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	

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

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.

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

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ACA Disclosure Requirements – HIPAA Special Enrollment Notice

This special enrollment notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive 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 because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health 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 by us, 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 group health 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 by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in our group health 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:

Matthew Young
Co-director
810-667-8970
myoung@chatfieldschool.org

Note: If you or your dependents enroll in a group health plan during a special enrollment period, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a preexisting condition exclusion period of more than 12 months. Any preexisting condition exclusion period will be reduced by the amount of your prior creditable health coverage.

Delta Dental of Michigan
Dental Benefits Highlights
High Pediatric Dental Plan

DELTA DENTAL

2017 ESSENTIAL HEALTH BENEFITS (EHB) for individuals under the age of 19 Delta Dental PPO (Point-of-Service)	In-Network		Out-of-Network
	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	80%	60%	60%
Oral Surgery Services – extractions and dental surgery	80%	60%	60%
Endodontic Services – root canals	80%	60%	60%
Periodontic Services – to treat gum disease	80%	60%	60%
Relines and Repairs – to bridges and dentures	80%	60%	60%
Other Basic Services – misc. services	80%	60%	60%
Major Services			
Prosthodontic Services – bridges and dentures	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%

**When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.*

***Note:** Composite resin restorations are optional on posterior teeth. An allowance will be made for an amalgam (silver) filling.*

In-Network Annual Out-of-Pocket Maximum – An Out-of-Pocket Maximum is the maximum amount that an Eligible Person will pay for EHB Covered Services throughout a Benefit Year. The In-Network Annual Out-of-Pocket Maximum for EHB Covered Services shall be $350 per Benefit Year if this Certificate covers one Eligible Person under the age of 19, or $700 per Benefit Year if this Certificate covers two or more Eligible Persons under the age of 19. Any Copayments, Deductibles, or other out-of-pocket expenses paid by an Eligible Person for In-Network EHB Covered Services provided shall count toward that In-Network Annual Out-of-Pocket Maximum. The In-Network Annual Out-of-Pocket Maximum will not include any amounts paid for the following: (i) premiums; (ii) non-covered services; (iii) Out-of-Network Dentists; (iv) Copayments, Deductibles, or other out-of-pocket expenses for services other than EHB Covered Services; or (v) Copayments, Deductibles, or other out-of-pocket expenses paid for EHB Covered Services provided to individuals 19 years of age and older. Once the applicable In-Network Annual Out-of-Pocket Maximum is reached for the Benefit Year, all In-Network EHB Covered Services provided to an Eligible Person will be covered at 100% of the Maximum Approved Fee.

Out-of-Network Annual Out-of-Pocket Maximum – There is no annual Out-of-Pocket Maximum for Out-of-Network EHB Covered Services. Eligible Persons will be responsible for all Copayments, Deductibles, and other out-of-pocket expenses associated with all Out-of-Network EHB Covered Services provided to Eligible Persons throughout the Benefit Year.

Annual and Lifetime Maximum Payments There are no annual or lifetime Maximum Payments for EHB Covered Services under this Certificate.

Deductibles for EHB Covered Services – None.

Waiting Period for EHB Covered Services – There are no waiting periods for Eligible Persons under the age of 19 seeking EHB Covered Services

Delta Dental of Michigan
Dental Benefit Highlights for
Chatfield Management Corporation #5515

Delta Dental PPO (Point-of-Service) *Coverage effective September 1, 2017*	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Non-participating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services - exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment - to temporarily relieve pain	100%	100%	100%
Brush Biopsy - to detect oral cancer	100%	100%	100%
Radiographs - X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services - fillings and crown repair	90%	80%	80%
Endodontic Services - root canals	90%	80%	80%
Periodontic Services - to treat gum disease	90%	80%	80%
Oral Surgery Services - extractions and dental surgery	90%	80%	80%
Other Basic Services - misc. services	90%	80%	80%
Relines and Repairs - to bridges, implants, and dentures	90%	80%	80%
Major Services			
Major Restorative Services - crowns	60%	50%	50%
Prosthodontic Services - bridges, implants, and dentures	60%	50%	50%
Orthodontic Services			
Orthodontic Services - braces	50%	50%	50%
Orthodontic Age Limit -	Up to age 19	Up to age 19	Up to age 19

** When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.*

Maximum Payment – $1,000 per person total per Benefit Year on all services except orthodontic services. $1,000 per person total per lifetime on orthodontic services.

Deductible – $50 Deductible per person total per Benefit Year limited to a maximum Deductible of $150 per family per Benefit Year. The Deductible does not apply to diagnostic and preventive services, emergency palliative treatment, brush biopsy, X-rays, and orthodontic services.

Note - *This document is only intended to provide a brief description of your benefits. Please refer to your Certificate and summary for a complete description of benefits, exclusions, and limitations.*

DELTA DENTAL

Welcome to Michigan's largest dental benefits family!

As a member of Delta Dental of Michigan, you have access to the nation's largest dental networks: Delta Dental PPO and Delta Dental Premier.

- It's easy to find a dentist! Four out of five dentists nationwide participate in our network.
- You have superior access to care and fee savings because of our agreements with participating dentists.
- Our dentists cannot balance bill you, which means more money in your pocket!
- No troublesome paperwork! Network dentists will fill out and file your claims.
- Pay only your copayments and/or deductibles when you receive care from network dentists -- there are no hidden fees.
- You can still visit nonparticipating dentists, but you may be billed the full amount at the time of service and then have to wait to be reimbursed.

Quality Dental Program

With our quick and accurate claims processing, *we pay more than 90% of claims in 10 days or less.* Delta Dental also offers world-class customer service from our Certified Center of Excellence call center, as awarded by Benchmark Portal.

Online Access

Our online Consumer Toolkit lets you access your dental plan securely over the Internet. You can find a dentist, check benefits, select paperless notices, review claims and amounts used toward maximums, print ID cards, and more -- all at your own convenience.

A Healthy Smile

Keep your smile healthy with dental benefits from Delta Dental. Your smile is a good indicator of your health. Did you know that your dentist can detect up to 120 different diseases, including diabetes and heart disease? Early detection is one of the best ways to prevent further complications.

Questions?

If you have questions, please call our Customer Service team at 800-524-0149 (TTY users call 711) or look online at www.DeltaDentalMI.com.

ACA Disclosure Requirements – Michelle's Law Notice

Michelle's Law Coverage for Dependent College Students

Michelle's Law ensures that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law is named after a New Hampshire college student, Michelle Morse, who continued her studies while battling colon cancer in order to maintain health insurance coverage under her parents' plan. Michelle died of colon cancer in November 2005 at the age of 22.

The 2010 health care reform bill, or Affordable Care Act (ACA), further expanded coverage requirements for dependents. Under ACA, group health plans or insurers who provide dependent coverage for the children of a participant must continue to make coverage available until the participant's child attains age 26, regardless of student or marriage status.

Coverage Benefits

Michelle's Law allows seriously ill or injured college students, who are covered dependents under group health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status.

Under Michelle's Law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

Notice Requirements

The law requires group health insurance plans to provide notice of the requirements of Michelle's Law, in language understandable to the typical plan participant, along with any notice regarding a requirement for certifying student status for plan coverage.

Effective Date

This federal coverage mandate applies to health plans governed by the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA) and the Internal Revenue Code (IRC). It became effective for plan years beginning on or after October 9, 2009 and calendar year plans were required to comply beginning January 1, 2010.

Impact of Health Care Reform

The Affordable Care Act (ACA) diminished the impact of Michelle's Law. ACA states that if a group health plan or insurer provides dependent coverage for the children of a participant, the plan must continue to make the coverage available until the child reaches age 26, regardless of student status. However, the plan is not required to make dependent coverage available to dependents that are eligible to enroll in their own employer-sponsored health plan. Thus, the impact of Michelle's Law on group health plans will generally be limited to plans not yet subject to ACA's requirements, grandfathered plans before 2014 and other plans that provide coverage to dependent students who are age 26 or over.

ACA Disclosure Requirements – WHCRA Notice

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that requires all health plans, which provide medical and surgical benefits for a mastectomy, to also cover breast reconstruction. The law became effective on October 21, 1998 and is administered by the U.S. Departments of Labor and Health and Human Services.

What does WHCRA cover?

If you are enrolled in a health plan that covers the medical and surgical costs of a mastectomy, the WHCRA states that your plan must also cover the costs of certain reconstructive surgery and other post-mastectomy benefits, including:

- 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
- External breast forms that fit into your bra for before or during reconstruction
- Treatment of any physical complications of the mastectomy, including lymphedema

I had a mastectomy due to non-cancer related health issues. Am I covered under WHCRA?

Yes. These rights are not limited to cancer patients. If your plan covers mastectomies, WHCRA rights apply.

My job doesn't offer a group health plan. Does WHCRA apply to my individual health plan?

Yes. WHCRA applies to group health plans that are provided by an employer or union, as well as to individual health insurance policies that are not based on employment.

I receive health benefits through my church. Am I still covered under WHCRA?

There are certain "church" and "governmental" plans that are not subject to this law. Generally, though, any plan that provides coverage for mastectomies must also comply with WHCRA. Check with your provider for information specific to your plan.

Will my copay for reconstructive surgery be more expensive than my copay for other conditions?

No. If your health plan requires a copay for other health conditions, the copay for your mastectomy benefits must be the same. For example, it is a violation of WHCRA for your plan to cover 90% of hip replacement surgery, but to only cover 70% of breast reconstruction.

Is my health plan required to inform me of my WHCRA rights?

Yes. Your health plan must provide you with a notice of your rights under WHCRA when you first enroll in the plan and then annually after that.

Coverage that travels

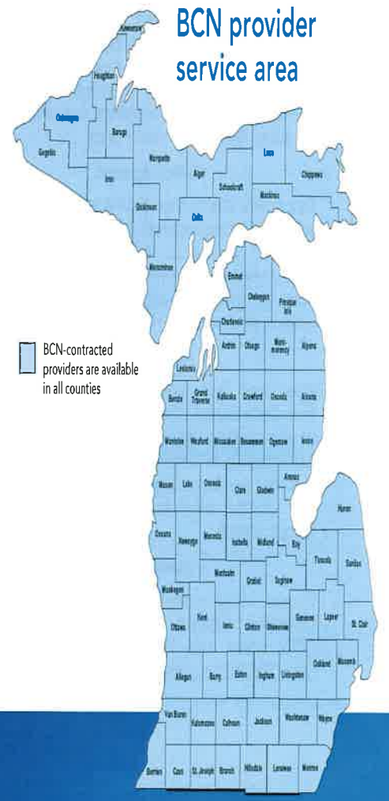
As a Blue Care Network member with BlueCard coverage, you can receive benefits when you're away from home. So can your dependents.

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.



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.

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.

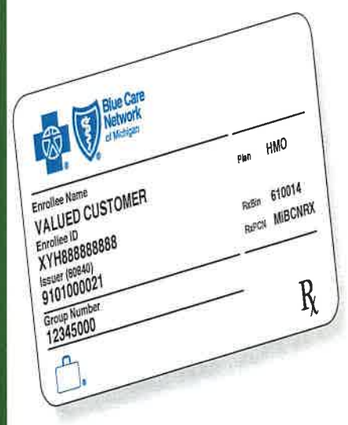
Pharmacy coverage

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

A nonpro it corpora ion an independent licensee lue Cross and Blue S ield Asso ia ion

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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.

ACA Disclosure Requirements – CHIPRA Notice

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, 2014. Contact your State for more information on eligibility.

ALABAMA – MEDICAID

Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447

ALASKA – MEDICAID

Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP

Website: http://www.azahcccs.gov/applicants
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

COLORADO – MEDICAID

Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – MEDICAID

Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – MEDICAID

Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

IDAHO – MEDICAID

Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx

Medicaid Phone: 1-800-926-2588

INDIANA – MEDICAID

Website: http://www.in.gov/fssa

Phone: 1-800-889-9949

IOWA – MEDICAID

Website: www.dhs.state.ia.us/hipp/

Phone: 1-888-346-9562

KANSAS – MEDICAID

Website: http://www.kdheks.gov/hcf/

Phone: 1-800-792-4884

LOUISIANA – MEDICAID

Website: http://www.lahipp.dhh.louisiana.gov

Phone: 1-888-695-2447

MAINE – MEDICAID

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html

Phone: 1-800-977-6740

TTY 1-800-977-6741

MASSACHUSETTS – MEDICAID AND CHIP

Website: http://www.mass.gov/MassHealth

Phone: 1-800-462-1120

MINNESOTA – MEDICAID

Website: http://www.dhs.state.mn.us/

Click on Health Care, then Medical Assistance

Phone: 1-800-657-3629

MONTANA – MEDICAID

Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml

Phone: 1-800-694-3084

NEBRASKA – MEDICAID

Website: www.ACCESSNebraska.ne.gov

Phone: 1-800-383-4278

NEVADA – MEDICAID

Medicaid Website: http://dwss.nv.gov/

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – MEDICAID

Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf

Phone: 603-271-5218

NEW JERSEY – MEDICAID AND CHIP

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

NEW YORK – MEDICAID

Website: http://www.nyhealth.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – MEDICAID

Website: http://www.ncdhhs.gov/dma

Phone: 919-855-4100

NORTH DAKOTA – MEDICAID

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/

Phone: 1-800-755-2604

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.

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Blue Cross
Online Visits℠

Medical

Getting health care online in 2018: What you need to know

When you use **Blue Cross Online Visits℠** (previously called 24/7 online health care), you'll have access to online medical services anywhere in the U.S.

You can rest assured knowing you and your covered family members can see and talk to a doctor for minor illnesses such as a cold, flu or sore throat when your primary care doctor isn't available.

After Jan. 1, 2018, here's what you need to do to use online visits:

- **Mobile** – Download the BCBSM Online Visits℠ app
- **Web** – Visit **bcbsmonlinevisits.com**
- **Phone** – Call **1-844-606-1608**

If you're new to online visits, sign up after Jan. 1, 2018. Be sure to add your Blue Cross or Blue Care Network health plan information. You'll also need to add the service key **BLUE**.

If you currently use Blue Cross' 24/7 online health care from Amwell®, use the new app, website or phone number after Jan. 1, 2018. Your login information stays the same and will be transferred to our new site. Verify your password and your account information. You may need to re-enter some information.

Online medical care doesn't replace primary doctor relationships.

The website and app use the American Well® technology platform and provider network. American Well® is an independent company that provides online visits for Blue Cross and BCN members.

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

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Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

OKLAHOMA – MEDICAID AND CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

PENNSYLVANIA – MEDICAID

Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – MEDICAID

Website: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – MEDICAID

Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - MEDICAID

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – MEDICAID

Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – MEDICAID AND CHIP

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – MEDICAID AND CHIP

Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.famis.org/
CHIP Phone: 1-866-873-2647

WASHINGTON – MEDICAID

Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – MEDICAID

Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – MEDICAID

Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING – MEDICAID

Website: http://health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

ACA Disclosure Requirements – HIPAA Privacy Notice

Your Right to Privacy

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 in order 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.

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 Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

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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?

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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 in order 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 bring suit against 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 taken action. 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/

Health Privacy Project
www.healthprivacy.org

Blue Care Network of Michigan

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

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

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply 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.

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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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

ACA Disclosure Requirements – Medicare Part D

Notice from The Chatfield School 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 Chatfield School 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.

Important Information About Your Current Coverage and Medicare's Prescription Drug Coverage

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two 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 The Chatfield School coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current The Chatfield School 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?

If you drop or lose your current prescription coverage with The Chatfield School 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 19 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

For further information, please contact the person listed below.

Matthew Young
Co-director
810-667-8970
myoung@chatfieldschool.org

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 The Chatfield School changes. You also may request a copy of this notice from Human Resources at any time.

For More Information on Medicare Prescription Drug Coverage Options

More detailed information about Medicare plans that offer prescription drug coverage can be found 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 on Medicare Prescription Drug Coverage, visit www.medicare.gov, call your State Health Insurance Assistance Program (see the inside back cover of the "Medicare & You" handbook for their telephone number) or for personalized help call 800.MEDICARE (800.633.4227). TTY users call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this help, visit www.socialsecurity.gov or call the Social Security office at 800.772.1213. TTY users call 800.325.0778.

Keep This Creditable Coverage Notice

Remember to 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)

Blue Care Network of Michigan

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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

Blue Care Network of Michigan

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Client: CHATFIELD NONPROFIT MANAG

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

ACA Disclosure Requirements – Exchange Notice

New Health Insurance Marketplace Coverage Options and Health Coverage 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 your 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. It 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 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 the 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.*

Note If you purchase a health plan through the Health Insurance 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 the coverage offered by your employer, please check your summary plan description or contact Human Resources.

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.

*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% of such costs.

Newborns and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act), signed into law on September 26, 1996, requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).

This law was effective for group health plans for plan years beginning on or after January 1, 1998.

On October 27, 1998, the Department of Labor, in conjunction with the Departments of the Treasury and Health and Human Services, published interim regulations clarifying issues arising under the Newborns' Act. The changes made by the regulations are effective for group health plans for plan years beginning on or after January 1, 1999.

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

The Newborns' Act, and its regulations, prohibit incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

The type of coverage provided by the plan (insured or self-insured) and state law will determine whether the Newborns' Act applies to a mother's or newborn's coverage.

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on State law. Based on a recent preliminary review of State laws, if the coverage is in Wisconsin and several U.S. territories, it appears that the Federal Newborns' Act applies to the plan. If the coverage is in any other state or the District of Columbia, it appears that State law applies in lieu of the Federal Newborns' Act.

All group health plans that provide maternity or newborn infant coverage must include a statement in their summary plan description (SPD) advising 'Act requirements.

This fact sheet has been developed by the U.S. Department of Labor, Employee Benefits Security Administration, Washington, DC 20210. It will be made available in alternate formats upon request: Voice telephone: 202-693-8664; TTY: 202-501-3911. In addition, the information in this fact sheet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996

Who is Eligible?

If you are employee (working 30 or more hours per week) you are eligible to enroll in the benefits described in this guide. You are eligible for benefits immediately from the date of hire.

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

- Your Spouse
- Your Child(ren) – Children are eligible up to the end of the month in which they turn age 26.

How to Enroll

The first step is to review your current benefit elections. Verify your personal information and make any changes if necessary. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

Coverage Period

The Plan year is September 1, 2018 - August 31, 2019

How to Make Changes

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period.

Qualified changes in status include: Marriage; divorce; legal separation; birth or adoption of a child; change in child's dependent status; death of spouse, child or other qualified dependent; change in residence due to an employment transfer for you or your spouse; commencement or termination of adoption proceedings; or change in spouse's employment status.

This description of the benefits and options that are available for this plan year provides a general overview of the benefits. Actual provisions contained in the insurance contracts and plan documents will be relied upon solely, in administration and interpretations of the plans. Carrier insurance contracts will govern any discrepancies or misrepresentations.

Welcome to The Chatfield School

The Chatfield School 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

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KEY CARRIER CONTACT INFORMATION

Blue Cross Blue Shield of Michigan	Blue Cross Blue Shield Phone: 800-675-7168 Website: www.bcbsm.com
DELTA DENTAL	Delta Dental Phone: 800-482-8915 Website: www.deltadentalmi.com
eyemed	Eyemed Phone: 866-939-3633 Website: www.eyemedvisioncare.com

MEADOWBROOK INSURANCE AGENCY
DIVISION OF MEADOWBROOK INSURANCE GROUP℠

Primary Account Manager (Day-to-Day Service Issues):
Michelle Amador Account Manager
Phone: 517-990-8949
Email: michelle.amador@meadowbrook.com

Sales (Overall Account Responsibility):
Scott Wooster Vice President
Phone: 248-204-8265
Email: scott.wooster@meadowbrook.com

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Employee Benefits Guide

Plan Year: September 1, 2018 - August 31, 2019