To be eligible the employee must work at least 20 hours per week and not currently eligible for health care benefits including Medicare, Medicaid or other employer sponsored health coverage. M&M Home Care pays 50% of the employee only enrollment. Those employees that wish to enroll their spouse or dependents will be responsible for the additional premium.

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.

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 M&M Home Care 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. M&M Home Care 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.

GROUP MEDICAL INSURANCE COVERAGE

Plan Year – January 1st – December 31st

Deductible/Out of Pocket Reset:
Calendar Year

NOTES:

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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.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.THCmi.com or call Customer Service at 1-800-826-2862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.heatlhcare.gov/sbc-glosssary or call 1-800-826-2862 to request a copy.

IMPORTANT QUESTIONS	ANSWERS	WHY THIS MATTERS:
What is the overall deductible?	In Network: **$1,000 annual per member** **$2,000 annual per family** Deductible does not apply to preventive care. Out of Network: N/A Integrated deductible applies to both Medical and Pharmacy.	See the Common Medical Events chart below for your costs for services this plan covers. Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In Network: **$1,250 annual per member** **$2,500 annual per family** Out of Network: N/A. Out-of-pocket limit combined for medical and pharmacy.	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

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

Will you pay less if you use a network provider?	Yes. See **www.THCmi.com** or call **1-800-826-2862** for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, Chiropractic/Podiatry visits require written PCP referral. No referral for other specialists.	This plan will pay some or all of the costs to see a Chiropractic or Podiatric specialist for covered services but only if you have a referral before you see the specialist.

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

COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	WHAT WILL YOU PAY		LIMITATIONS, EXCEPTIONS, & OTHER IMPORTANT INFORMATION
		NETWORK PROVIDER (You will pay the least)	OUT-OF-NETWORK PROVIDER (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20.00 copay/visit	Not covered	-------None-------
	Specialist visit	$20.00 copay/visit	Not covered	-------None-------
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	100% coverage after deductible	Not covered	Tests performed in an outpatient hospital are subject to deductible.
	Imaging (CT/PET scans, MRIs)	100% coverage after deductible	Not covered	Written PCP referral required. Tests performed in an outpatient hospital are subject to deductible.

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

COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	WHAT WILL YOU PAY		LIMITATIONS, EXCEPTIONS, & OTHER IMPORTANT INFORMATION
		NETWORK PROVIDER (You will pay the least)	OUT-OF-NETWORK PROVIDER (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://thcmi.com/pharmacy/	Generic drugs (Tier 1)	$10 copay	Not covered	Retail Prescription: up to 30 day supply Mail Order: 90 day supply
	Preferred brand drugs (Tier 2)	$40 copay	Not covered	Retail Prescription: up to 30 day supply Mail Order: 90 day supply
	Non-preferred brand drugs (Tier 3)	$80 copay	Not covered	Prior authorization and step therapy apply to select drugs. Retail Prescription: up to 30 day supply Mail Order: 90 day supply
	Specialty drugs (Tier 4)	25% coinsurance	Not covered	Prior authorization and step therapy apply to select drugs. Specialty prescription: up to a 90 day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100% coverage after deductible	Not covered	Written PCP referral required
	Physician/surgeon fees	100% coverage after deductible	Not covered	Written PCP referral required
If you need immediate medical attention	Emergency room care	$100 copay, waived if admitted to hospital	$100 copay waived if admitted to hospital	-------None-------
	Emergency medical transportation	$75 copay	$75 copay	When medically necessary
	Urgent care	$40 copay	Not covered	-------None-------
If you have a hospital stay	Facility fee (e.g., hospital room)	100% coverage after deductible	Not covered	Prior approval required
	Physician/surgeon fees	100% coverage after deductible	Not covered	Prior approval required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay	Not covered	Prior approval required
	Inpatient services	100% coverage after deductible	Not covered	Prior approval required

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

COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	WHAT WILL YOU PAY		LIMITATIONS, EXCEPTIONS, & OTHER IMPORTANT INFORMATION
		NETWORK PROVIDER (You will pay the least)	OUT-OF-NETWORK PROVIDER (You will pay the most)	
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	100% coverage	Not covered	Depending on the type of services, a [copayment, coinsurance, or deductible] may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	100% coverage after deductible	Not covered	No prior authorization required for hospital stays for a mother & her newborn of up to 48 hrs following vaginal delivery & 96 hrs following cesarean section
If you need help recovering or have other special health needs	Home health care	100% coverage after deductible	Not covered	Prior approval required
	Rehabilitation services	100% coverage after deductible	Not covered	Prior approval required. Physical & Occupational Therapy (including Osteopathic and Chiropractic Manipulation) limited to a combined 30 visits/year. Speech Therapy limited to 30 visits/year. Cardiac & Pulmonary Rehab limit to a combined 30 visits/year.
	Habilitation services	100% coverage after deductible	Not covered	Prior approval required
	Skilled nursing care	100% coverage after deductible	Not covered	Prior approval required for Skilled Nursing Care, Inpatient Rehabilitative Services and Sub Acute Care. Limit to 45 days per calendar year.
	Durable medical equipment	No charge	Not covered	Authorization requirements change frequently. To determine if a service requires authorization, log into www.THCmi.com.
	Hospice services	100% coverage after deductible	Not covered	Prior approval required. Includes Inpatient and Outpatient hospice care.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 exam per year
	Children's glasses	No charge	Not covered	1 pair per year up to age 18. Limited to 1 pair every 2 years for adults 18 and over.
	Children's dental check-up	Not covered	Not covered	-------None-------

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

Excluded Services & Other Covered Services:

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

- Abortion with the exception of limited services
- Acupuncture
- Dental Care (Adult)
- Infertility Treatment (i.e. in-vitro, artificial insemination)
- Long Term Care
- Non-emergency care outside of the U.S.A.
- Private-duty nursing

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

- Allergy Testing and Injections
- Bariatric Surgery
- Chiropractic care
- Cosmetic Surgery (Medically Necessary)
- Durable Medical Equipment
- Emergency Services outside of the U.S.A.
- Hearing aids
- Infertility Treatment Consult
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Insurance and Financial Services, PO Box 30220, Lansing, MI 48909-7720, Phone No. 1-877-999-6442 or Department of Labor's Employee Benefits Security Administration at 1-866-444-3272. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Total Health Care USA, 3011 W. Grand Blvd. Ste. 1600, Detroit, MI 48202, Phone No. 1-800-826-6442 or: Department of Insurance and Financial Services, PO Box 30220, Lansing, MI 48909-7720, Phone No. 1-877-999-6442.

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

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

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

Nondiscrimination Notice — February 1, 2017

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

Total Health Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free (no cost) language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Total Health Care at (800) 826-2862, 24 hours a day, seven days a week. TTY users call 711.

If you believe that Total Health Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

- Total Health Care Civil Rights Coordinator, 3011 W. Grand Blvd, Suite 1600, Detroit MI 48202, (800) 826-2862 (TDD/TTY: 711), Fax: (800) 826-6406 or email: thc@thcmi.com.
- You can file a grievance by mail, fax or email. If you need help filing a grievance, Total Health Care Customer Service is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TDD)

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

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

English: ATTENTION: If you speak English, language assistance services, at no cost, are available to you. Call (800) 826-2862 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 826-2862 (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم رقمهاتف الصم والبكم: 826-2862 (800)--1 (TTY: 711).

Chinese Mandarin: 注意: 如果您说中文普通话/国语, 我们可为您提供免费语言援助服务。请致电: (800) 286-2862 (TTY: 711)。

Chinese Cantonese: 注意: 如果您使用粵語, 您可以免費獲得語言援助服務。請致電 (800) 826-2862 (TTY: 711)。

Syriac: ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܡܦܠܚܝܬܘܢ ܚܠܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ (800) 826-2862. (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 826-2862 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në (800) 826-2862 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 826-2862 (TTY: 711) 번으로 전화해 주십시오.

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ (800) 826-2862 (TTY: 711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 826-2862 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 826-2862 (TTY: 711)

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (800) 826-2862 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(800) 826-2862 (TTY: 711)まで、お電話にてご連絡ください。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 826-2862 (TTY: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (800) 826-2862 (TTY-711 Telefon za osobe sa oštećenim govorom ili sluhom).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 826-2862 (TTY: 711).

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

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

About these Coverage Examples:

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

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

▪ The plan's overall deductible	$1,000.00
▪ Specialist *[cost sharing]*	$20.00
▪ Hospital (facility) *[cost sharing]*	0% after ded
▪ Other *[cost sharing]*	0% after ded

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

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000.00
Copayments	$80.00
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60.00
The total Peg would pay is	**$1,140.00**

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

▪ The plan's overall deductible	$1,000.00
▪ Specialist *[cost sharing]*	$20.00
▪ Hospital (facility) *[cost sharing]*	0% after ded
▪ Other *[cost sharing]*	0% after ded

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

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$134.00
Copayments	$1,030.00
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55.00
The total Joe would pay is	**$1,219.00**

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

▪ The plan's overall deductible	$1,000.00
▪ Specialist *[cost sharing]*	$20.00
▪ Hospital (facility) *[cost sharing]*	0% after ded
▪ Other *[cost sharing]*	0% after ded

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

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$283.00
Copayments	$285.00
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$568.00**

Platinum HMO $1,000 - 0%

BENEFIT INFORMATION	
BENEFIT PERIOD: Calendar year	
Medical Deductible	$1,000 Annual per Member $2,000 Annual per Family
Coinsurance	0%
Combined Out-of-Pocket Maximum	$1,250 per Member $2,500 per Family
PHYSICIAN/PREVENTIVE SERVICES	
Primary Care Visit	$20 Co-Pay
Specialty Care	$20 Co-Pay
Preventative Care/Screening/Immunizations	100% Coverage
Prenatal and Postnatal Care	100% Coverage
Well Baby Visits	100% Coverage
Allergy Injections	100% Coverage
Allergy Testing	100% Coverage
Chiropractic Care (Limited to 30 visits per calendar year in combination with PT/OT)	100% Coverage after Deductible
PT/OT (Limited to 30 visits per calendar year in combination with Chiropractic Care)	100% Coverage after Deductible
Rehabilitative & Habilitative Devices	100% Coverage after Deductible
Rehabilitative Speech Therapy (30 visits per calendar year)	100% Coverage after Deductible
Diabetes Education	100% Coverage
Dietician Services (Nutritional Counseling)	100% Coverage
Family Planning	100% Coverage
Habilitation Services	100% Coverage after Deductible
Infertility Testing (Underlying causes only)	100% Coverage after Deductible
Mammograms	100% Coverage
Weight Loss Programs	100% Coverage
INPATIENT SERVICES	
Inpatient Stay	100% Coverage after Deductible
Inpatient Physician & Surgical Services	100% Coverage after Deductible
Bariatric Surgery (One procedure per lifetime)	100% Coverage after Deductible
Delivery & All Inpatient Services for Maternity Care	100% Coverage after Deductible
Reconstructive Surgery	100% Coverage after Deductible
Transplant	100% Coverage after Deductible
OUTPATIENT SERVICES	
Outpatient Surgery Physician/Surgical Services	100% Coverage after Deductible
Outpatient Facility Fee	100% Coverage after Deductible
Outpatient Rehabilitation Services (Includes Cardio/Pulmonary Rehab)	100% Coverage after Deductible
Chemotherapy	100% Coverage after Deductible
Dialysis	100% Coverage after Deductible
Imaging (CT/PET Scans, MRIs)	100% Coverage after Deductible
Infusion Therapy	100% Coverage after Deductible
Laboratory Outpatient & Professional Services	100% Coverage after Deductible
Radiation Therapy	100% Coverage after Deductible
Temporomandibular Joint Disorders	50% Coverage
X-Rays & Diagnostic Imaging	100% Coverage after Deductible
EMERGENCY/AFTER HOURS MEDICAL SERVICES	
Emergency Room Copay (Waived if Admitted)	$100 Co-Pay
Urgent Care	$40 Co-Pay
Ambulance Services (When medically necessary)	$75 Co-Pay

Platinum HMO $1,000 - 0%

BENEFIT INFORMATION	
MENTAL HEALTH/SUBSTANCE ABUSE SERVICES	
Mental/Behavioral Health Outpatient Services	$20 Co-Pay
Mental/Behavioral Health Inpatient Services	100% Coverage after Deductible
Substance Abuse Outpatient	$20 Co-Pay
Substance Abuse Intermediate	$20 Co-Pay
Substance Abuse Inpatient	100% Coverage after Deductible
OTHER SERVICES	
Home Health Care	100% Coverage after Deductible
Skilled Nursing Facility (Limited to 45 days per calendar year)	100% Coverage after Deductible
Hospice Services	100% Coverage after Deductible
DURABLE MEDICAL EQUIPMENT/PROSTHETIC DEVICES	
DME	100 % Coverage by Plan's DME Provider
Prosthetic Devices	100% Coverage after Deductible
HEARING SERVICES	
Hearing Exam	100% Coverage
Hearing Aids	Plan pays a max $600 per ear every 3 years
VISION SERVICES	
Routine Eye Exam (Adult & Pediatric)	100% Coverage
Eye Glasses for Adults	100% Coverage on selected lenses & frames
Eye Glasses for Children	100% Coverage on selected lenses & frames
TELADOC	
Teladoc	100% Coverage
PHARMACY	
Generic Drugs	$10 Co-Pay
Preferred Brand Name Drugs	$40 Co-Pay
Non-Preferred Brand Name Drugs	$80 Co-Pay
Specialty Drugs	25% Coinsurance
90-day supply Medications available through Plan's Mail Order Pharmacy	2 times the normal Co-Pay

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

HEALTHCHOICE OF MICHIGAN HEALTHCARE INSURANCE COVERAGE

Employees that work less than 30 hours per week and not eligible for the Employer Sponsored Medical Health Care Plan, may elect to enroll in the Wayne County program through **HealthChoice of Michigan**. To be eligible the employee must work at least 20 hours per week and not currently eligible for health care benefits including Medicare, Medicaid or other employer sponsored health coverage.

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.

Wayne County/Oakland County
Benefits at a Glance for HealthChoice Small Business Program
Co-pay Package

This is intended as an easy-to-read summary. It is not a contract. An official description of benefits is contained in applicable HealthChoice Subscriber certificates and riders. Payment amounts are based on the HealthChoice approved amount, less any applicable co-pay amounts required by the program. This coverage is provided pursuant to a current, signed group-operating agreement between the group and the HealthChoice Executive Director. Services must be provided by member's primary care physician (PCP) or receive prior approval from health plan.

HEALTHCHOICE BENEFITS AT A GLANCE

Preventive Services

Preventive Physical Exam	**Covered – No co-pay for Preventive Health Exam** **(1 preventive health exam is provided per calendar year for adults; and as required by federal preventive care guidelines for children),** **Non-preventive office visits are subject to $20.00 co-pay**
Annual Gynecological Exam	**Covered**
Annual Pap Smear Screening	**Covered**
Annual Mammography Screening	**Covered**
Well Baby and Child Care	**Covered**
ACIP Required/Recommended Immunizations – pediatric and adult	**Covered**
Prostate Specific Antigen (PSA) screening	**Covered**
Hearing Screening	**Covered**

Physician Office Visits

Office Visits	**Covered - $20.00 co-pay**
Specialist Visits	**Covered - $30.00 co-pay**

Prescription Drugs

Generic Drugs	**Covered - $10.00 co-pay per prescription**
Brand Name Drugs	**Covered - $20.00co-pay per prescription**
Psychotherapeutics	**Covered – 50% of each prescription drug**

Emergency Care

Hospital Emergency Visit	**Covered –$100.00 co-pay if not admitted; No co-pay if admitted. Provider is only responsible for reimbursement rate negotiated with in-network providers for emergency services. Members are liable for any and all charges that exceed this amount.**
Urgent Care Center (24 hour access)	**Covered - $25.00 co-pay per visit**
Ambulance Services – medically necessary	**Covered - $200.00 co-pay**

Mental Health and Substance Abuse Services

Inpatient Mental Health and/or Substance Abuse Services*	**Covered - $200.00 co-pay per admission. Subject to limitations indicated in the Subscriber's Certificate**
Outpatient Mental Health and Substance Abuse /Professional Services	**Covered - $20.00 co-pay**

***- Requires Prior Authorization**

Diagnostic and Therapeutic Services

Radiology	**Covered – No co-pay**
Diagnostic Laboratory	**Covered – No co-pay**
Physical Therapy	**Covered - $20.00 co-pay (30 visits/year limit)**
Durable Medical Equipment	**Covered – 50% per prescribed equipment**

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	**Covered - $20.00 co-pay**
Delivery and Nursery Care	**Covered –$200.00 co-pay per admission**

Hospital Care

Inpatient physician care, general nursing care, Hospital Services and Supplies	**Covered – $200.00 co-pay per admission. Subject to limitations indicated in the Subscriber's Certificate**
Outpatient Hospital Services	**Covered - $50.00 co-pay**

Alternatives to Hospital Care

Home Health Care	**Covered - $20.00 per visit**

Surgical Services

Surgery – includes all related services and anesthesia. See member certificate for specifics	**Covered – (see hospital care co-pay above)**

Other Rider Services

Vision Exam & Glasses	**Covered subject to Co-payments and certain exclusions. See subscriber certificate**
Dental	**Covered subject to co-payments and certain exclusions. See subscriber certificate**

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.

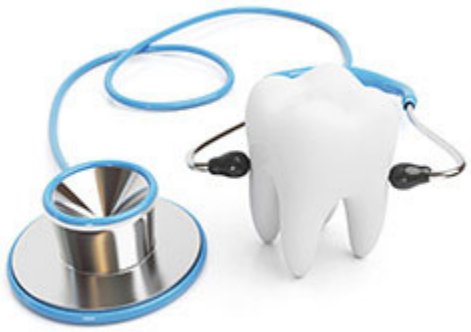
Please contact your local retail pharmacy or visit their website for current and specific drug coverage programs.

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.



GROUP VOLUNTARY DENTAL INSURANCE COVERAGE

Plan Year – January 1st – December 31st

Deductible/Out of Pocket Reset:
Calendar Year

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

M & M Home Care

PLAN: SmartPremium 100/80/50-1000

POLICY EFFECTIVE DATE: 01/01/2020 **GROUP #:** MI02615

WHY BEAM

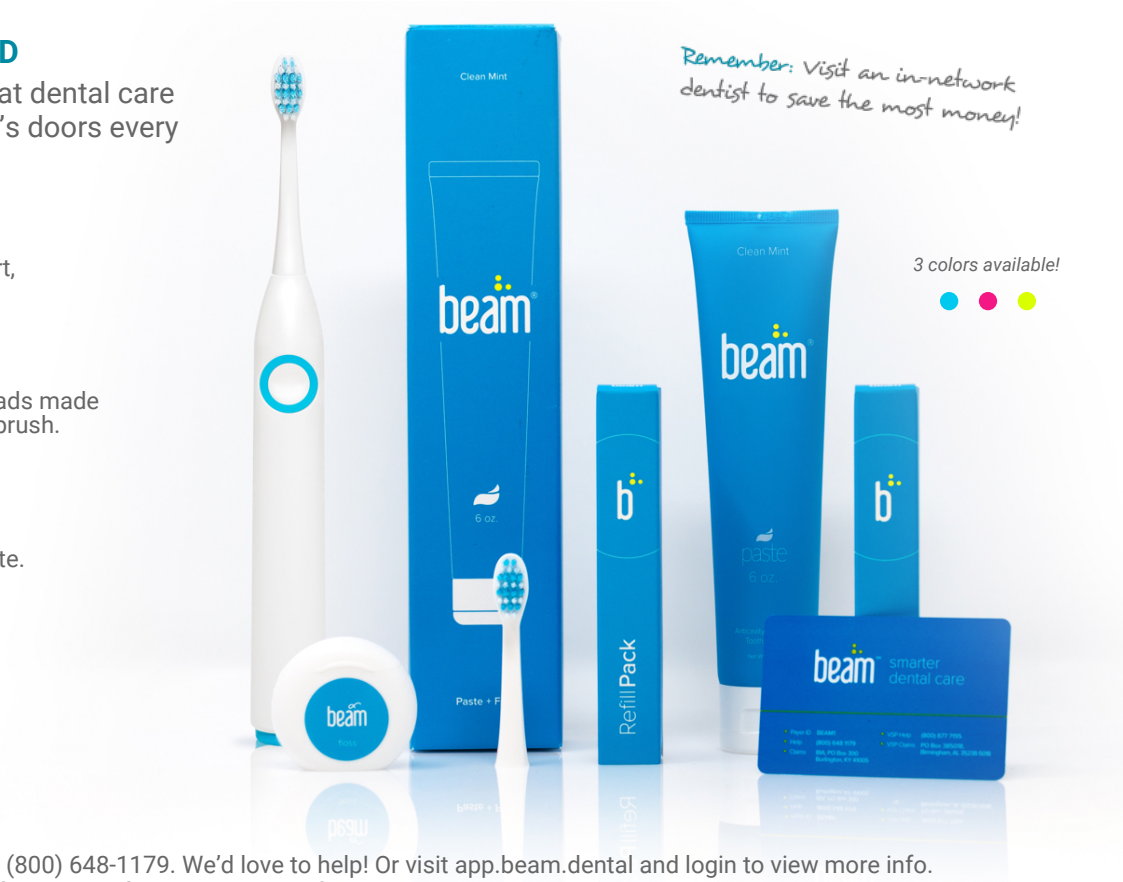
Beam is the future of group dental insurance for employers large and small. We're pairing innovative tech with personal service to deliver an insurance experience unlike any other.

- **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%

PLAN MAXES

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

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

PLAN DEDUCTIBLE

The deductible is waived for diagnostic & preventive services.

INDIVIDUAL	$50.00 /yr
FAMILY	$150.00 /yr

FREQUENCIES & LIMITATIONS

COVERAGE RULES

CODE	PROCEDURE	COVERED UNDER	FREQUENCY	NOTES
D1110	Prophylaxis	Preventive	Two per benefit period	Shared frequency with D4910
D0120	Periodic oral exam	Preventive	Two per benefit period	No shared frequency with D0140
D0140	Limited oral exam	Preventive	Two per 12 months	Can do treatment on same day
D0150	Comprehensive oral exam	Preventive	One per 60 months per location	Shared frequency with D0160
D0210	Radiographs – FMX	Preventive	One per 60 months	Shared frequency with D0330, D0274
D0220, 0230	Radiographs – periapical	Preventive	One per 6 months per location	
D0270 - 0277	Radiographs – bitewings	Preventive	Every 6 months, to the date	Can perform 6 months after D0210
D0330	Radiographs – panoramic	Preventive	One per 60 months	Shared frequency with D0210
D1206, 1208	Fluoride	Preventive	One per 12 months	Covered through age 16
D1351, 1352	Sealants	Preventive	One per 48 months	Covered through age 16, 1st & 2nd permanent molars
D2390 - 2394	Fillings	Minor Restorative	One per 24 months, per surface	No downgrades on posterior composite
D3330	Root canal *(N, X2)*	Endodontics	One per lifetime, same tooth	
D4341, 4346	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)*	Preventive	Once per lifetime	No exams within 5 days
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 90 days	Shared frequency with D1110, covered 90 days after D4341
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
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	
D7953	Bone replacement graft *(N, X)*	Oral surgery	One per 60 months	Only covered in conjunction with an implant
D9110	Emergency palliative treatment *(N)*	Emergency Palliative	Three per 12 months	Only medically necessary x-rays same day
D9223, 9243	General anesthesia *(N)*	Emergency Palliative	No frequency restrictions	No tooth-specific guidelines
D9310	Consultation	Preventive	Two per 12 months per location	Can do treatment same day
D9940	Occlusal mouthguards *(N)*	Periodontics	One per 60 months	For bruxism only
D0431	Cancer screening	Preventive	One per benefit period	No age limit

Not covered: D0350. D0364. D0470. D1330. D1525. D2962. D3110. D3120. D8093. D9230. D9248

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 – need 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 recommended for $300+ claims

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 applicable

CLAIMS INFORMATION

Beam Insurance Administrators
PO Box 75372
Cincinnati, OH 45275

Electronic payer ID
BEAM1

Fax number
844 688 4821

Phone number
(800) 648-1179

Claim form accepted
ADA form 2006 or later

Beam Dental PPO Standard coverages, as of August 1, 2018

GROUP VOLUNTARY VISION 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.

VISION BENEFITS SUMMARY

VSP Choice Plan #1

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

Policy Effective Date: 01/01/2020 **GROUP #:** MI02615

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 M&M Home Care 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 M&M Home Care 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. M&M Home Care has determined that the prescription drug coverage offered by the Total Health Care HMO 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 M&M Home Care 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 M&M Home Care 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 M&M Home Care 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 Michael Malecki at (248) 599-2410 for further information or email at michael@MMHomeCare.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 M&M Home Care 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).

M&M Home Care

17940 Farmington Rd. #225
Livonia, MI 48152
Michael Malecki
(248) 599-2410

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, 2020

This Notice of Privacy Practices applies to the following organizations.

M&M Home Care

Michael Malecki • (248) 599-2410

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 Michael Malecki (248) 599-2410.

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)
M&M Home Care	46-5452778
5. Employer address	**6. Employer phone number**
17940 Farmington Rd. #225	(248) 599-2410

7. City	8. State	9. ZIP code
Livonia	MICHIGAN	48152

10. Who can we contact about employee health coverage at this job?	
Michael Malecki	
11. Phone number (if different from above)	**12. Email address**
	michael@mmhomecare.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 employees, except any person employed on a temporary, union 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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