Employee Benefit Guide

Plan Year: September 1, 2020 – August 31, 2021

MEADOWBROOK INSURANCE AGENCY
MEMBER OF AMERITRUST GROUP

Welcome

Chatfield Management Company offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

In this Issue

Terms of Use

The following Terms of Use Agreement ("TOUA") describes the terms and conditions applicable to your access and use of the Employee Benefits Enrollment Guide ("Guide"). By using this guide, you are accepting and agreeing to the TOUA. If you do not agree to the TOUA, do not use this guide. We reserve the right to change the TOUA at any time, without notice to you. Continued use of the guide will constitute acceptance of such changes. This guide provides an overview and a brief description of the Chatfield Management Company Health and Welfare Plan options available to you and your family members. Please review this information carefully. This guide is provided for informational use only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet Certificate, and Group Policy) to determine governing contractual provisions including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. If any conflict arises between this summary and any plan provisions, the terms of the actual summary plan description and plan documents will prevail in all cases. Benefits are subject to modification at any time. Nothing within this guide, nor the proposals or any other materials it illustrates, should be deemed a contract for coverage or a solicitation of an application for coverage. You may not be eligible for all the insurance products or services described in this guide even if you received this booklet. This guide does not constitute an offer of insurance and is subject to the approval of the respective insurance providers. No contract for the provision of a policy of insurance is formed by use of this guide.

Rating Guidelines

The approved rates submitted by the insurance carrier(s) have been used in our calculation. While every attempt has been made to provide you with an accurate cost for the premium based on those rates, the rates quoted in this guide may be subject to change based on final enrollment and/or final underwriting requirements. We do not make any warranties or representations regarding the quotes, fees, terms, rates, coverage or services offered or made available by the insurance carrier(s). We do not guarantee that quotes, fees, terms, rates, coverage or services offered by the insurance carrier(s) are the best available. Rates have not been adjusted for Federal or State COBRA enrollees. Please consult with Chatfield Management Company Benefits Administrator for actual rates and benefits available to you. The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. Dependent Children may become ineligible for coverage on their 26th birthday; effective date of change may vary by carrier.

Waiver Provisions

Employee may elect to "Waive" the benefits offered by Chatfield Management Company if you have access to coverage through a Spouse, Domestic Partner or another plan. Any employee who declines participation in the benefit plans offered by Chatfield Management Company must complete and submit the Enrollment/Waiver form provided by Chatfield Management Company. **Note:** You may enroll at a future date should you experience a "Qualifying Event" within 30-days of that event, documentation will be required. See Human Resources should this occur.

Qualified Event change in status include: Marriage, Divorce, Legal Separation, Birth or Adoption of a Child, Change in Child's dependent status, Judgement or Decree of Court order (Qualified Child Medical Support Order), Death of a Spouse or Child, Change in Residence due to employment transfer for you or your spouse, Commencement or Termination of Adoption proceedings or changes in your Spouse's employment status.

Who is Eligible?

If you are an employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this Benefits Guide. You are eligible for benefits on your date of hire.

The family members listed below are eligible for Medical, Dental & Vision insurance coverage:

- Your Spouse
- Your Child(ren) – biological, step or adopted through the end of the year of their 26th birthday for Medical and end of the month for Dental & Vision.

Coverage Period

September 1, 2020 – August 31, 2021

Coverage Terminates

At the end of the day that you are no longer eligible for company benefits. This includes but not limited to transitioning from full-time to part-time, no longer employed, secure coverage elsewhere etc.

How do I Enroll/Waive offered benefits?

First step is to review your current benefit elections. Next, verify your personal information is correct and make any changes, if necessary. Finally, make your selections from the 2020 benefit plans offered in this Benefits Guide by completing the Enrollment/Waiver form provided by Chatfield Management Company. ALL eligible employees must complete and submit a form.

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Glossary of Health Coverage and Medical Terms

Deductible	An amount you pay during the plan year for covered services before your plan begins to pay
Coinsurance	Your share of the cost of a covered health care service – example: 80/20 Plan, you pay 20% and the plan pays 80%
Maximum Out-Of-Pocket Cost	This is also referred to as TROOP – True Out of Pocket. This is the maximum you would pay for all services under the plan during the plan year
Copayment	A fixed amount you pay for covered health care services – example: $15.00 Office Visit or $150.00 Emergency Room Visit
In-Network	Means the Preferred Provider the Insurance Carrier has a contract with
Non-Network	Means the Provider does not have a contract with the Carrier - Balance Billing may apply plus HMO Insurance such as Blue Care Network do not cover Non-Network Providers or Services
Balance Billing	When a Provider bills you for the balance that your Insurance does not cover. This is the amount between the actual billed amount and the allowed amount set by the Insurance Carrier. Non-Network services is an example of Balance Billing
Excluded Services	Plan does not cover these services under any circumstances
Formulary RX	A list of drugs your plan covers
Medically Necessary	Services or supplies needed to prevent, diagnose or treat and illness or injury that meet the accepted standards of medicine. Prior Authorization for the Insurance Carrier may be required
Prior Authorization	Also known as Preauthorization – A decision by your Health Insurance or plan that health care service or treatment plan is medically necessary, no guarantee Insurance/Plan will approve or pay for services
Primary Care Physician (PCP)	A physician who provides and coordinates a range of health care services for you, typically required with an HMO plan
Provider	A Physician or Facility that provides health care services such as a PCP, Hospital, Skilled Nursing Facility etc.
Specialist Provider	Physician or Facility that focuses on a specific area of medicine
Usual, Customary and Reasonable (UCR)	The amount paid for a service in a geographic area based on what providers in the area usually charge for the same or similar services

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BCN HMO SM 10%

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract**. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums

Note: The **Deductible** will apply to certain services as defined below.

Deductible **Note:** Coinsurance and select fixed dollar copays apply once the deductible has been met.	None
Fixed dollar copays	$20 for office visits, $30 for specialist visits, $35 for urgent care visits, $150 for emergency room visits, $150 for high tech imaging and $5 for allergy injections
Coinsurance	10% and 50% for select services as noted below
Annual Coinsurance Maximum – The following services DO NOT apply to the Annual Coinsurance Maximum if they are included in your coverage: • Deductible amounts • Services with a flat dollar copay • Infertility services • Male Mastectomy • Reduction Mammoplasty • Male Sterilization • Elective Abortion • TMJ • Orthognathic Surgery • Weight Reduction procedures • Durable Medical Equipment • Prescription Drugs • Prosthetics and Orthotics • Diabetic Supplies	$1,000 per member/$2,000 per family per calendar year
Annual out-of-pocket maximums – applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays	$5,000 per member/$10,000 per family per calendar year

Preventive Services – as defined by the Affordable Care Act and included in your Certificate of Coverage

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%

Physician Office Services

PCP Office Visits	Covered – $20 copay
Online Visits	Covered – $20 copay
Consulting Specialist Care – when referred for other than preventive services	Covered – $30 copay

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted	Covered – $150 copay
Urgent Care Center	Covered – $35 copay
Ambulance Services – medically necessary	Covered – 90%

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100%
Diagnostic Tests and X-rays	Covered – 90%
High Technology Imaging (MRI, CAT, PET)	Covered – $150 copay
Radiation Therapy	Covered – 90%

Maternity Services Provided by a Physician

Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered – $20 copay
Delivery and Nursery Care	Covered – 100% for professional services; see Hospital Care for facility charges

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 90%; unlimited days
Outpatient Surgery – See member certificate for select surgical coinsurance	Covered – 90%

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 90% up to 45 days per calendar year
Hospice Care	Covered – 100% when authorized
Home Health Care	Covered – $30 copay

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 90%
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – 50%
Elective Abortion (One procedure per two year period of membership)	Covered - 50%
Human Organ Transplants (subject to medical criteria)	Covered – 90%
Reduction mammoplasty (subject to medical criteria)	Covered – 50%
Male Mastectomy (subject to medical criteria)	Covered – 50%
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50%
Orthognathic Surgery (subject to medical criteria)	Covered – 50%
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 100%

Mental Health Care and Substance Use Disorder Treatment

Inpatient Mental Health Care and Substance Use Disorder Care	Covered – 90%
Outpatient Mental Health Care	Covered – $20 copay
Outpatient Substance Use Disorder Care	Covered – $20 copay

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	Covered – $20 copay
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18 Physical, speech and occupational therapy for autism spectrum disorder is unlimited.	Covered – $30 copay
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit

Other Services

Allergy Testing and serum	Covered – 50%
Allergy office visits	Covered – 50%
Allergy Injections	Covered – $5 copay
Chiropractic Spinal Manipulation – when referred	Covered – $30 copay; up to 30 visits per calendar year
Outpatient Physical, Speech and Occupational Therapy – subject to meaningful improvement within 60 days	Covered – $30 copay; limited to 60 visits per calendar year for any combination of therapies
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% on all associated costs
Durable Medical Equipment	Covered – 50%
Prosthetic and Orthotic Appliances	Covered – 50%
Diabetic Supplies	Covered – 90%

CLSSLG, CI10%, 5000PM, 1KECM, CO20, 30RP, ER150, UR35, IMG150, WRCWR, DSR10%, OMRR, VACR50

Custom Select Drug List℠ $4/$15/$40/$80/20%/20% Prescription Drug Coverage

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Prescription Drugs

Tier 1A – Preferred Generics	$4 Copayment
Tier 1B - Generics	$15 Copayment
Tier 2 – Preferred Brand Drugs	$40 Copayment
Tier 3 – Non-Preferred Brand Drugs	$80 Copayment
Tier 4 – Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment $200)
Tier 5 Non-Preferred Specialty	20% Coinsurance of the BCN Approved Amount (Maximum Copayment $300)
• Multi-Source Brand Drugs • Sexual Dysfunction Drugs • Weight Loss Drugs • Cough & Cold Remedies • Compounds • Select High Abuse Drugs	Not Covered
Contraceptives **Note:** Your cost sharing may be waived for Tier 1B, Tier 2 or Tier 3 contraceptive drugs if there are no appropriate generic products or preferred drugs available.	• Tier 1A – Covered in Full • Tier 1B – $15 Copay • Tier 2 - $40 Copay • Tier 3 - $80 Copay • Tier 4 – Not applicable • Tier 5 – Not applicable
Preventive Medications **Note:** A and B Preventive Medications must be dispensed through a Participating Pharmacy with a prescription.	Covered in full for Generic and Single Source Brand names on the Custom Select Drug List. Multi-Source brands are not covered.
31-90 day supply for Mail-Order Pharmacy	Three times applicable copay minus $10
84-90 day supply for Retail Pharmacy	Three times applicable copay minus $10
Out-of-Pocket Maximum	Your medical out-of-pocket maximum is integrated with your BCN covered Prescription Drugs. The out-of-pocket maximum amount is listed with your medical benefits.

Definitions

Brand Name Drug	Manufactured and marketed under a registered trade name and trademark. • Multi-source Brand Name Drug: a drug that is available from a brand name manufacturer and also has a generic version. • Single Source Brand Name Drug: the drug can only be produced by the company holding the patent; no generics are available.
Generic Drugs	Prescription drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Non-Preferred Brand Drugs	Prescription drugs that may not have a proven record for safety or their clinical record may not be as high as the BCN preferred alternatives.
Non-Preferred Specialty Drugs	Specialty drugs that may not have a proven record for safety or their clinical value may not be as high as the Preferred Specialty Drugs.
Out-of-Pocket Maximum	The highest amount of money you have to pay for covered services during the Calendar Year.
Preferred Brand Drugs	Prescription drugs that are Single Source Brand drugs that have a proven record for safety and effectiveness.
Preferred Generics	Prescription drugs that have a proven clinical value essential for treatment of chronic conditions.
Preferred Specialty Drugs	Generic or Single Source Brand Specialty drugs that have a proven record for safety and effectiveness and offer the best value to our members.

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FYI for members

Your primary care physician: Your Blue Care Network connection to care

Why a primary care physician

Selecting a primary care physician, or PCP, is an important first step to a healthier lifestyle. Your doctor will become your partner in maintaining your good health.

PCP care starts with regular checkups, health screenings and immunizations. It includes treatment for illness, injury and chronic conditions, like a heart condition or asthma. Your PCP also arranges for specialty care, lab tests and hospitalization.

Connect to care

It's important to choose a PCP as soon as you become a member so you can get the care you need.

You have choices

Each member of your family can select a PCP, or you can choose one for your whole family. Your BCN primary care physician may be an M.D. (medical doctor) or a D.O. (osteopathic doctor). Your PCP must be from one of the following categories:

- **Family medicine and general practice:** Practitioners who treat patients of all ages, from newborns to adults
- **Internal medicine:** Internists trained to identify and treat adult and geriatric medical conditions
- **Internal medicine/pediatrics:** Physicians trained in internal medicine and pediatrics who treat infants, children, adolescents and adults
- **Pediatrics:** Pediatricians who treat infants, children and adolescents 18 years and younger

How to choose a PCP

With thousands of qualified primary care physicians in our network, how do you decide?

Start with convenience. Search for physicians by county and city at **bcbsm.com/find-a-doctor**. You can also search for a doctor by hospital affiliation and extended office hours.

If you want more information, call the doctor's office or BCN Customer Service. Here are some questions to ask:

- Is the doctor in my plan?
- How many years has the doctor been in practice?
- What languages are spoken in the office?

BCN Advantage℠ is an HMO and HMO-POS plan with a Medicare contract. Enrollment in BCN Advantage depends on contract renewal.

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Which doctor did you select?

We need to know your PCP.

- If you named your PCP on your enrollment form, you've given us the information we need.
- If you selected a PCP online and clicked Submit, you've given us the information we need.

  To select your PCP online, log in to your member account at **bcbsm.com** and then click the *Doctors & Hospitals* tab.

You can also call Customer Service and tell us which PCP you selected.

For your information

Call the Customer Service number on the back of your member ID card (TTY: 711).

Blue Care Network of Michigan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación de miembro.

ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية متوفرة لك بالمجان.
اتصل برقم الهاتف الظاهر على الجهة الخلفية لبطاقة العضوية الخاصة بك.

Blue Cross Online Visits℠

Medical and behavioral health

Convenient online care for body and mind

It's as simple as using your smartphone, tablet or computer anywhere in the U.S. to meet with:

- A doctor for minor illnesses such as a cold, flu or sore throat when their primary care doctor isn't available.
- A behavioral health professional or psychiatrist to help work through different challenges such as anxiety or grief.

For the whole family

Family members on your plan can also use online visits. Just add children younger than 18 to your account. Your spouse, and children 18 and over, should create their own accounts.

What's included in online visits

Medical care

Use it when you're traveling or at home with a sick child. Or when your primary care doctor isn't available.

Visits last about 10 minutes although the doctor will spend as much time as needed. You can see a doctor on demand or by appointment 24 hours a day, seven days a week.

Behavioral health care

Online visits give you more choices for behavioral health care. Talk to therapists and psychiatrists about life's challenges from the comfort of home.

Therapy visits

Therapists such as psychologists, licensed clinical social workers, marriage and family therapists and professional counselors use talk therapy.

Therapy is available to adults and children age 10 and older by appointment from 7 a.m. to 11 p.m. Visits typically last 45 minutes.

Psychiatry visits

Psychiatrists can make diagnoses and prescribe and manage medications.

Psychiatry is available to adults age 18 and over and visits are by appointment only. Extended hours during evenings and on weekends may be available. The initial visit usually lasts 45 minutes with 15 minute follow-up visits.

Prescriptions

Doctors may write prescriptions, if appropriate. They don't write prescriptions for controlled substances.

How does it work?

Fast and convenient

Sign up now

Mobile – Download the BCBSM Online Visits℠ app

Web – Visit **bcbsmonlinevisits.com**

Phone – Call 1-844-606-1608

Add your Blue Cross or Blue Care Network health care plan information.

See a doctor or therapist

1. Launch the online visits app or website, and log in to your account.
2. Choose a service: *Medical, Therapy* or *Psychiatry*.
3. Pick a doctor or begin a scheduled visit and enter your payment information.
4. Meet with the doctor or therapist online.
5. Get a prescription, if appropriate, sent to a local pharmacy.
6. Send a visit summary to your primary care doctor or other health care provider at the end of your online visit.

Choose a doctor or therapist who's right for you

There are hundreds of doctors and therapists to choose from. They're all specially trained in online visits. You can read their profiles to learn more about them such as languages they speak and other experience.

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

The masters- and doctoral-level therapists are licensed and credentialed in the state where you're having a visit.

For questions about your online visits account or an online visit, call 1-844-606-1608, 24 hours a day, seven days a week.

Remember to coordinate all care through your primary care doctor. Blue Cross Online Visits℠ uses the American Well® technology platform and provider network, and is powered by American Well®. American Well® is an independent company that provides online visits for Blue Cross and BCN members.

We speak your language

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Important disclosure

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

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

know. compare. choose.

Register for your Blue Cross member account from any device

Your Blue Cross member account keeps your health care information securely in one place. Check your coverage, out-of-pocket balance, claims and more from your computer, smartphone or tablet.

HAVE YOUR BLUE CROSS OR BLUE CARE NETWORK ID CARD AVAILABLE — YOU CAN'T REGISTER WITHOUT IT.

Let's get started.

REGISTER IN ONE OF TWO WAYS:

Go to bcbsm.com/register.

1. Select *Register Now*.
2. Enter your first name, last name, enrollee ID and birth date.
3. Check that your information is entered correctly and select *Continue*.
4. Follow the instructions to verify your eligibility and identity.

Use our app.

1. Download the app on the App Store® or Google Play™ (search for **BCBSM**).
2. Tap the app icon.
3. Tap *Register*.
4. Use the app to snap a photo of your ID card. Your enrollee ID number will be entered for you.
5. Enter your birth date and tap *Continue*. Verify your eligibility and identity.

Register today:

bcbsm.com/register

Get the app.

Download on the App Store

GET IT ON Google Play

Search BCBSM.

Sign up for emails and text messages that tell you when your account has updated plan information.

CREATE YOUR PROFILE AND SET SECURITY.

1. Enter your log-in and contact information:
   - Username
   - Password
   - Phone number
   - Email address
2. Choose a security question from two pull-down menus, and enter the answer.

THAT'S IT. YOU'RE NOW REGISTERED.

THE 5 KEYS TO SECURITY

1. **Think length.** Create a password with at least eight characters.
2. **Be creative.** Include uppercase and lowercase letters, numbers and special characters (!, @, #, &). Consider passphrases (IL1kemYPl@n!). They're easier to remember but tough for someone else to guess.
3. **Mix it up.** Use different passwords for different accounts.
4. **Keep to it yourself.** Don't write down or share your passwords.
5. **Use your options.** Use a numeric PIN code or a fingerprint scanner to lock your screen.

Passwords

Strong: I@mBlue32!
Weak: Abcd1234

Source: "Password management and mobile security," Pew Center Research, January 2016.

"Highest Member Satisfaction among Commercial Health Plans in Michigan"

Blue Cross Blue Shield of Michigan received the highest score in Michigan in the J.D. Power 2018 U.S. Member Health Plan Study of customers' satisfaction with their commercial health plan. Visit jdpower.com/awards.

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FYI for members

Have a health-related question? Call our 24-Hour Nurse Advice Line

Is it a cold? Should you seek care? Want to speak with a health care professional without having to schedule an appointment? Now you can.

Connecting you to care

You can speak with a registered nurse 24 hours a day, seven days a week by calling **1-855-624-5214 (TTY: 711)**. Whether it's as simple as how to use a thermometer to take an infant's temperature or as complex as learning about a surgical procedure, a registered nurse is ready to answer your questions. This free and confidential service can help you determine your next steps while providing you with peace of mind.

Options, advice and more

Our team of nurses can discuss treatment options and provide advice on how to handle situations that in the past would have prompted everything from unnecessary anxiety to a needless trip to the emergency room. Now you can call a registered nurse with any health-related questions you may have — whether you have a cold or a chronic condition. Our nurses are here to support you.

You can call a registered nurse for:

- **Health information** — Our nurses will talk with you about your health care questions or concerns.
- **Symptom management** — Our nurses will assess your symptoms to determine the appropriate level of care and medical follow-up needed. They can also provide self-care tips so you can feel better faster.
- **Health decision support** — Our nurses will advise you about treatment options for a condition or disease.

During your call, you can choose the AudioHealth Library® to listen to health information on a variety of topics including:

- Common and chronic conditions
- Illness prevention tips
- Identifying warning signs
- How to administer self-care

Have a health-related question? We've got the answer. Just call **1-855-624-5214**. If you have questions about your plan benefits, call the Customer Service number on the back of your member ID card (TTY: 711).

Blue Care Network of Michigan

Confidence comes with every card.®

BCN Advantage℠ is an HMO and HMO-POS plan with a Medicare contract. Enrollment in BCN Advantage depends on contract renewal.

H5883_O_NurseLineFYI FVNR 0217

Confidence comes with every card

With BlueCard coverage, you and your dependents can rely on getting care when you're away from home in the United States. Just show your ID card everywhere you go.

Physicians and hospitals that contract with Blue plans nationwide participate in BlueCard. You can locate BlueCard providers at **bcbsm.com**. Select *Find a doctor* from the home page. Then select *Traveling? Find out how to get care* from the search options on that page. You can also call BlueCard at **1-800-810-2583**.

Pharmacy coverage

Your BCN ID card is accepted at thousands of pharmacies nationwide, including most major chains, that participate with Blue plans.

Emergency and urgent care

You're always covered for emergency and urgent care — in Michigan, across the country and around the world. Just show your BCN ID card.

When travelling outside the United States, you may be required to pay for services and then seek reimbursement. To speed reimbursement, bring back an itemized bill and any medical records you can get.

BCN Customer Service

1-800-662-6667

(TTY users: **711**)

Or call the number on the back of your ID card.

8 a.m. to 5:30 p.m.
Monday through Friday

bcbsm.com

Blue Care Network of Mi i

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Health care coverage that travels — **that's peace of mind**

Whether you're vacationing at a nearby resort or wintering down south, Blue Care Network coverage travels with you.

Only members with employer-sponsored coverage have BlueCard.

Coverage that travels

As a Blue Care Network member with BlueCard coverage, you can receive benefits when you're away from home. So can your dependents.

Always carry your ID card for access to service. You may have to pay your usual out-of-pocket expenses (deductible, copays and coinsurance) for services. But you shouldn't have any other up-front health care expenses if you use a Blue plan provider.

Arrange for care before you go

Check with your primary care physician to arrange for coordinated care and required authorizations. For behavioral health services (substance abuse care and mental health services), call the mental health help number on the back of your member ID card 24 hours a day, seven days a week. A care manager will evaluate your needs and arrange for services.

Also, call Customer Service for details about your health care benefits.

BCN provider service area

Away from home

If your coverage includes BlueCard®, a program of the Blue Cross and Blue Shield Association, you have nationwide access to Blue plan physicians and hospitals. Learn more about the BlueCard program by reading the disclosure document online at **bcbsm.com/bluecarddisclosure**, or call Customer Service at **1-800-662-6667** to have a copy sent to you.

The chart below tells you how to access and arrange care when you're away from home.

If you're traveling	And you need	Here's what you do
In Michigan 	EMERGENCY CARE (The symptoms are severe enough that someone with average health knowledge believes that immediate medical attention is needed.)	Call **911** or go to the nearest emergency room.
	URGENT CARE (The condition requires medical evaluation within 48 hours.)	To locate a participating urgent care center, call Customer Service, or visit **bcbsm.com/find-a-doctor**.
	NONURGENT CARE	Call your primary care physician to coordinate services that don't require immediate attention.
In the United States but outside Michigan 	EMERGENCY CARE	Call **911** or go to the nearest emergency room.
	URGENT CARE	Call BlueCard at **1-800-810-BLUE (2583)**.
	FOLLOW-UP CARE (To treat or monitor a chronic condition)	Call Customer Service for details about your health benefits and required authorizations.
	ROUTINE CARE (Doctor's visit for a minor illness)	Call BlueCard at **1-800-810-BLUE** (2583) to find a physician at your destination.
	OTHER SERVICES (Examples are: elective surgeries, hospitalizations, mental health or substance abuse services)	Call Customer Service for details about your health benefits and to determine which services require prior authorization.
Outside the United States	EMERGENCY CARE	Go to the nearest emergency room. (You may be required to pay for services and then seek BCN reimbursement.)

The information provided here is for members with the BlueCard benefit who are travelling or temporarily located outside Michigan. It's not meant for members who permanently live outside the state service area.

Michigan Manufacturers Association

Dental Benefit Summary for **Chatfield Management**

Preferred *PLUS* 2.0 Plan GCert2000

Coverage Type **Dental Expense Period: Jan 1 – Dec 31**	**In Network -** % of PDP Fee	**Out of Network –** % of R&C Fee (90th)
Type A – **Preventive**	**100%**	**100%**
Type B – **Basic Restorative**	**90%**	**80%**
Type C – **Major Restorative**	**60%**	**50%**
Orthodontia	**50%**	**50%**
Deductible – B & C services only	**$50 / 3x per Family**	
Annual Maximum - per Individual	**$2,000**	
Orthodontia Maximum - Lifetime	**$1,000**	
Type A – Preventive	**How Many / How Often**	
Prophylaxis – Cleanings	Once every 6 months	
Oral Examinations (including problem-focused exams)	Once every 6 months	
Topical Fluoride Applications	Once in 12 months for children under age 14	
Space Maintainers	For children under age 14	
Sealants	1 per 60 months on permanent 1st and 2nd molars up to age 14	
Bitewing X-rays (Adult / Child)	1 set every 12 months	
Full Mouth X-rays	1 set every 60 months	
Other X-rays		
Type B – Basic Restorative	**How Many / How Often** **We recommend a pre-treatment estimate for any service over $300.**	
Fillings – Amalgam & Composite	1 per tooth in 24 months	
Extractions		
Oral Surgery		
Endodontic – Root Canal	1 in 24 months for the same tooth	
Periodontal Maintenance	4 in 1 calendar year, includes preventive cleanings	
Periodontics	Once per quadrant in 24 months	
Periodontal Surgery	Once per quadrant in 36 months	
Emergency Palliative		
Type C – Major Restorative	**How Many / How Often** **We recommend a pre-treatment estimate for any service over $300.**	
General Anesthesia		
Crowns / Dentures / Bridges	10 year replacement	
Implants	10 year replacement	
Occlusal Guards /Bruxism Appliances		
Type D - Orthodontia		
Diagnostics & Treatment	Children under age 19	

For a List of **Participating Network Dentists (PDP PLUS Network) - www.metlife.com/dental**

MetLife Dental Claims : **P.O. Box 981282, El Paso, TX 79998-1282** **800-275-4638, Fax: 859-389-6505**

This summary is for informational purposes only.
(For complete benefit details including exclusions and limitations, please refer to the certificate of insurance. In the event of a conflict between this summary and your certificate of insurance, the certificate of insurance governs.) Rvsd: 1016

Find a dental provider

With MetLife Dental insurance, you can choose from thousands of general dentists and specialists nationwide. You can find the names, addresses, languages spoken and phone numbers of participating dentists by searching our online **Find a Dentist** directory or by calling 1-800-ASK-4-MET (1-800-275-4638). Follow these step-by-step instructions for each:

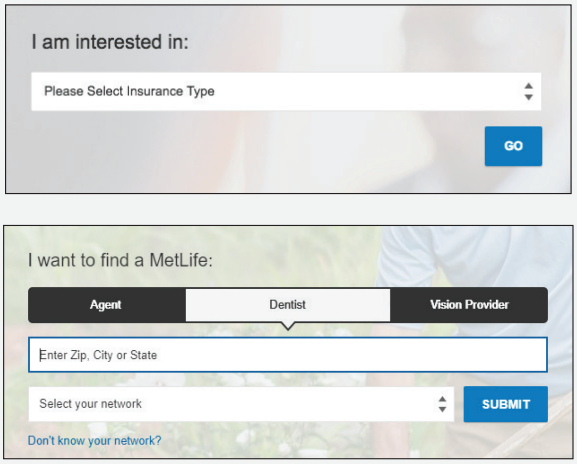
Step 1:
Go to metlife.com

Step 2:
Select "I want to find a MetLife:"

Click "Dentist", enter your ZIP Code, and select your network "PDP Plus".

Step 3:
Advanced Search

Use the Advanced Search option to locate a dentist by name, language spoken, specialty or gender.



1(800) ASK-4-MET

1(800)275-4638

SELECT PROMPT 1
For member

SELECT PROMPT 1
For Dental Coverage

SELECT PROMPT 1
If member or family covered member, input your Social Security number or Member ID followed by the # sign. Dental claims and verification of dental coverage will be confirmed.

SELECT PROMPT 3
To request a list of participating dentists in your area

SELECT PROMPT 2
To have the dental directory mailed to you.

When asked, request either English or Spanish versions of the directory.

When asked, enter the Zip Code of the area you are requesting. The directory will also include the surrounding area.

metlife.com

Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166
L0619515416[exp0620][MI]

In collaboration with

Michigan Manufacturers Association

MetLife

Michigan Manufacturers Association

Basic Life Benefit Summary for **Chatfield Management**

Covered Employees	**All Active Full Time Employees**

Basic Life / AD&D GCert2000	
Employee Life Benefit	**Flat $25,000**
Employee AD&D Benefit	**Equal to Basic Life Benefit**
Age Reduction	At Age **65** – Benefit reduces by 35% of the original amount At Age **70** – Benefit reduces by 50% of the original amount
Waiver of Premium Continued Death Benefits to age 65	If you become totally disabled before your life benefits end and you are less than 60 years old and remain totally disabled, premium will be waived (after 9 months of total disability) and benefits will continue to age 65.
AD&D Exclusions No benefit will be paid for any loss caused or contributed by:	*Use of drugs not prescribed by a physician or any drug not used in accordance to directions *Committing or attempting to commit a felony *War, riot or while in armed services *Physical or mental disease or infection *Suicide or self-inflicted injury
Seatbelt	Provides an additional **10%** of scheduled benefit amount to a maximum of **$25,000,** if the employee dies as a result of an accident while driving or riding in a private passenger car while wearing a properly fastened seat belt.
Air Bag	We will pay an additional benefit of **5%** to a maximum of **$10,000** upon death, if the covered person is wearing a Seat Belt and the Air Bag deploys while driving or riding as a passenger in a passenger car equipped with an Air Bag.
Accelerated Benefit	For Basic Life benefits of **$20,000** or more, this feature allows terminally ill insured (with a life expectancy of 12 months or less) to receive an advance pay-out of their group life benefit of 80% of your basic life amount (not to exceed $500,000).
Conversion	Available

Life Insurance Claims:

MMA Service Corporation
P.O. Box 14247
Lansing, MI 48901

Gin Salmon
Call: 800-842-6513 x 9, 525 or **517-487-8525**
Fax: 517-853-3325

This summary is for informational purposes only.
(For complete benefit details including exclusions and limitations, please refer to the certificate of insurance. In the event of a conflict between this summary and your certificate of insurance, the certificate of insurance governs.) Rvsd 1016

Michigan Manufacturers Association

Long Term Disability Benefit Summary for **Chatfield Management**

Covered Employees	**All Active Full Time Employees**

Long Term Disability – Employer Pay All GCert2000

Benefit	**60%** of pre-disability earnings to a maximum of **$4,000 / month** (Reduced by other income benefits as described in the certificate.)
Elimination Period	**90 Days**
Definition of Disability (24 Month Own Occ)	Due to a Sickness, or as a direct result of accidental injury: • The employee is receiving appropriate care and treatment and complying with the requirements of such treatment, and • During the elimination period and the next 24 months is unable to earn more than 80% of pre-disability earnings at their Own Occupation for any employer in their local economy, and • After such period, is unable to earn more than 60% of their pre-disability earnings from any employer in their Local economy at any gainful occupation for which they are reasonably qualified taking into account their training, prior education and experience.
Pre-Existing Condition	3 months / 12 months
Survivor Benefit	3 Month Lump Sum
Benefit Duration	The later of your normal retirement age or the period below: Under age 60-Benefits to age 65 Age 60 - Benefits for 60 months Age 61 - Benefits for 48 months Age 62 - Benefits for 42 months Age 63 - Benefits for 36 months Age 64 - Benefits for 30 months Age 65 - Benefits for 24 months Age 66 - Benefits for 21 months Age 67 - Benefits for 18 months Age 68 - Benefits for 15 months Age 69 + - Benefits for 12 months
Special Disabilities: (see certificate for complete details and limitations)	**Substance Abuse / Addiction** **Mental & Nervous** **Chronic Fatigue Syndrome** **Neuromuscular** **Musculoskeletal** **Soft Tissue Disorder** The lesser of 24 months or the Maximum Benefit Duration (No limit on schizophrenia, dementia or organic brain disease)
Exclusions – No benefit will be paid for any loss caused or contributed by:	*Committing or attempting to commit a felony *War, riot or while in armed services. *Suicide or self-inflicted injury

MetLife Disability Claims:

P.O. Box 14590
Lexington, KY 40511-4590

Call: 800-300-4296
Fax: 800-230-9531

This summary is for informational purposes only.
(For complete benefit details including exclusions and limitations, please refer to the certificate of insurance. In the event of a conflict between this summary and your certificate of insurance, the certificate of insurance governs.) Rvsd: 1016

Chatfield Management CO

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only.

Take a sneak peek before enrolling

- You're on the **Insight** Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1-866-804-0982
- For LASIK providers, call 1-877-5LASER6

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out of Network Reimbursement
Exam With Dilation as Necessary	$10 Copay	Up to $40
Retinal Imaging	Up to $39	N/A
Frames	$0 Copay; $150 allowance, 20% off balance over $150	Up to $105
Standard Plastic Lenses		
Single Vision	$25 Copay	Up to $30
Bifocal	$25 Copay	Up to $50
Trifocal	$25 Copay	Up to $70
Lenticular	$25 Copay	Up to $70
Standard Progressive Lens	$80 Copay	Up to $50
Premium Progressive Lens[Δ]	$110 Copay - $200 Copay	Up to $50
Tier 1	$110 Copay	Up to $50
Tier 2	$120 Copay	Up to $50
Tier 3	$135 Copay	Up to $50
Tier 4	$200 Copay	Up to $50
Lens Options *(paid by the member and added to the base price of the lens)*		
UV Treatment	$15	N/A
Tint (Solid and Gradiant)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate - age 19 and over	$40	N/A
Standard Polycarbonate - under age 19	$0	Up to $32
Standard Anti-Reflective Coating	$45	Up to $5
Premium Anti-Reflective Coating[Δ]	$57 - $68	Up to $5
Tier 1	$57	Up to $5
Tier 2	$68	Up to $5
Tier 3	$85	Up to $5
Photochromic/Transitions	$75	N/A
Polarized	20% off Retail Price	N/A
Other Add-Ons and Services	20% off Retail Price	N/A
Contact Lens Fit and Follow-up *(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)*		
Standard Contact Lens Fit & Follow-Up:	$40	N/A
Premium Contact Lens Fit & Follow-Up:	10% off Retail Price	N/A
Contact Lenses *(Contact Lens allowance includes materials only)*		
Conventional	$0 copay, $150 allowance, 15% off balance over $150	Up to $150
Disposable	$0 copay, $150 allowance, plus balance over $150	Up to $150
Medically Necessary	$0 copay, Paid-In-Full	Up to $210
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and low price guarantee on discounted hearing aids	
Frequency		
Examination	Once every 12 months	
Lenses (in lieu of contact lenses)	Once every 12 months	
Contacts (in lieu of lenses)	Once every 12 months	
Frame	Once every 12 months	

QL-0000056974

[Δ] Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level . All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of anyWorkers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

CHOOSE A DOC

EyeMed members choose from the right mix of thousands of providers—independent eye doctors, your favorite retail stores and everything in between. Find your ideal fit at eyemed.com or the EyeMed Members App.

CREATE AN ACCOUNT

Get special offers with an account on eyemed.com. Enter your email, choose a password and sign up for emailed savings. Log in 24/7 to view your benefit details or health and wellness information.

MOBILIZE YOUR BENEFITS

The EyeMed Members App makes your benefits easy to understand—and even easier to use. Find an eye doctor near you, schedule an appointment and manage your vision benefits.

72%
AVERAGE SAVINGS

on eye exams and glasses for EyeMed members*

Learn more about enrolling in EyeMed vision benefits at **enroll.eyemed.com** and see more of the good stuff

**Based on a sample transaction on the Insight network with a covered exam and eyewear benefits*

eyeMed | INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL sears OPTICAL JCPenney | optical

PDF-1609-M-557

Department of Labor Annual Notices

Please review the following documents:

- HIPAA Privacy Notice
- Michelle's Law
- COBRA General Notice
- Creditable Coverage
- Health Insurance Marketplace
- HIPAA Special Enrollment Rights
- Women's Health & Cancer / Newborn's & Mothers Act
- CHIPRA

Note: The "Plan" is in reference to your Employer.

Please contact the Plan Administrator listed below should you require additional information:

Chatfield Management Company
Matthew Young; Co-Director
231 Lake Drive
Lapeer, MI 48446
myoung@chatfieldschool.org
(810) 667-8970

MEADOWBROOK INSURANCE AGENCY
MEMBER OF AMERITRUST GROUP

HIPAA Privacy Notice

In April 2003, the final regulations that place restrictions on how personally identifiable health information may be used and disclosed by certain organizations became effective. These regulations (the Privacy Rules) implement the privacy requirements contained within the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). While some states have laws that protect health information, the HIPAA Privacy Rules establish a uniform, minimum level of privacy protection for all health information.

Summary of HIPAA Privacy Rules
The HIPAA Privacy Rules:

- Set limits on how health information may be used and disclosed
- Require that individuals be told how their health information will be used and disclosed
- Provide individuals with a right to access, amend and/or copy their medical records
- Give individuals a right to receive an accounting of disclosures, to request special restrictions and to receive confidential communications
- Impose fines where the requirements contained within the regulations are not met

Restrictions on Use and Disclosure
The HIPAA Privacy Rules allow health care providers, health plans and health care clearinghouses (Covered Entities) to use and disclose your personally identifiable health information for purposes of treatment, payment or health care operations.

For example, your health care provider may submit your health information to a health insurance company to seek payment for the treatment provided to you. Your primary care physician can share your health information with a specialist that he or she recommends you consult. In these cases, your written permission to disclose your health information is not required.

In general, any use or disclosure not considered treatment, payment or a health care operation requires your written authorization, unless an exception applies. For example, your physician may not share your health information with your employer or a life insurance carrier without your written permission. However, disclosure of health information is permitted for certain purposes specifically listed in the HIPAA Privacy Rules, such as national security, law enforcement and public health issues. If you authorize release of your health information to a third party, the information released may no longer be protected by HIPAA.

Notice of Privacy Practices
You are entitled to receive an explanation, from each of your healthcare providers, of how your personally identifiable health information will be used and disclosed.
For example, a physician or hospital is required to provide you with a Notice of Privacy Practices at your first visit. You will be required to sign an acknowledgment indicating that you received the Notice of Privacy Practices.

If you have health insurance coverage, the insurance company or health plan will also provide you with a Notice of Privacy Practices after you are enrolled in the plan. It is important that you read the Notice of Privacy Practices to understand your rights and know who to contact if you feel your privacy rights have been violated.

Right to Access, Amend or Copy
You have a right to view and copy your medical records. You may be charged a fee for the cost of reproduction.
If you believe that information within your medical records is incorrect or if important information is missing, you have a right to request that your medical records be amended.

Right to an Accounting of Disclosure
You also have a right to a list of uses and disclosures made of your medical records where the use or disclosure was not for purposes of treatment, payment, health care operations or pursuant to your written authorization.

Right to Request Restrictions
You may request, in writing, that a health care provider or health plan not use or disclose information for treatment, payment or other administrative purposes unless specifically authorized by you, when required by law or in emergency circumstances. Health care providers and health plans must consider your request but are not legally obligated to agree to those restrictions.
Confidential Communications
You have a right to receive confidential communications containing your health information. Health care providers and health plans are required to accommodate your reasonable requests. For example, you may ask a physician to contact you at your place of employment or send communications regarding treatment to an alternate address.

Violations of Privacy Rights
If you believe that your privacy rights have been violated, you may contact the Privacy Officer for the organization that you feel has violated your right to privacy. The name of the Privacy Officer should be included in the Notice of Privacy Practices provided to you by that organization.

If the Privacy Officer does not adequately resolve your concerns, you may contact the Department of Health and Human Services - Office of Civil Rights (OCR). OCR is responsible for enforcing the HIPAA Privacy Rules. For instructions on how to file a complaint, visit www.hhs.gov/ocr/privacy/hipaa/complaints. For a complaint form, visit www.hhs.gov/ocr/ privacy/hipaa/complaints/hipcomplaintpackage.pdf.

Penalties for Noncompliance
The HIPAA Privacy Rules do not provide individuals with a private right to sue, although methodologies for allowing a portion of civil penalties to be paid to affected individuals must be established by February 17, 2012.

- Currently, health care providers, health plans and health care clearinghouses that do not comply with the HIPAA Privacy Rules may be subject to civil money penalties ranging from $100 to $50,000 per violation, with maximum penalties ranging from $25,000 per year to $1.5 million per year.
- Criminal violations of the HIPAA Privacy Rules may also be referred to the Department of Justice for enforcement. Criminal penalties for such violations include:
- $50,000 fine and/or up to 1 year in prison for knowingly obtaining or disclosing protected health information not permitted by law
- $100,000 fine and/or up to 5 years in prison for obtaining or disclosing protected health information under false pretenses; and
- $250,000 fine and/or up to 10 years in prison for obtaining protected health information with an intent to sell, transfer or use it for commercial advantage, personal gain or malicious harm

State Attorneys General (AG) may also sue Covered Entities to enjoin further violations and obtain damages on behalf of residents of their states, if the Department of Health and Human Services has not already acted.
The State Attorneys General may seek damages of up to $100 per violation, with a maximum of $25,000 per year for identical violations.
HIPAA Privacy Resources
Department of Health and Human Services - Office of Civil Rights
www.hhs.gov/ocr/ www.healthprivacy.org

Michelle's Law Notice

Note: Pursuant to Michelle's Law, you are being provided with the following notice because the Plan group health benefit provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of the Plan group health benefit coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the Plan group health benefit will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the Plan group health benefit, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

- The Plan group health benefit must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and
- Must being enrolled in the plan immediately prior to the first day of the medically necessary leave of absence.

General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Contact Person on first page.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Creditable Coverage Important Notice from the Plan 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 the Plan 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. The Plan has determined that the prescription drug coverage offered by the 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 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Plan coverage will not be affected. *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.] If you do decide to join a Medicare drug plan and drop your current Plan coverage, be aware that you and your dependents will not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with the Plan 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 the person listed on page one for further information:

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Sample Company 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).

SPECIAL ENROLLMENT RIGHTS WITH HIPAA

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

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

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a 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, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact the person listed on page one of Department of Labor notices.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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 the person listed on page one of the Department of Labor notices.

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.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductible and coinsurance apply based on your plan selection. If you would like more information on WHCRA benefits, contact the person listed on page one for more information.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

Contact your Plan Administrator listed on page one of the Department of Labor notices section for more information.

NEWBORNS' and MOTHER'S HEALTH PROTECTION ACT

Group Health plans and health insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48-hours following a vaginal delivery or less than 96-hours following a cesarean section. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48-hours (or 96-hours if applicable). In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48-hours or 96-hours.

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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	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

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137. OMB Control Number 1210-0137 (expires 1/31/2023)

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