Bloomfield Hills Schools

2022 Workbook

Medicare Part D - Prescription Drug Information

If you have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see workbook for more details.

Annual Open Enrollment

Frequently Asked Questions

What is the plan year?

January 1 – December 31

When is the annual enrollment period?

October 28—November 5

When will the benefit elections for this enrollment be effective?

January 1 through December 31.

What if I do not want to change my benefit selections?

Enrollment is mandatory. You must log on to the web enrollment system to enroll for your benefits.

Log on to https://benefits.plansource.com

We will continue to utilize the benefits administration system to help you manage and understand your employee benefit plans. To log in for the first time, type in your assigned user name by using the first initial of your first name, up to the first six characters of your last name, and the last four digits of your Social Security number. For example, if your name is John Williams and the last four digits of your Social Security number are 1234, then your user name would be *jwillia1234*.

Next you will enter your password. The first time you log into the site, your password will be your date of birth in numeric format without any slashes. It will be entered in the following format: YYYYMMDD. For example, if your date of birth is January 5, 1970, enter 19700105 as the password. Once you have entered your user name and password, click the 'Log In' button. If your password needs to be re-set please contact the Benefits Coordinator (sdare@bloomfield.org or khealy@bloomfield.org).

Can I enroll online if I am a part-time staff member?

Yes, part-time staff members also enroll online.

How do I determine what benefits I am eligible to receive and what option is the best fit for me?

The benefit plans you are eligible to receive are detailed on the Benefit Summaries included in the workbook. For further clarification, you should review your employment agreement for specific program eligibility provisions.

Additional benefit education materials describing your benefit options are included in the workbook. Please review your workbook and Benefits at a Glance/Summary of Benefits carefully so your choice in benefits will be an ***Educated Choice.***

Where can I find a list of doctors who participate in my medical plan?

Provider directories are available on the carrier web site www.bcbsm.com. Click on the Find a Doctor box and follow the prompts.

How do I enroll?

You must enroll for your benefits via the online site. Log on to https://benefits.plansource.com
Enrollment is mandatory.

How do I opt out of medical coverage?

You can opt out of medical coverage for yourself and your dependents as indicated in your employment agreement. When you enroll, you should decline the medical option and enroll into the Medical Opt Out plan. Make sure to check the box next to each of your dependents. This information is used to determine who would be eligible for medical coverage and the value of your opt out amount (single, two-person or family).

Do I need to list a beneficiary?

Yes. Your life insurance beneficiary designation information will be stored on line in the enrollment system. During the enrollment process, you will be asked to enter beneficiary information for your employee life insurance policies. **Note that you must go on line during the annual enrollment period indicated above and declare a beneficiary.** You will need to enter the name, address, date of birth and Social Security number for your beneficiary. Please have this data readily available prior to logging in.

What are the eligibility requirements for my dependent(s) in order for them to be covered under my medical dental and vision plan?

Coverage in the medical, dental and vision plans is for you, your spouse and your eligible dependents. Children are eligible until the end of the month that they reach age 26.

Disabled unmarried children may remain on the medical plan after they turn age 26 if all of the following apply :

They cannot support themselves due to a diagnosis of: A physical disability or developmental disability and they depend on you for support and maintenance.

You must provide a physician's certification proving the child's disability. Bloomfield Hills Schools must receive the certification prior to the child's 19th birthday. BCBS will decide if the child meets the requirements.

What are the eligibility requirements for coverage under my life insurance plan for my dependent(s)?

All employees must be actively at work to be eligible for the dependent life insurance plan. Your dependents must be conducting normal activities of daily living in order to be enrolled. If hospital confined, coverage begins when hospital confinement ends. Newborns are covered from birth to 6 months for $1,000. The benefit will be $5,000 or $10,000, depending on the option chosen.

PLEASE NOTE:
Dependent children from birth to age 26 may be covered under your dependent life insurance plan through the end of the month in which they turn age 26. Please be sure to have available Social Security number(s) for all covered dependents.

How can I access my FSA reimbursement account?

As a reimbursement participant, you will have access to a reimbursement administration system via the web or by calling the Benefit Center toll free at 866.369.1387. The Plan Source system will provide services to help you manage your reimbursement accounts. To access the reimbursement account system, log onto https://benefits.plansource.com/, click on 'Participants' and then click on 'FSA/HRA/HSA Plan Participants'. Finally, click on 'FSA/HRA/HSA System Login', then enter your Employee ID and your Employer ID. Your Employer ID is NGE4965. You will have the ability to submit claims, check your balance, update your personal information and view past claims.

What is the maximum amount of money I can contribute to the Health Care Reimbursement Account for the calendar year?

$2,750

What is the maximum amount of money a family can contribute to the Dependent Care Reimbursement Account for the calendar year?

$5,000 per family per calendar year. Please be sure to coordinate your contributions with your spouse, if applicable.

Health Savings Account (HSA)
Frequently Asked Questions

What is a Health Savings Account (HSA)?

An HSA is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in an IRS qualified high deductible health plan (HDHP). The funds contributed to an HSA are not subject to federal income tax at the time of deposit.

What is a IRS qualified High Deductible Health Plan (HDHP)?

It is a health insurance plan with lower premiums and higher deductibles than a traditional health plan. Annually the IRS publishes the minimum deductible amount required to qualify. IRS qualified plans require deductibles to be satisfied before Rx copays may apply. Office visit copays do not exist with IRS qualified HDHP's.

Why do I need to know this?

Your medical plan options are all IRS qualified High Deductible Health Plans (HDHP) accompanied by a Health Savings Account (HSA).

What is the difference between a Health Savings Account (HSA) and a Flexible Spending Account (FSA)

Unlike an FSA, HSA funds roll over and accumulate year to year if not spent. HSAs are owned by the individual. HSA funds may be used to pay for qualified medical expenses at any time without federal tax liability or penalty. Withdrawals for non-medical expenses are treated very similarly to those in an individual retirement account (IRA) in that they may provide tax advantages if taken after retirement age, and they incur penalties if taken earlier.

Use the chart below to learn the differences between a health savings account (HSA) and a health care flexible spending account (FSA).

	HSA	HEALTH CARE FSA
What is it?	It's a personal bank account to help you save and pay for covered health care services and qualified medical expenses.	It's an account to help you pay for covered health care services and eligible medical expenses.
How do I get it?	You have to sign up for a high-deductible health plan that meets a deductible amount set by the IRS. You also have to meet other IRS guidelines to be eligible to have it. You can learn about these at irs.gov.	You can sign up for a health care FSA if it is offered by your employer. You do not need to sign up for a health plan.
Who owns it?	You do.	Your employer.
Who puts the money in it?	You. Your employer, family, and others can put money into it if they choose.	You. Your employer can also put money into it if they choose.
How is money put in it?	You can make deposits like you do with other personal bank accounts. Your employer and family can also put money into the account. Your employer may allow you to deposit money straight from your paycheck, before the money is taxed.	Your employer will take money out of each paycheck, before taxes, and put it into the account.

	HSA	HEALTH CARE FSA
Is there a limit on how much I can put in it?	Yes. The IRS sets a limit on how much you can put into it each year. You can usually find the limits in your health plan documents and at irs.gov. While there are annual limits, there is no limit to how much you can save over time.	Yes. The IRS sets a limit on how much you can put into it each year. You can usually find the limits in your health plan documents and at irs.gov. Your employer can decide what the annual limit will be but it can't be more than the IRS limit.
If I don't spend it all this year, can I use it next year?	Yes. Since you own the account, the money will stay in it until you choose to spend it. You can save and use it into retirement.	No. BHS does not allow you to carry over unused funds.
Can I cash it out at any point?	Yes. But if you cash it out and do not use the money for qualified medical expenses, you will have to pay taxes on it. And you may also have to pay a 20% tax penalty.	No.
Can I keep it if I leave my employer? What happens to the money?	Yes. You own the account.	No. You have 60 days after termination date to submit receipts for reimbursement from the account. Any funds remaining will be forfeited.
When can I start spending it?	You can start spending the HSA once you have signed up for a high-deductible health plan and have opened the account, as funds are deposited and become available.	You can start spending the FSA on the first day of the plan year.
Do I have to pay taxes on it?	No. You don't have to pay federal or, in most instances, state income taxes on: • Deposits you or others make to an HSA • Money you spend from an HSA on qualified expenses • Interest earned from an HSA If you put money into an HSA using pre-tax payroll deposits through your employer, you don't have to pay Social Security taxes on it either.	No. You don't have to pay federal, state and Social Security taxes on this money. You also don't have to pay federal income taxes on any money that is reimbursed to you.
If I don't spend it, will it earn interest for me?	Yes, an HSA can earn interest. But the amount you can earn depends on the bank you use and how much you have in the account.	No.
What can I pay for with it?	You can pay for hundreds of qualified medical expenses, which are determined by the IRS. This can include services covered by a health plan. You can also use it to pay for dental, vision and many other health care services and supplies that are listed under Section 213(d) of the Internal Revenue Code.	You can pay for hundreds of eligible medical expenses, which are determined by the IRS and your employer. This can include services covered by a health plan. It can also be used for dental, vision and many other health care services and supplies that are listed under Section 213(d) of the Internal Revenue Code.
Can I use it for things other than health care?	No, as long as you are under the age of 65. And if you use it for services that aren't qualified medical expenses, you could pay a 20% penalty tax. If you are over the age of 65, you can use it for pretty much anything.	No.
Can I have any other accounts with it?	Yes. You can have an HRA, which can only be used for eligible dental and vision services.	Yes. You can have an HRA or a dependent care FSA. You can use a dependent care FSA to pay for eligible day care and elder care services.
If I receive COBRA benefits, do COBRA rights apply to it?	COBRA does not apply to the account. But COBRA rights apply to the high-deductible health plan offered by your employer. Check with your employer for details.	Yes, COBRA rights apply. Check with your employer for details.
Can I use it to pay for COBRA plan premiums or other plan premiums?	Yes.	No.

Can I be enrolled into both the HSA and FSA plans?

No, you cannot be enrolled in an HSA and a traditional general purpose FSA plan. However, similar to an FSA, you can use an existing HSA account for medical, dental and vision expenses.

What are my options if I am age 65 (or over)?

If you are 65 or over and enrolled in Medicare, you are not eligible to open an HSA. You should consider an FSA.
If you are age 65 or over and not yet enrolled in Medicare you may open an HSA. Bloomfield assumes you have enrolled in Medicare unless you contact a BHS HR Coordinator and advise that you have made arrangements with Social Security Administration to delay your Medicare Enrollment (Parts, A, B and D). We strongly encourage seeking financial/tax advisor counsel.

Are there any eligibility requirements that would make me ineligible to enroll into the HSA plan?

Yes, during the enrollment process you will be asked the following six questions to determine your eligibility to enroll into an HSA. If you answer yes to any of these questions you are not eligible to enroll into the HSA.

1. Are you currently enrolled in Medicare?
2. Are you enrolled in another medical plan that is not a high-deductible health plan?
3. Per IRS regulations, one cannot be enrolled into a Health Savings Account (HSA) and a Health Care Flexible Spending Account (FSA) at the same time. On January 1, will you or your spouse be enrolled in an FSA or have money left in an FSA?
4. Will you be claimed as a dependent on another person's tax return this year?
5. Are you a veteran who has received VA benefits from a VA facility, for treatment not related to a service connected disability, within the 3 months preceding your HSA plan eligibility?
6. Do you receive health benefits under TRICARE (the health care program for active duty and retired members of the uniformed services, their families and survivors?)

What are the maximum contribution amounts for the HSA?

The IRS regulates the maximum contribution limits for HSA accounts. 2022 HSA Limits (Full Plan Year January 1 through December 31, 2022)

- For Single Coverage – $3,650
- For Family Coverage - $7,300

Will Bloomfield Hills Schools be contributing any funds to my HSA ?

If you enroll into the HSA plan, BHSD **may** contribute to your HSA or provide you with a taxable lump sum distribution. The amount BHSD may fund will be detailed on your confirmation statement, which you can access and view online.

IRS Regulated Contribution and Out-of-Pocket Limits for Health Savings Accounts and High-Deductible Health Plans			
	2022	2021	Change
HSA contribution limit (employer + employee)	Self-only: $3,650 Family: $7,300	Self-only: $3,600 Family: $7,200	Self-only: +$50 Family: +$100
HSA catch-up contributions (age 55 or older)	$1,000	$1,000	No change
HDHP minimum deductibles	Self-only: $1,400 Family: $2,800	Self-only: $1,400 Family: $2,800	No change
HDHP maximum out-of-pocket amounts (IRS limits) (deductibles, co-payments and other amounts, but not premiums)	Self only: $7,050 Family: $14,100	Self only: $7,000 Family: $14,000	Self-only: +$50 Family: +$100

Bloomfield Hills Schools

IMPORTANT NOTICE

***

When both spouses are employed by Bloomfield Hills School District and both have dual medical coverage, each staff member will receive the single Health Risk Assessment Credit

Table of Contents

Every effort has been made to ensure the accuracy and completeness of the benefit descriptions contained within this workbook. However, if statements in this workbook differ from the applicable contracts, certificates and riders, then the terms of those contracts, certificates and riders prevail.

Welcome to your *Educated Choices* Annual Enrollment!

Educated Choices is an innovative, progressive flexible benefit plan that gives you the choice to select your benefits from a menu of options, based on your employment agreement. Each year, you have the opportunity to select the right benefit combination for you and your family.

Using Your Benefit Education Materials

This workbook contains information you need to know about ***Educated Choices***. It provides an informative overview of your benefit options and is designed to help you in selecting your benefits. In addition to this workbook, several other benefit education resources have been included in your Enrollment package. Please review these materials carefully so your choice in benefits will be an ***Educated Choice***.

- Pre-Enrollment Email – outlines Open Enrollment details, including how and when to enroll
- Summary of Benefits – details benefit options available to you, based on your employment agreement

Educated Choices Glossary

It may be helpful for you to review some of the common terms used throughout this workbook to increase your understanding of the ***Educated Choices*** program.

- **Approved Amount** – The fee that BCBSM approves as the "reasonable and customary" fee for a specific service in a particular geographic location.
- **Benefits-At-A-Glance/Summary of Benefits** – An easy to read summary of in-network and out-of-network deductibles, co-pays and dollar maximums for certain covered services under the plan. It is a summary, not an all-inclusive list of the benefit plan. A complete description of benefits can be found in the certificates and riders for each plan.
- **Benefit Dollars** – The credits available to an employee which are used to purchase benefit options offered through ***Educated Choices***.
- **Brand-name drugs** – Prescription drugs that are patent protected. When the patent expires, other manufacturers can produce the generic equivalent of the brand and sell it under a generic name. See Tier 2 and Tier 3 descriptions on each Medical/Rx plan Benefit Summary.

Educated Choices Glossary

- **Coinsurance** – The fixed percentage of expenses you share with the insurance carrier. The coinsurance begins after the deductible has been satisfied.
- **Co-payment** – The fixed dollar amount you pay for certain services. **Coverage Status** – This is the number of individuals eligible to be covered under your health plan (single, two-person or family).
- **Deductible** – The expense you incur before the plan or insurance carrier begins paying your covered expenses. The deductibles are met each calendar year for medical. Vision deductibles will vary according to your employment agreement (outlined in your Summary of Benefits).
- **Effective Date** – All ***Educated Choices*** benefits will be effective on January 1st for the full calendar year.
- **Eligible Dependent** – This includes your spouse and eligible dependents between the ages of 1 day-26 years, regardless of marital, student and financial status. Disabled Dependents
- **Formulary** – A regularly updated list of medications reviewed by the Blues' Pharmacy and Therapeutics Committee that represents the clinical judgment of Michigan Physicians, pharmacists and other health care experts in the diagnosis and treatment of disease and preservation of health.
- **Flexible Spending Account (FSA)**– This account allows you to use pre-tax dollars to pay for IRS approved medical, dental and vision expenses.
- **Generic drugs** – Non-brand name drugs that produce the same effects in the body as the equivalent brand-name drugs. The Food and Drug Administration requires that generic drugs have the same active ingredients as the equivalent brand-name drugs. They may differ from brand-name drugs in color and shape. Since the major difference between brand-name and generic drugs is price, your prescription will be filled with the generic equivalent when medically appropriate. See Tier 1 description on the Benefit Summaries.
- **Health Savings Account (HSA)** – A tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high-deductible health plan (HDHP). This money remains the property of the subscriber even if employment is terminated. **This is not an option for someone who is not enrolled with an IRS qualified High Deductible Health Plan or someone who is enrolled in Medicare.**
- **Health Equity is the provider for the Health Savings Account. You can access these funds using your benefit debit VISA or through the online banking system. This is your personal bank account. Your employer has no access to these funds.**
- **High Deductible Health Plan (HDHP)** – a health insurance plan with lower premiums and higher deductibles than a traditional health plan.
- **In-Network** – This means your doctor or facility participates in and accepts the High Deductible Health Plan and has agreed to a reduced fee schedule.
- **Life Status Change** – If you have a life status change (e.g., your spouse's employment changes or is terminated involuntarily, or you have a birth, marriage, death of a dependent or spouse, or divorce in your family), you may be able to add or drop certain types of coverage for dependents. If you have any questions as to what is considered an acceptable status change, please contact your Benefits Coordinator within thirty (30) days of the life status event. **Mid-plan year life status changes require a meeting with the Benefits Coordinator. Please contact her within 30 days of the life event to schedule an appointment. Health Savings Account Changes may be made every 30 days and also require a meeting with the Benefits Coordinator. A life status event does not need to occur to make this type of change to payroll deductions.**

  Note: Mid-plan year changes cannot be made via online enrollment systems, email or through voice message systems.
- **Out-of-Network** – This means your doctor or facility is **not** part of and does not accept the Simply Blue PPO HSA plan. Out-of-network services will be covered at a lower percentage, you will be responsible for the difference. BCN DOES NOT COVER ANY SERVICES IF YOU GO OUT-OF-NETWORK!
- **Out-of-Pocket Maximum** – The most you would pay in a plan year for eligible medical expenses, including deductibles, coinsurance and copays.
- **Plan Year** – The current ***Educated Choices*** Plan Year is January 1 through December 31 of each year. Each fall, you will make your selections for the following calendar year.

Open Enrollment Updates

Medical Plan Deductible

IRS regulations state, High Deductible Health Plans (HDHP) must have minimum deductible amounts of $1,400 for single coverage and $2,800 for family coverage. Bloomfield Hills Schools offers three High Deductible Health Plans. Two PPO plans through BCBSM and one HMO through BCN. Health Equity will service any health savings accounts (HSA) associated with any of these medical plans.

Waiver of Medical Insurance Forms

If you choose to decline the medical coverage offered by Bloomfield Hills Schools, you will be able to waive coverage during the online enrollment process if you decline to enroll into a medical option.

Health Risk Assessment Credit

Bloomfield Hills Schools will continue to offer a credit to employees and spouses (if applicable), who participate in the annual Health Risk Assessment. In order to be eligible to receive the Health Risk Assessment credit for the upcoming plan year, the completed form must be submitted to the Benefits Coordinator no later than September 15th annually. Forms received after the due date will not qualify for any credit. There will be no exceptions. These forms are available on the Bloomfield Hills Schools Intranet under Human Resources, Benefits. If you are unable to locate the form please contact the Benefits Coordinator at sdare@bloomfield.org.

Please note that, for all employees who turned in a Health Risk Assessment form, you will not be able to view this credit in the online enrollment system, however it will be detailed on your online confirmation statement.

Your Choices

Bloomfield Hills Schools understands that the benefit decisions you make today may not be right for you in future years. Therefore, you have an opportunity each year in the fall to make changes in benefits for the upcoming calendar year. **The available choices, as outlined in your employment agreement, are displayed on your Summary of Benefits. The funding of options by Bloomfield Hills Schools can be viewed on the online enrollment system.** If you have any questions regarding your enrollment, benefit coverage or options described herein, please contact:

Sarah Dare, Benefits Coordinator
sdare@bloomfield.org
(248) 341-5431 or (248) 452-1429

Karen Healy, Director
Human Resources and Payroll
khealy@bloomfield.org
(248) 341-5432

Public Act 152

State Legislature changed the funding of benefits for public school employees. Bloomfield Schools elected to comply with the law with the "hard cap".

Governor Snyder signed a new law that limits public employer contributions to employee health insurance, effective with each collective bargaining agreement that expires on or after January 1, 2012. This law will apply to all public schools in the state. The "Publicly Funded Health Insurance Contribution Act" provides two mechanisms that limit employer contributions to healthcare: a "hard cap" and an optional "80/20" plan. The Act applies to "medical benefit plans" that provide payment of medical benefits, including, but not limited to, hospital and physician services, prescription drugs, and related benefits. The Act does not apply to dental or vision care plans.

The Default Limit: The Hard Cap

The Act is drafted to apply a maximum that a public employer may pay towards public employee health care costs. The limit on a public employer's total contribution for employee health insurance for the upcoming plan year is equivalent to:

- $7,304.51 times the number of employees and elected public officials with single-person coverage
- $15,276.01 times the number of employees and elected public officials with individual-and-spouse coverage or individual-plus-1-nonspouse-dependent coverage
- $19,9221.45 times the number of employees and elected public officials with family coverage

The State of Michigan releases the annual Hard Cap in the spring each year, so the new limits will be factored into the online annual open enrollment process.

The amount necessary to purchase health insurance for employees that exceeds this "cap" must be paid by employees.

Q: What employers are affected by the Act?

The law applies broadly to "public employers." The Act applies to local units of government, political subdivisions of the state, and "any intergovernmental, metropolitan, or local department, agency, or authority, or other local political subdivisions." Also included are school districts, community or junior colleges, and certain other institutions of higher education.

Q: What employer costs count toward the cap?

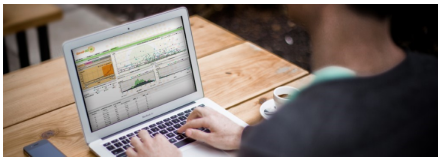
The annual premium or illustrative rate and any payments for reimbursements of co-pays, deductibles, or payments into Health Savings Accounts, or similar accounts used for health care are included as employer costs.

Q: Will the caps ever change?

Yes. The State Treasurer will adjust the caps each year based on the change in the medical care component of the U.S. Consumer Price Index. The newly adjusted caps will be effective January 1 of each year.

Educated Choices Online Enrollment Instructions

The ***Educated Choices*** Online enrollment system is an easy, convenient way to enroll in your benefits using your computer. **Please note, enrollment is mandatory.**



Enrollment System

The ***Educated Choices*** Online enrollment system is available 24 hours a day, seven days a week during the enrollment period. Open Enrollment will be held:

- **October 28, 2021 through November 5, 2021 for an effective date of January 1 through December 31, 2022.**

It is very important for you to note these dates. Please plan to enroll during the designated enrollment period.

Once you have enrolled using the Web site, you have almost completed the enrollment process. **During the enrollment period, you are required to provide documentation for any newly added dependents which includes: Birth certificate, adoption certificate, marriage license (if spouse) and social security card.**

Process for Life Insurance Beneficiaries

It is extremely important to declare one or more beneficiaries for the life insurance benefits you receive as an employee of Bloomfield Hills Schools. Your beneficiary information is being stored online in the enrollment system. During the enrollment process, you will be asked to enter beneficiary information for your employee life insurance policies. **Note that you must go online during the annual enrollment period indicated in this workbook and confirm a beneficiary.**

Preparing for Enrollment

Please review your ***Educated Choices*** newsletter, workbook, and Summary of Benefits.

When you have decided on each of your ***Educated Choices*** benefit options, gather dependent information, including Social Security numbers and dates of birth. You are now ready to enroll!

Completing Your Enrollment

- To enroll, logon to the ***Educated Choices*** Web site at benefits.plansource.com. Instructions on how to login, including your "Username" and "Password", can be found on your pre-enrollment email included with your enrollment materials.
- The system will ask you to verify your email address(es). Please be sure to include your email address; this is required for you to receive a confirmation email once your enrollment is complete.
- You will be able to review, update, add or delete your dependent information. This information determines your coverage status (single, two-person, or family) for your medical, dental and vision choices. Review this information carefully.
- Continue to the benefit election screen where you will make your election choices. The online enrollment system will show your payroll deductions per pay period. Deductions are taken over a 20 pay cycle for the Plan Year January 1 through December 31, no deductions are taken in July or August.
- Once you have confirmed your elections in the online system, your enrollment is complete! You will be offered the opportunity to receive an email confirmation and receive a congratulatory message. **Be sure to upload any required documentation and print your confirmation statement.**
- If you need to make changes to your benefit selections, you may return to the ***Educated Choices*** online enrollment system as many times as you wish within the annual enrollment period.

Educated Choices Online Enrollment Instructions

Confirmation Statement Process

Print your confirmation statement at the end of the enrollment process.

Please review your confirmation statement carefully to ensure that your selections were recorded correctly. The dependents listed on your confirmation statement will dictate to the insurance providers the covered participants under your plan.

While online….

You will receive a Personal Health Statement (PHS) if you made change(s) to your voluntary life election over the guaranteed issue amount. You will need to complete this medical questionnaire and return the fully completed form to the life insurance carrier. Please do not send the fully completed Personal Health Statement to the Human Resources Department. Also, please note, increased life insurance amounts remain pending until written approval is received from the carrier. You have until January 1st of the plan year to submit the PHS to the carrier. Failure to do so will results in your request being closed.

Insurance Carrier Contact Information

If you need to contact the carriers directly, customer service phone numbers and Web site addresses are listed below.

Medical, Prescription, Dental and Vision Coverage

Blue Cross/Blue Shield of Michigan
BCBS PPO Plans
Customer Service: 1-800-790-2583
Web site: www.bcbsm.com

Blue Care Network—HMO
Customer Service: 1-800-662-6667
Website: www.bcbsm.com

Health Savings Account (HSA)

Health Equity
Customer Service: 1-866-346-5800 Hours of Operation: 24/7 365 days per year
Web site: www.healthequity.com

Flexible Spending Accounts

PlanSource
Phone: 1-866-369-1387
Fax: 1-888-267-0839
Web site: www.plansource.com

Employee and Dependent Life Insurance Protection, AD & D, and Long Term Disability

Reliance Standard
Customer Service Phone: 1-800-351-7500
Customer Service Email: customer.service@rsli.com
Web site: www.RelianceStandard.com

Eligibility and Additional Resources for your *Educated Choices*

BCBSM Secure Member Services and BCN Secure Member Services

The online Secure Member Services will help you learn more about:

- Managing Your Health
- Personalized Health Care
- Managing Your Claims
- Medication Guides and Brochures
- Helping Members Save Money
- Establishing an Advance Directive
- Member Publications
- Member Forms
- Member FAQs

http://www.bcbsm.com/member

Additional BCBSM and BCN Member Services

Blue Cross Blue Shield of Michigan also offers a variety of in-store discounts in addition to Weight Watchers discounts; Naturally Blue discounts.

You can contact Blue Cross Blue Shield by calling Customer Service at 1-877-790-2583 or BCN Customer Service at 800-662-6667 or logging online at www.bcbsm.com

Download our Mobile App

The most convenient way to stay informed about your plan

Ever been surprised by your bill at the doctor or pharmacy? You can use the BCBSM mobile app to find out what you'll owe ahead of time. It connects you securely to the health plan info on your bcbsm.com account when you need it.

How to get the app

It's available through the App Store® and Google Play™. Make sure your phone/tablet is:

- An iPhone® or iPad® using iOS 10.0 or better
- A smartphone or tablet using Android™ version 5.0 or better

Sorry, the app isn't available yet for BlackBerry® or Windows® phones.

Download on the App Store | GET IT ON Google Play

Eligible Dependent Requirements

Coverage in the ***Educated Choices*** medical, dental and vision plans is for you, your spouse and your eligible dependents. Due to Health Care Reform regulations, children are eligible until the end of the month that they reach age 26.

During the enrollment process, you will need to enter your eligible dependent's Social Security number (SSN) and date of birth. **Note that all insurance carriers must have an accurate SSN on file for your dependents in order to process claims**. Eligible dependents between the ages of 19 and 26 must meet the requirements listed below and can be covered through the end of the month in which they turn 26. This is regardless of student, financial, marital or dependency status.

Dependent children of the subscriber or the subscriber's spouse are eligible provided such children are:

- Between 19-26 years old
- Related by blood, marriage or legal adoption

Disabled unmarried children may remain on the medical plan after they turn age 26 if all of the following apply:

- They cannot support themselves due to a diagnosis of:
  - ⇒ A physical disability or a developmental disability;
  - ⇒ They depend on you for your support and maintenance

You must provide a physician's certification proving the child's disability. BCBS must receive the certification within 31 days prior to the child's 19th birthday. BCBS will decide if the child meets the requirements.

Please note: Coverage provisions for dependent children may vary based on insurance carrier.

Medical and Prescription Drug Benefits

Your Medical Plan Choices

The available choices, as outlined in your employment agreement, are displayed on your Summary of Benefits. Your cost and the employer cost/credits are displayed as you online enroll.

Medical Plans

This section outlines the medical plans offered through ***Educated Choices***.

The BCBS HDHP plan has an in-network option that gives you access to quality medical services. Obtaining services from an in-network provider reduces the cost as these doctors and hospitals have agreed to provide medical services at reduced rates. You decide whom you want to see at the time of service. If you select an in-network doctor or hospital from the online directory, your covered benefits are typically greater and your cost is usually less. However, the in-network deductible is higher than traditional health plans and there is a deductible for out-of-network services that must be met each calendar year. After the deductible is satisfied, Prescription Drugs (including contraceptives) have a co-pay. Prescription Drugs have a mail order and retail, 90-day supply option with a reduced co-pay (after deductible).

Services provided by an out-of-network provider may not be covered. **You are responsible for deductible fees incurred for services provided.**

Being covered by this HDHP may allow you to contribute to a **Health Savings Account (HSA)**. An **HSA** is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high-deductible health plan (HDHP). The funds contributed to an HSA are not subject to federal income tax at the time of deposit. Unlike a flexible spending account (FSA), HSA funds roll over and accumulate year to year if not spent. HSA funds may currently be used to pay for qualified medical expenses at any time without federal tax liability or penalty. Withdrawals for non-medical expenses are treated very similarly to those in an individual retirement account (IRA) in that they may provide tax advantages if taken after retirement age, but they incur penalties if taken earlier. More information on HSAs can be found on the FAQ sheet included in your enrollment materials.

The IRS regulates the maximum contribution limits for HSA accounts. Below are the details for the plan year.

HSA Contribution Limits

- **For Single Coverage – $3,650**
- **For Family Coverage - $7,300**

HSA participants between age 55 and 64 who are not enrolled in Medicare, have the option to **contribute an additional $1,000 annually.**

In order to be eligible for a health savings account, you must be able to answer no to all of the following questions:

1. Are you currently enrolled in Medicare?
2. Are you enrolled in another medical plan that is not a high-deductible health plan?
3. Per IRS regulations, one cannot be enrolled into a Health Savings Account (HSA) and a Health Care Flexible Spending Account (FSA) at the same time. On January 1, will you or your spouse be enrolled in an FSA or have money left in an FSA?
4. Will you be claimed as a dependent on another person's tax return this year?
5. Are you a veteran who has received VA benefits from a VA facility, for treatment not related to a service connected disability, within the 3 months preceding your HSA plan eligibility?
6. Do you receive health benefits under TRICARE (the health care program for active duty and retired members of the uniformed services, their families and survivors?)

For full details of this medical plan, please review the summary of benefits included with your materials.

Medicare Enrolled Staff or Family Members

If you or a family member are enrolled with Medicare, a copy of the enrollment card must be forwarded to the Benefits Coordinator during annual open enrollment. BCBS and the Center for Medicare/Medicare Services (CMMS) coordinate benefits with Bloomfield Hills School District being the primary payee. It is critical that we have the correct information to submit to these servicing agencies in order for claims to be properly paid. If you or a family member become enrolled with Medicare during the plan year, a copy of the enrollment card should be forwarded to the Benefits Coordinator within 30 days.

Medical and Prescription Drug Benefits

Prescription Drugs

BCBSM and BCN have different formularies and different copay tiers. (Formulary is a list of covered medicines) What you pay depends on what tier your drug is in and whether you are enrolled in the PPO or HMO plan.

BCBSM Copays

Tier 1 – Generic—$5 copay applies after deductible is met

Tier 1 drugs are generic drugs. They require the **lowest co-payment**, making them the most cost effective option for treatment. Many prescription drugs are available as generics.

Tier 2 – Formulary Brand—$25 copay applies after deductible is met

Tier 2 drugs are brand-name drugs. Tier 2 drugs are also safe and effective but require a **higher co-payment** than Tier 1 drugs.

Tier 3 – Non-formulary Brand—$50 copay applies after deductible is met

Tier 3 drugs are brand-name drugs not included in Tier 2. These drugs require the highest co-payment. You may also have to pay the difference between the cost of the Tier 3 non-formulary brand-name drug and the generic if a generic equivalent is available but the brand is dispensed.

BCN Copays

Tier 1A – Preferred Generic - $10 copay applies after deductible is met.

Tier 1A drugs are cost effective generic drugs. They require the lowest co-payment, making them the most cost effective option for treatment.

Tier 1B – Generic - $30 copay applies after deductible is met.

Tier 1B drugs are generic medications but have a higher cost associated with them than the preferred generics.

Tier 3 – Formulary Brand - $60 copay applies after deductible is satisfied.

Tier 3 drugs are cost effective name brand drugs and require a higher copayment than generics.

Tier 4 – Non Formulary Brand - $80 copay applies after deductible is met.

Tier 4 drugs are brand name drugs not included in Tier 3 and require a higher copayment than generics or Formulary Brand.

Tier 5 – Formulary Specialty – 20% coinsurance applies after deductible is met (maximum cost to member is limited to $200 per refill)

Tier 5 drugs are specialty medications that can be used to treat chronic and/or severe medical conditions but are considered more cost effective than other specialty medications.

Tier 6 – Non Formulary Specialty – 20% coinsurance applies after deductible is met (maximum cost to member is limited to $300 per refill)

Tier 6 drugs are specialty medications that are the most costly and have the highest copayments.

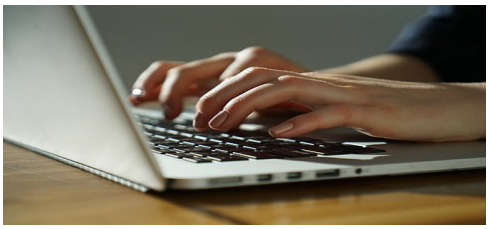
Medical and Prescription Drug Benefits

Generic equivalents or formulary brand-name alternatives are available for many of these Tier 3 drugs. Similar drugs with generic equivalents may also be available. If you want to know if you can have your prescription changed to a Tier 1 or Tier 2 medication, speak with your physician to see if a change is appropriate for you.

BCBSM and BCN's *Custom Formulary Quick Guide for Members* lists commonly prescribed medications available under each tier. You can find the *Custom Formulary Quick Guide for Members* at **www.bcbsm.com**.From the Member Page:

- Click on For Members
- Click on Group Plans—More than 50 Employees
- Click on Large Group Employer
- Choose PPO or HMO
- Click on custom drug list

A drug you are taking may not be covered under this prescription drug plan. You should check the *Custom Formulary Quick Guide for Members* prior to your new plan's effective date to see if your medication is covered. If it isn't covered, contact your physician to have your prescription changed, if determined appropriate, to a covered drug.



Telemedicine/Online Visits

With online visits, you have access to around-the-clock medical care or scheduled behavioral health care, anywhere in the U.S. Here's how to sign up:
Mobile—Download the BCBSM Online Visits App
Web—Visit bcbsmonlinevisits.com
Phone—Call 1-844-606-1608
Add your BCBS or BCN plan information.

What illnesses can be treated online?
Sinus and respiratory infections, cold and flu, eye irritation or redness, sore throat, painful urination, anxiety, depression and grief.

How do I have an online visit?

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 an optional visit summary to your primary care doctor or other health care provider at the end of your visit.

How much does it cost? Medical visits are $59. Costs for behavioral health visits vary depending on the type of provider and the services you receive. Your cost share is based on your existing outpatient behavioral health benefits.

Duplication of Coverage/Dual Medical Coverage

You have the ability to enroll with **Dual Medical Coverage**. However, if you are enrolled with the District's High Deductible Health Plan with a Health Savings Account you are not eligible to be enrolled through a Non-High Deductible Health Plan with your spouse or parent. If you are enrolled with a Non-High Deductible Health Plan, you are eligible to enroll in the BHSD medical coverage in addition to enrolling in the medical coverage provided through the medical plan provided by your spouse's employer. (However, you will not be eligible to enroll with the health savings account). To do this you will be required to provide the district with the following information:

- Spouse's Employer's Name
- Address of Carrier
- Employee and Spouse's Name
- Group Number
- Insured's Name and Social Security Number
- I.D. Number
- Name of Carrier
- Effective Date of Coverage

Medical Opt-Out

You can opt-out of medical coverage for yourself and your dependents as indicated in your employment agreement. If you involuntarily lose your other medical coverage, this plan allows you to select a Bloomfield Hills Schools' medical plan. **However, you must notify the Benefits Coordinator within 30 days of your loss of coverage in order to opt back into a medical plan.**

Mid-plan year life status changes require a meeting with the Benefits Coordinator. Please contact the Benefits Coordinator within 30 days of the life event to schedule an appointment. Voluntary changes can only be made once per year during the *Educated Choices* open enrollment.

If you choose to decline the medical coverage offered by Bloomfield Hills Schools, you will not need to complete a waiver form. Instead, you will be able to waive coverage during the online enrollment process if you decline to enroll into a medical option. To enroll in the Medical Opt-Out plan online, you will first need to decline the Medical options. Bloomfield Hills Schools will add the cash credit to each paycheck through the flex plan year payroll process (no contributions made in July and August), if you are eligible for this benefit.

Dental and Vision Coverage

Dental Plan Coverage

Dental plans encourage you and your eligible dependents to seek quality dental care on a regular, preventive basis as part of a total health care program. When participating in the dental plan, you have the flexibility to select your own dentist.

Covered Services

Dental services are divided into categories and reimbursements are based on "reasonable and customary" charges.

- **Class I Preventive** – Benefits include examinations, cleanings and periodic X-rays
- **Class II Basic Services** – Benefits include fillings, root canal therapy, extractions, oral surgery, repair of dentures and bridges and periodontal services
- **Class III Major Services** – Benefits include inlays, crowns, bridges and dentures
- **Class IV Orthodontia Services** – Benefits, if applicable to your employment agreement, may include services, treatment and procedures for the alignment or correction of teeth, up to age 19

Your Dental Plan Choices

The available choices, as outlined in your employment agreement, are displayed on your Summary of Benefits which follow. Your cost and the employer cost/credits are displayed as you online enroll.

Vision Plan Coverage

Eyesight is important to your well being. Your current vision plan helps you maintain quality eye care. When participating in the vision plan, you have the flexibility to select your own optometrist or ophthalmologist, however you will pay less out of your pocket when using a VSP network provider.

Covered Services

The vision plan offers you the following benefits:

- Eye exam screening and analysis
- Corrective lenses or contact lenses
- Frames

A co-pay is required for each eye exam and for new lenses and frames (combined).

Limitations

The following expenses are **not covered**:

- Surgical or medical care for treatment of eye disease and/or injury
- Sunglasses (plain or prescription); photo-sensitive, anti-reflective or aniseikonic glasses; or other tinted glasses of any kind to the extent that the charges exceed the charge for clear lenses or safety lenses or goggles
- Additional cost for progressive lenses
- Expenses incurred for cosmetic or fashion reasons
- Replacement of lost, stolen or broken lenses or frames

Your Vision Plan Choices

The available choices, as outlined in your employment agreement, are displayed on your Summary of Benefits included in your Open Enrollment Packet. Your cost and the employer cost/ credits are displayed as you online enroll.

BLUE CROSS/BLUE SHIELD

MEDICAL

PPO $1,400/$2,800

Blue Cross Blue Shield of Michigan

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

BLOOMFIELD HILLS BD OF ED
0070029560009 - 08091
Effective Date: 01/01/2022

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

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

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

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

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

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

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

Eligibility Information

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

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

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Benefits	In-network	Out-of-network
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage. **Note:** The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	$1,400 for a one-person contract $2,800 for a family contract (2 or more members) each calendar year **(no 4th quarter carry-over)**	$2,800 for a one-person contract $5,600 for a family contract (2 or more members) each calendar year **(no 4th quarter carry-over)**
	Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Deductibles may increase annually. Please call your customer service center for an annual update.	
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	None	20% of approved amount for most covered services
Annual out-of-pocket maximums-applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	$2,250 for a one-person contract $4,500 for a family contract (2 or more members) each calendar year	$4,500 for a one-person contract $9,000 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam-includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered

14/28K-28/56KAS;ADM PLANYR JAN;ASCMOD 6684;CDH-HSA;DC 26-ME ASC;HEQ;PDTTC52550RXCMA;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAC0IN20ONA;SBDHSAOCSM24ASC;SD ASC

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

000013825394

Benefits	In-network	Out-of-network
Pap smear screening- laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices-includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the **same** calendar year are subject to your deductible and coinsurance, if applicable.	80% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy **Note:** Medically necessary colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance, if applicable.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	

14/28K-28/56KAS;ADM PLANYR JAN;ASCMOD 6684;CDH-HSA;DC 26-ME ASC;HEQ;PDTTC52550RXCMA;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAC0IN20ONA;SBDHSAOCSM24ASC;SD ASC

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

000013825394

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services - must be medically necessary	100% after in-network deductible	100% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

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

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	100% after in-network deductible	80% after out-of-network deductible
Note: Nonemergency services must be rendered in a **participating** hospital.	Unlimited days	
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible

14/28K-28/56KAS;ADM PLANYR JAN;ASCMOD 6684;CDH-HSA;DC 26-ME ASC;HEQ;PDTTC52550RXCMA;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAC0IN20ONA;SBDHSAOCSM24ASC;SD ASC

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

000013825394

Benefits	In-network	Out-of-network
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care- must be in a **participating** skilled nursing facility	100% after in-network deductible	100% after in-network deductible
	Limited to a maximum of 90 days per member per calendar year	
Hospice care	100% after in-network deductible	100% after in-network deductible
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods-provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	100% after in-network deductible	100% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization-consult with your doctor	100% after in-network deductible	100% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery-includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	100% after in-network deductible	80% after out-of-network deductible
Voluntary abortions	100% after in-network deductible	80% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% after in-network deductible -in designated facilities **only**
Bone marrow transplants-must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible

Benefits	In-network	Out-of-network
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • Treatment must be preauthorized • subject to medical criteria	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible in participating facilities **only**
• Online visits - by physician or **BCBSM** selected vendor	100% after in-network deductible	80% after out-of-network deductible
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance use disorder treatment-in approved facilities **only**	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment-when rendered by an approved board-certified behavioral analyst-is covered through age 18, subject to preauthorization **Note**: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not covered	Not covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

Other covered services

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

Simply Blue HSA with Prescription Drugs

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

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

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

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

Member's responsibility (copays and coinsurance amounts)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until you have met the Simply Blue HSA annua deductible. After you have satisfied the deductible you are require to pay applicable prescription drug copays and coinsurance amounts which are subject to your annual out-of-pocket maximums.

Note: The following prescription drug expenses will not apply to your Simply Blue HSA deductible or annual out-of-pocket maximum

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 20% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $10 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $50 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay plus an additional 20% of the BCBSM approved amount

14/28K-28/56KAS;ADM PLANYR JAN;ASCMOD 6684;CDH-HSA;DC 26-ME ASC;HEQ;PDTTC52550RXCMA;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAC0IN20ONA;SBDHSAOCSM24ASC;SD ASC

Blue Cross Blue Shield of Michigan is a nonprofit corporation and Independent licensee of the Blue Cross and Blue Shield Association.

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
	31 to 83-day period	No coverage	After deductible is met, you pay $100 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $100 copay	After deductible is met, you pay $100 copay	No coverage	No coverage

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

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Prescribed over-the-counter drugs - when covered by BCBSM	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	No coverage	100% of approved amount	80% of approved amount

14/28K-28/56KAS;ADM PLANYR JAN;ASCMOD 6684;CDH-HSA;DC 26-ME ASC;HEQ;PDTTC52550RXCMA;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAC0IN20ONA;SBDHSAOCSM24ASC;SD ASC

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

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance **plus** an additional 20% prescription drug out-of-network penalty
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty for insulin or other covered injectable legend drug
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty

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

Features of your prescription drug plan

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

14/28K-28/56KAS;ADM PLANYR JAN;ASCMOD 6684;CDH-HSA;DC 26-ME ASC;HEQ;PDTTC52550RXCMA;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAC0IN20ONA;SBDHSAOCSM24ASC;SD ASC

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

BLUE CROSS/BLUE SHIELD

Medical

PPO $2,000/$4,000

Blue Cross Blue Shield of Michigan

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

BLOOMFIELD HILLS BD OF ED
0070029560026 - 08098
Effective Date: 01/01/2022

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

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

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

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

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

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

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

Eligibility Information

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

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

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Benefits	In-network	Out-of-network
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage. **Note:** The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	$2,000 for a one-person contract $4,000 for a family contract (2 or more members) each calendar year **(no 4th quarter carry-over)**	$4,000 for a one-person contract $8,000 for a family contract (2 or more members) each calendar year **(no 4th quarter carry-over)**
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	None	20% of approved amount for most covered services
Annual out-of-pocket maximums-applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	$3,000 for a one-person contract $6,000 for a family contract (2 or more members) each calendar year	$6,000 for a one-person contract $12,000 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam-includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered

ADM PLANYR JAN;ASCMOD 8527 MED;CDH-HSA;DC 26-ME ASC;DHSAD2KIN4KON A;HEQ;HSAOPM3KIN6KONA;PDTTC52550RXCMA;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAC0IN20ONA;SBDHSAOCSM24ASC;SD ASC

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

000013810648

Benefits	In-network	Out-of-network
Pap smear screening- laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices-includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the **same** calendar year are subject to your deductible and coinsurance, if applicable.	80% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy **Note:** Medically necessary colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance, if applicable.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	

ADM PLANYR JAN;ASCMOD 8527 MED;CDH-HSA;DC 26-ME ASC;DHSAD2KIN4KON A;HEQ;HSAOPM3KIN6KONA;PDTTC52550RXCMA;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAC0IN20ONA;SBDHSAOCSM24ASC;SD ASC

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

000013810648

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Online visits - by physician or **BCBSM** selected vendor must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services - must be medically necessary	100% after in-network deductible	100% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

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

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	100% after in-network deductible	80% after out-of-network deductible
Note: Nonemergency services must be rendered in a **participating** hospital.	Unlimited days	
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible

ADM PLANYR JAN;ASCMOD 8527 MED;CDH-HSA;DC 26-ME ASC;DHSAD2KIN4KON A;HEQ;HSAOPM3KIN6KONA;PDTTC52550RXCMA;$BD HSA ASC;$BD HSA OLV ASC;$BDHSAC0IN20ONA;$BDHSAOCSM24ASC;$D ASC

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

000013810648

Benefits	In-network	Out-of-network
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care- must be in a **participating** skilled nursing facility	100% after in-network deductible	100% after in-network deductible
	Limited to a maximum of 90 days per member per calendar year	
Hospice care	100% after in-network deductible	100% after in-network deductible
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods-provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	100% after in-network deductible	100% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization-consult with your doctor	100% after in-network deductible	100% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery-includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males **Note**: For voluntary sterilizations for females, see **"Preventive care services."**	100% after in-network deductible	80% after out-of-network deductible
Voluntary abortions	100% after in-network deductible	80% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% after in-network deductible -in designated facilities **only**
Bone marrow transplants-must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials **Note**: BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible

ADM PLANYR JAN;ASCMOD 8527 MED;CDH-HSA;DC 26-ME ASC;DHSAD2KIN4KON A;HEQ;HSAOPM3KIN6KONA;PDTTC52550RXCMA;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAC0IN20ONA;SBDHSAOCSM24ASC;SD ASC

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

000013810648

Benefits	In-network	Out-of-network
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility: • covered mental health services **must** be performed in a residential psychiatric treatment facility • Treatment must be preauthorized • subject to medical criteria	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible in participating facilities **only**
• Online visits - by physician or **BCBSM** selected vendor	100% after in-network deductible	80% after out-of-network deductible
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance use disorder treatment-in approved facilities **only**	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment-when rendered by an approved board-certified behavioral analyst-is covered through age 18, subject to preauthorization **Note**: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not covered	Not covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

ADM PLANYR JAN;ASCMOD 8527 MED;CDH-HSA;DC 26-ME ASC;DHSAD2KIN4KON A;HEQ;HSAOPM3KIN6KONA;PDTTC52550RXCMA;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAC0IN20ONA;SBDHSAOCSM24ASC;SD ASC

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

000013810648

Other covered services

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

Simply Blue HSA with Prescription Drugs

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

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

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

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

Member's responsibility (copays and coinsurance amounts)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are require to pay applicable prescription drug copays and coinsurance amounts which are subject to your annual out-of-pocket maximums.

Note: The following prescription drug expenses will not apply to your Simply Blue HSA deductible or annual out-of-pocket maximum

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 20% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $10 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $50 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay plus an additional 20% of the BCBSM approved amount

ADM PLANYR JAN;ASCMOD 8527 MED;CDH-HSA;DC 26-ME ASC;DHSAD2KIN4KON A;HEQ;HSAOPM3KIN6KONA;PDTTC52550RXCMA;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAC0IN20ONA;SBDHSAOCSM24ASC;SD ASC

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

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
	31 to 83-day period	No coverage	After deductible is met, you pay $100 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $100 copay	After deductible is met, you pay $100 copay	No coverage	No coverage

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

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Prescribed over-the-counter drugs - when covered by BCBSM	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	No coverage	100% of approved amount	80% of approved amount

ADM PLANYR JAN;ASCMOD 8527 MED;CDH-HSA;DC 26-ME ASC;DHSAD2KIN4KON A;HEQ;HSAOPM3KIN6KONA;PDTTC52550RXCMA;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAC0IN20ONA;SBDHSAOCSM24ASC;SD ASC

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

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved **generic** and **select brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance **plus** an additional 20% prescription drug out-of-network penalty
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty for insulin or other covered injectable legend drug
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty

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

Features of your prescription drug plan

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

ADM PLANYR JAN;ASCMOD 8527 MED;CDH-HSA;DC 26-ME ASC;DHSAD2KIN4KON A;HEQ;HSAOPM3KIN6KONA;PDTTC52550RXCMA;SBD HSA ASC;SBD HSA OLV ASC;SBDHSAC0IN20ONA;SBDHSAOCSM24ASC;SD ASC

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

BLUE CARE NETWORK

Medical

HMO $1,400/$2,800

Benefits-at-a-Glance
BCN High Deductible Health Plan - Self-funded Large Groups
00112357-SF01 Bloomfield Hills Bd of Ed
Effective Date: 01/01/2022

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 certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and 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 group is self-funded. Blue Care Network provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Services must be provided or arranged by the member's primary care physician or health plan.

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

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

Deductible, Copays and Dollar Maximums	
Deductible - Combined for both medical and drug coverage.	$1,400 for a one-person contract/$2,800 for a family contract (2 or more members) each calendar year (no 4th quarter carry-over)

	Deductible - The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract
Fixed Dollar Copays	None
Coinsurance	50% for select services as noted below
Out of Pocket Maximum	$2,350 for a one-person contract. $4,700 for a family contract (2 or more members) each calendar year
	Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drug copays.

Preventive Services	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening	100%
Well-Baby and Child Care	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Female Sterilization	100%
Breast Pumps (DME guidelines apply.)	100%
Maternity Pre-Natal care	100%

Physician Office Services	
PCP Office Visits	100% after deductible. Deductible does not apply to preventive services and routine maternity care
Medical Online Visits	100% after deductible. Deductible does not apply to preventive services and routine maternity care
Consulting Specialist Care	100% after deductible. Deductible does not apply to preventive services and routine maternity care

Emergency Medical Care	
Hospital Emergency Room	100% after deductible
Urgent Care Center	100% after deductible
Retail Health Clinic	100% after deductible
Ambulance Services	100% after deductible

Diagnostic Services	
Laboratory and Pathology Services	100% after deductible
Diagnostic Tests and X-rays	100% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100% after deductible
Radiation Therapy	100% after deductible

Maternity Services Provided by a Physician	
Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care)	100% (Deductible applies for non-routine maternity care)
Delivery and Nursery Care	100% after deductible

Hospital Care	
General Nursing Care, Hospital Services and Supplies	100% after deductible
Outpatient Surgery	100% after deductible

Alternatives to Hospital Care	
Skilled Nursing Care	100% after deductible
	Up to 45 days per calendar year
Hospice Care	100% after deductible

Surgical Services	
Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	100% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Male - 50% after deductible
Elective Abortion (One procedure per two year period of membership)	50% after deductible
Human Organ Transplants	100% after deductible
Reduction Mammoplasty	50% after deductible
Male Mastectomy	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible
Orthognathic Surgery	50% after deductible
Weight Reduction Procedures	50% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)	
Inpatient Mental Health Care	100% after deductible
Residential Substance Use Disorder	100% after deductible
Outpatient Mental Health Care includes online visits Note: For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	100% after deductible
Outpatient Substance Use Disorder	100% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment	
Applied Behavioral analysys (ABA) treatment	100% after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	100% after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visit and preventive benefit.

Other Services	
Allergy Testing and Therapy	100% after deductible
Allergy Injections	100% after deductible
Chiropractic Spinal Manipulation - when referred	100% after deductible
	(up to 30 visits per calendar year)
Outpatient Physical, Speech and Occupational Therapy	100% after deductible
	60 visits per calendar year for any combination of outpatient rehabilitation therapies.
Infertility Counseling and Treatment	50% after deductible (Excludes In-vitro fertilization)
Durable Medical Equipment	50% after deductible
Prosthetic and Orthotic Appliances	50% after deductible
Diabetic Supplies	100% after deductible
Hearing Aid	Not covered
	Note: This Group is self-funded. Blue Care Network provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims

Prescription Drugs	
Prescription Drugs - (Eff. 1/1/21 Certain diabetic supplies are covered through the pharmacy benefit if you have BCN pharmacy coverage. Applicable pharmacy cost-sharing will apply.)	Tier 1A - $10 after ded, Tier 1B - $30 copay after ded, Tier 2 - $60 copay after ded, Tier 3 - $80 copay after ded, Tier 4 - 20% coinsurance after ded (Max $200), Tier 5 - 20% coinsurance after ded (Max $300)

	Sexual Dysfunction drugs - 50% coinsurance after deductible
	Contraceptives – T1A- 100% (deductible does not apply), Tier 1B - $30 after deductible, T2 - $60 after deductible, T3-$80 after deductible; 30 day supply
Mail Order Prescription Drugs	30 day supply or less - applicable tiered copay/coinsurance, 31-90 day supply - 3x's the 30 day copay/coinsurance minus $10 after deductible
Prescription Drug Deductible	Prescription drug deductible integrated with the medical deductible
	Effective 1/1/20 -Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs

BLUE DENTAL

...Plans are displayed by bargaining group

Blue Cross Blue Shield of Michigan

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

BLOOMFIELD HILLS BD OF ED
A1FPG9
007002956 - Teachers, Technicians, Interpreters/Interveners, Clerical, Instr. Assist., Para Educ, Aux, Unaf Z
Dental Coverage
Effective Date: On or after January 2022
Benefits-at-a-glance

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

Coverage determination: Claims are subject to dental necessity verification and availability of dental benefits when they are processed, as well as the terms and conditions of the applicable BCBSM certificates and riders.

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

Blue Dental PPO network- Blue Dental members have unmatched access to PPO (in-network) dentists through the Blue Dental PPO network, which offers more than 535,000 dentist locations* nationwide. PPO dentists agree to accept our approved amount as full payment for covered services, and members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152**.

**A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices is two dentist locations.*

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

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

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

Benefits	Coverage
Deductible	None
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services • Class II services	None (covered at 100%)
• Class III services	30%
• Class IV services	40%
Dollar maximums • Annual maximum for Class I, II and III services	$1,250 per member
• Lifetime maximum for Class IV services	$1,000 per member

ADM DC26MEVIS;ADM PLANYR JAN;ASCMOD 8818 VIS;BLUE DENTAL;BLUE VISION;BVC-$7.50;BVFLE;BVPP CHOICE NET;CDC-DC 26-ME;DO-PPO;PK015

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

Class I services

Benefits	Coverage
Oral exams	100% of approved amount **Note:** Twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount **Note:** Twice per calendar year
Panoramic or full-mouth x-rays	100% of approved amount **Note:** Once every 60 months
Prophylaxis (cleaning)	100% of approved amount **Note:** Twice per calendar year
Sealants - for members age 19 and younger	100% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Emergency palliative treatment	100% of approved amount
Fluoride treatments	100% of approved amount **Note:** Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	100% of approved amount **Note:** Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	100% of approved amount **Note:** Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	100% of approved amount **Note:** Replacement fillings covered after 12 months or more after initial filling
Crowns, onlays, inlays, and veneer restorations - permanent teeth - for members age 12 and older	100% of approved amount **Note:** Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	100% of approved amount **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery	100% of approved amount
Root canal treatment	100% of approved amount **Note:** Once per tooth per lifetime; retreatment of previous root canal therapy (after 12 months from the date of the original therapy) once per tooth per lifetime.
Scaling and root planing	100% of approved amount **Note:** Once every 24 months per quadrant
Limited occlusal adjustments	100% of approved amount **Note: Limited** occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	100% of approved amount **Note:** Once every 12 months
General anesthesia or IV sedation	100% of approved amount **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	100% of approved amount **Note:** Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	100% of approved amount **Note:** Once per arch in any 36 consecutive months
Tissue conditioning	100% of approved amount **Note:** Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	70% of approved amount **Note:** Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	70% of approved amount **Note:** Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	70% of approved amount **Note:** Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	60% of approved amount
Minor treatment to control harmful habits	60% of approved amount
Interceptive and comprehensive orthodontic treatment	60% of approved amount
Post-treatment stabilization	60% of approved amount
Cephalometric film (skull) and diagnostic photos	60% of approved amount

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

Blue Cross Blue Shield of Michigan

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

BLOOMFIELD HILLS BD OF ED
A1FPG9
007002956 - Administration, Assistant Superintendent and Superintendent
Dental Coverage
Effective Date: On or after January 2022
Benefits-at-a-glance

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

Coverage determination: Claims are subject to dental necessity verification and availability of dental benefits when they are processed, as well as the terms and conditions of the applicable BCBSM certificates and riders.

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

Blue Dental PPO network- Blue Dental members have unmatched access to PPO (in-network) dentists through the Blue Dental PPO network, which offers more than 535,000 dentist locations* nationwide. PPO dentists agree to accept our approved amount as full payment for covered services, and members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152**.

**A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices is two dentist locations.*

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

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

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

Benefits	Coverage
Deductible	None
Coinsurance (percentage of BCBSM's approved amount for covered services) • Class I services	None (covered at 100%)
• Class II services	None (covered at 100%)
• Class III services	30%
• Class IV services	40%
Dollar maximums • Annual maximum for Class I, II and III services	$1,500 per member
• Lifetime maximum for Class IV services	$1,000 per member

ADM DC26MEVIS;ADM PLANYR JAN;ASCMOD 8818 VIS;BLUE DENTAL;BLUE VISION;BVC-$7.50;BVFLE;BVPP CHOICE NET;CDC-DC 26-ME;DO-PPO;PK015

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

Class I services

Benefits	Coverage
Oral exams	100% of approved amount **Note:** Twice per calendar year
A set (up to 4 films) of bitewing x-rays	100% of approved amount **Note:** Twice per calendar year
Panoramic or full-mouth x-rays	100% of approved amount **Note:** Once every 60 months
Prophylaxis (cleaning)	100% of approved amount **Note:** Twice per calendar year
Sealants - for members age 19 and younger	100% of approved amount **Note:** Once per tooth in any 36 consecutive months when applied to the first and second permanent molars
Emergency palliative treatment	100% of approved amount
Fluoride treatments	100% of approved amount **Note:** Two per calendar year
Space maintainers - missing posterior (back) primary teeth - for members 18 and younger	100% of approved amount **Note:** Once per quadrant per lifetime

Class II services

Benefits	Coverage
Fillings - permanent (adult) teeth	100% of approved amount **Note:** Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	100% of approved amount **Note:** Replacement fillings covered after 12 months or more after initial filling
Crowns, onlays, inlays, and veneer restorations - permanent teeth - for members age 12 and older	100% of approved amount **Note:** Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	100% of approved amount **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery	100% of approved amount
Root canal treatment	100% of approved amount **Note:** Once per tooth per lifetime; retreatment of previous root canal therapy (after 12 months from the date of the original therapy) once per tooth per lifetime.
Scaling and root planing	100% of approved amount **Note:** Once every 24 months per quadrant
Limited occlusal adjustments	100% of approved amount **Note:** Limited occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	100% of approved amount **Note:** Once every 12 months
General anesthesia or IV sedation	100% of approved amount **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	100% of approved amount **Note:** Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	100% of approved amount **Note:** Once per arch in any 36 consecutive months
Tissue conditioning	100% of approved amount **Note:** Once per arch in any 36 consecutive months

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	70% of approved amount **Note:** Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	70% of approved amount **Note:** Once every 60 months
Endosteal implants - for members age 16 or older who are covered at the time of the actual implant placement	70% of approved amount **Note:** Once per tooth per lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services - Orthodontic services for dependents under age 19

Benefits	Coverage
Minor treatment for tooth guidance appliances	60% of approved amount
Minor treatment to control harmful habits	60% of approved amount
Interceptive and comprehensive orthodontic treatment	60% of approved amount
Post-treatment stabilization	60% of approved amount
Cephalometric film (skull) and diagnostic photos	60% of approved amount

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

BLUE VISION

Blue Cross Blue Shield of Michigan

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

BLOOMFIELD HILLS BD OF ED

A1FPA6 00700295600- Teachers, Technicians, Interpreters/Interveners, Administration, Clerical, Instructional Assist., Para Ed, Auxiliary Services, Unaf Z

Vision Coverage
Effective Date: On or after January 2022
Benefits-at-a-glance

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

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Note: Discounts up to 20% for additional prescription glasses and any amount over the allowance ***plus*** savings on non-covered lens extras (up to 25%) when obtained from a VSP provider

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	$5.00 copay	$5.00 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	$7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5.00 copay	Reimbursement up to $45 less $5.00 copay (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	$7.50 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $7.50 copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 12 **consecutive** months	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$150 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $7.50 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $70 less $7.50 copay (member responsible for any difference)
	One frame in any period of 12 **consecutive** months	

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$7.50 copay	Reimbursement up to $210 less $7.50copay(member responsible for any difference)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$150 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	

Life Insurance and Disability Protection

Life Insurance Protection

Bloomfield Hills Schools offers Life Insurance, AD&D and Optional Life through Reliance Standard. Please refer to your work agreement to determine if you are eligible for District provided employee life insurance.

Employee Life Insurance

This benefit provides protection for your family in the event of your death. Through the ***Educated Choices*** program, you may be eligible to receive basic Employee Life Insurance coverage based on your employment agreement (shown on your Summary of Benefits). You may also elect any level of additional insurance as outlined below:

Additional Life Insurance

Your choices for additional coverage may include*:

$ 5,000	$100,000	$225,000
$10,000	$125,000	$255,000
$25,000	$150,000	
$50,000	$175,000	
$75,000	$200,000	

** Your District paid life Insurance and additional life insurance may not exceed $300,000 combined.*

Detailed Information (Evidence of Insurability-EOI)

If you made change(s) to your voluntary life election over the guaranteed issue amount, you will be directed to complete a medical questionnaire.

The coverage and associated payroll deduction will not begin until your request for coverage is approved or denied by the carrier. If you do not submit an EOI form by January 1 of the new plan year, your request for the additional coverage will be terminated.

Please note: If you elect an additional Employee Life Insurance option requiring a Personal Health Statement to be completed, the coverage and associated payroll deduction will not begin until your request for coverage is approved or denied by the life insurance carrier. You will have until January 1 of each year to complete and submit your Personal Health Statement.

Imputed Income

Employer paid life insurance in excess of $50,000 is subject to imputed income. You are required to pay federal and state income taxes and Social Security tax on this "excess" amount. The amount of tax you pay is based on your age. The value of the life insurance in excess of $50,000 will be reported on your W-2.

Considerations for Enrollment

When choosing the level of life insurance that is right for you, consider your family situation.

- How many people depend on your income?
- In your household, is your income primary or secondary?
- If you died, what major expenses would continue, such as a mortgage on your home or tuition for your children's college education?
- Do you have any other sources of income, such as personal life insurance benefits, Social Security or pension benefits?
- How long would your basic employee life policy sustain your family?

Accidental Death and Dismemberment (AD&D)

AD&D coverage is provided to protect you or your family in case of your accidental death or the loss of a limb or your eyesight.

Benefits

In the event of your accidental death, your beneficiary would receive 100 percent of your basic coverage. In the event of a loss resulting from an injury, you would be entitled to payment based on the following schedule:

Life Insurance and Disability Protection

Schedule of Benefits

Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
One Hand or One Foot	50%
Sight of One Eye	50%

Limitations

Benefits will not be paid for a loss:

- caused by suicide or self-inflicted injuries
- caused by or resulting from war or any act of war, declared or undeclared
- to which sickness, disease or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor
- sustained during the Insured's commission or attempted commission or an assault or felony
- to which the Insured's acute or chronic alcoholic intoxication is a contributing factor

Dependent Life Insurance

Dependent Life Insurance is a voluntary benefit offered through ***Educated Choices*** on an after-tax basis. This insurance is designed to assist you financially in the event that your spouse or child(ren) dies.

Choices

You can choose from the following options for your spouse and eligible child(ren):

- No coverage, $5,000 or $10,000

Limitations

All employees must be actively at work to be eligible for the life insurance plan.

Accelerated Death Benefit

The accelerated death benefit allows an employee to elect 75% of their life insurance benefit up to a maximum of $500,000; the payout will be made in a lump sum. This benefit is payable to the Insured one time only and permanently reduces the Insured's death benefit, including any amount of eligible benefit under the waiver of premium and/or conversion provisions, if applicable.

In order to qualify for this benefit the member must be certified as terminally ill. Terminally ill refers to an illness or physical condition, when certified by a duly licensed physician acting within the scope of his license, is reasonably expected to result in death in less than 12 months. The application for this benefit must be made in writing (the Accelerated Benefit form) and include the beneficiary's signed acknowledgment and agreement to the payment of this benefit.

Dependent child life insurance limitations

If coverage is elected, children are covered through the end of the month in which they turn 26. The benefit amount is based on your election for the year and provides either $5,000 or $10,000 of coverage.

The tax laws require that this premium be deducted from your salary on an **after-tax** basis.

Detailed Information Regarding Personal Health Statements (Evidence of Insurability-EOI)

Personal Health Statements (Evidence of Insurability-EOI) may be required, based on your Dependent Life Insurance election. If you elect a Dependent Life Insurance option requiring completion of a Personal Health Statement, the coverage and associated payroll deduction will not begin until your request for coverage is approved or denied by the carrier.

Personal Health Statements are not required for children.

Life Insurance and Disability Protection

Considerations for Enrollment

- Do you have a working spouse?
- If your spouse is employed, does he or she have any life insurance protection through his or her employer?
- Do you currently have life insurance coverage for your children?
- How would you handle burial expenses in the event of the death of a family member?

Short-Term Disability

Bloomfield Hills Schools may provide Short-Term Disability coverage to you at no cost.

The specific features of your Short-Term Disability plan can be found in your employment agreement.

Long-Term Disability

Bloomfield Hills Schools may provide Long-Term Disability coverage through Reliance Standard to you at no cost.

The specific features of your Long-Term Disability plan can be found in your employment agreement.

Bloomfield Hills Schools will provide you (if eligible) with a disability benefit equal to a percentage of your basic monthly earnings, not to exceed your maximum monthly benefit as outlined in your employment agreement.

The minimum monthly benefit is the greater of $100, or 10 percent of employee's gross disability payment.

Upon approval from the carrier, payments begin after you satisfy a "waiting period" following the onset of your disability. If you become disabled prior to age 60, payments continue until you die, recover or reach age 65. Disabilities beginning after age 60 are paid by a schedule based on your age when the disability began.

Social Security and other income benefits paid to you and your family are included in the percentage amount. This disability plan makes up the difference between these amounts and the guaranteed percent of pay.

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

Bereavement Support Services
Comfort and Guidance for Challenging Times

Bereavement Support Services provide confidential and professional support services to all covered employees and family members to cope with the loss of a loved one—at no extra cost.

Your Reliance Standard Life Insurance Policy offers access to unlimited and confidential telephonic grief counseling, legal and financial consultation when you need it most. Professional clinicians, who are experienced in dealing with grief, are available to discuss any concerns and offer comfort to those in need of support.

Grief Counseling

- ***Unlimited*** Telephonic Assessment and Referral
- Global Network of 52,000+ Licensed Providers

Legal and Financial Services

- ***Unlimited*** Phone Consultation for Any Financial Issue
- ***Unlimited*** Phone Consultation for Any Legal Issue
- Online Legal and Financial Resource Center Including Document Preparation

Program Access

- All Covered Employees and Family Members Eligible, Regardless of Location or Relationship
- 24/7, 365 Days-a-year Dedicated Toll-Free Line, Always Live Answer

Questions or to Access Services

Contact ACI Specialty Benefits toll-free at

855-RSL-HELP

(855-775-4357)

rsli@acieap.com

Bereavement Benefit services are provided by ACI Specialty Benefits, under agreement with Reliance Standard Life Insurance Company.

Reliance Standard Life Insurance Company is licensed in all states (except New York), the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam. In New York, insurance products and services are provided through First Reliance Standard Life Insurance Company, Home Office: New York, NY. Product availability and features may vary by state.

Powered by ACI SPECIALTY BENEFITS

RS-1948 (07/2016)

Identity Theft Full Remediation Services

Identity Theft is the fastest growing crime in the United States. The statistics are staggering and getting worse. In 2013 Identity theft was the number one consumer reported crime with 13.1 million victims, spending on average 58 to 165 hours to regain pre-theft status.[1,2,3]

How it impacts business

A national consultant confirmed 48 percent of a company's employees on average experience business or personal legal-related issues each year, spending about 51 hours away from work to resolve them.[2] Studies show employees with legal problems usually:

- Are absent five times more than average
- Use their medical benefits four times more than average
- Use their sick leave twice as often as the average employee
- Experience a substantial reduction in their productivity

This startling productivity loss is often undocumented but far from invisible.

Employers who provide identity protection and restoration services for their employees can expect a triple-digit return on investment (ROI) based on the estimated number of victims in the workforce, the corresponding potential loss of productivity, and the cost of providing identity protection and restoration services.

Both you and your employees have access to this valuable service through your Reliance Standard insurance coverage.

1 - Federal Trade Commission, "Consumer Sentinel Network Data Book 2013, February 2014"
2 - Javelin Strategy and Research: 2014 Identity Fraud Report
3 - ITRC "Identity Theft: The Aftermath" 2008

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

www.reliancestandard.com

Full Identity Theft Remediation Services

Should an employee or anyone in their family fall victim to identity theft, InfoArmor® Identity Protection Experts will provide restoration services including:

- Dedicated InfoArmor Privacy Advocates® to act on their behalf
- Identity restoration experts trained by the Identity Theft Resource Center
- Investigation and confirmation of fraudulent activity including known, unknown, and potentially complicated sources of identity theft
- Resolution of key issues by maintaining and explaining the victim's rights
- Placing phone calls and preparing appropriate documentation on the victim's behalf including anything from dispute letters to defensible complaints
- Assist in issuing fraud alerts and victim's statements when necessary, with the three consumer credit reporting agencies, Federal Trade Commission, Social Security Administration and the U.S. Postal Service
- Completing and providing copies of all documentation, correspondence, forms and letters for recordkeeping
- Contacting, following up and escalating issues with affected agencies and institutions
- Providing restoration beyond just credit, including criminal, DMV, medical records, etc.
- Real time access to public records such as DMV, criminal, address changes, liens, judgments and more

WalletArmor®

WalletArmor® provides 24/7 Online Credential Monitoring on the Internet's Underground economy. We'll know quickly if there is fraudulent activity. An employee will receive a call from our Privacy Advocates® letting them know their personal information has been compromised. We work with businesses to identify and replace essential cards and documents, and we contact the authorities. WalletArmor stores and secures valuable information for easy retrieval.

The WalletArmor® encrypted vault secures and monitors:

- User IDs & Passwords
- ATM Cards
- Credit Cards
- Checking Accounts
- Driver's Licenses
- Health Insurance Cards
- Vehicle Insurance Cards records, etc.

About InfoArmor®

InfoArmor was established in Scottsdale, Arizona, in 2007 to help one of the largest US banks protect the identities of its 10 million credit card holders. Today it partners with businesses and organizations to help their employees, members, and customers gain control of their personal information and protect and recover their identities.

InfoArmor employs a dedicated team of professionals that provide world class service and expertise in identity theft restoration. In the event of identity theft, the victim will be assigned a dedicated Privacy Advocate that will act on behalf of the customer to completely restore their identity. The victim will know their Privacy Advocate by name and will be able to have a personal proponent for their identity restoration.

InfoArmor's Privacy Advocates have been trained by and receive continued support from the Identity Theft Resource Center, the primary national non-profit that focuses on identity theft. Privacy Advocates are also Certified Identity Theft Risk Management Specialists by the Institute of Fraud Risk Management.

How to begin

InfoArmor Identity Theft Remediation with WalletArmor® is an optional service available with Reliance Standard's group Long Term Disability (LTD) coverage. Interested in a full comprehensive identity protection service? We alsooffer the option to purchase the market's most comprehensive identity theft defense program, PrivacyArmor®, either proactively or following a data breach. Ask your broker or Reliance Standard Sales Representative or Account Manager to see a quote with this service included.

IDENTITY THEFT RECOVERY SERVICES ARE PROVIDED BY INFOARMOR. INFOARMOR IS NOT AFFILIATED WITH RELIANCE STANDARD LIFE INSURANCE COMPANY ("RSL").

THE IDENTITY THEFT RECOVERY SERVICES PROVIDED BY INFOARMOR ARE NOT PART OF THE RSL INSURANCE POLICY, AND RSL IS NOT RESPONSIBLE FOR ANY ACTS OR OMISSIONS OF INFOARMOR IN CONNECTION WITH OR ARISING UNDER THE IDENTITY THEFT RECOVERY SERVICES.

Reliance Standard Life Insurance Company is licensed in all states (except New York), the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam. In New York, insurance products and services are provided through First Reliance Standard Life Insurance Company, Home Office: New York, NY. Product availability and features may vary by state.

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

INFOARMOR
IDENTITY PROTECTION EXPERTS

www.reliancestandard.com

RS-2421 (1/15)

24-Hour Travel Assistance Services

Through your group coverage with Reliance Standard, you automatically receive travel assistance services provided by On Call International (On Call), pursuant to an agreement between Reliance Standard and On Call. On Call is a 24-hour, toll-free service that provides a comprehensive range of information, referral, coordination and arrangement services designed to respond to most medical care situations and many other emergencies you may encounter when you travel. On Call also offers pre-trip assistance including passport/visa requirements, foreign currency and weather information. The following is an outline of the On Call emergency travel assistance service program. For a complete description of all services and the program terms and limitations, please request a Description of Covered Services from your employer.

Covered Services

When traveling more than 100 miles from home or in a foreign country, On Call offers you and your dependents the following services:

Pre-Trip Assistance

- Inoculation requirements information
- Passport/visa requirements
- Currency exchange rates
- Consulate/embassy referral
- Health hazard advisory
- Weather information

Emergency Medical Transportation*

- Emergency evacuation
- Medically necessary repatriation
- Visit by family member or friend
- Return of traveling companion
- Return of dependent children
- Return of vehicle
- Return of mortal remains

Emergency Personal Services

- Urgent message relay
- Interpretation/translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage/personal possessions
- Legal assistance and/or bail bond

Medical Services Include:

- Medical referrals for local physicians/dentists
- Medical case monitoring
- Prescription assistance and eyeglasses replacement
- Convalescence arrangements

*The services listed above are subject to a maximum combined single limit of $250,000. Return of vehicle is subject to $2,500 maximum limit.

How It Works

At any time before or during a trip, you may contact On Call for emergency assistance services. It is recommended that you keep a copy of this summary with your travel documents. Simply detach the wallet card below to ensure convenient access to the On Call phone numbers.

TO REACH ON CALL VIA INTERNATIONAL CALLING: Go to http://www.att.com/esupport/traveler.jsp?group=tips for complete dialing instructions. It is recommended that you do this prior to departing the US, find the access code from the country you will be visiting, and note it on the cut-out card below so you will have the information readily available in case of an emergency. (AT&T provides English-speaking operators and the ability to place collect calls to On Call, whereas local providers may encounter difficulty placing collect calls to the US.)

Administered by

ON CALL INTERNATIONAL
It could happen to you!™

Provided with your benefits coverage through

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

On Call International is not affiliated with Reliance Standard Life Insurance Company or First Reliance Standard Life Insurance Company. Reliance Standard is not responsible for the content of the On Call travel assistance services, and is not responsible for, and cannot be held liable for, any services provided or not provided by On Call.

Reliance Standard Life Insurance Company is licensed in all states (except New York), the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam. In New York, insurance products and services are provided through First Reliance Standard Life Insurance Company, Home Office: New York, NY.

On Call is not responsible for the unavailability or results of any medical, legal or transportation services. You are responsible for obtaining all services not directly provided by On Call and for the expenses associated with them.

24-HOUR TRAVEL ASSISTANCE

ON CALL INTERNATIONAL

provided through

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

For emergency medical, legal and travel assistance information and referral service 24 hours a day, 365 days a year, call the numbers below.
To place a collect call, dial the INTERNATIONAL COUNTRY CODE: _____ followed by On Call's collect call number.

In the U.S., toll free	Worldwide, collect
(800) 456-3893	(603) 328-1966

Travel assistance services are provided by On Call International (On Call) under the terms and conditions of a service agreement with Reliance Standard. On Call International is not affiliated with Reliance Standard or with AT&T.

Reliance Standard is not responsible for the content of the On Call travel assistance services, and is not responsible for, and cannot be held liable for, any services provided or not provided by On Call.

Reliance Standard Life Insurance Company is licensed in all states (except New York), the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands. In New York State, benefits are underwritten by First Reliance Standard Life Insurance Company, Home Office: New York, NY.

On Call is not responsible for the unavailability or results of any medical, legal or transportation services. You are responsible for obtaining all services not directly provided by On Call and for the expenses associated with them.

RS-2110 (8/12)

Extended Disability: Providing Assistance When Assistance Runs Out

A Disability Doesn't End Just Because Your Benefits Did

Until now, there hasn't been a financial safety net for employees who have reached the end of their Long Term Disability (LTD) benefits. Traditional LTD policies are designed to partially replace the income employees would have earned had they been able to continue working, so they stop paying benefits when the employee reaches normal retirement age.

Reliance Standard Life (RSL) now offers the Extended Disability Benefit — five additional years of benefits for your disabled employees who have reached the maximum duration of benefits under your LTD policy and who meet the qualifications listed on the next page. This extended benefit pays 85% of the net monthly benefit that the employee received until reaching the maximum duration of benefits. It pays up to $5,000 per month for up to five years.

The Extended Disability Benefit is not a separate policy. It's a benefit included in your RSL Group policy, making it easy to add this valuable benefit to your LTD coverage.

Up to Five More Years of Benefits for Your Disabled Employees

At a time when the average person has adjusted to living on a fixed income, the loss of an LTD benefit can be disastrous. The Extended Disability Benefit adds a continuing source of income for those who need it most—employees who are still totally disabled when they reach the end of their LTD benefits. If you have the Extended Disability Benefit and they have already been receiving benefits under your Reliance Standard Life LTD policy, they will continue to receive 85% of those benefits.

By having a benefit for five more years, a family will be able to relieve some of the stress of adjusting to a reduced income. The income can be used for any purpose.

Help For Those Who Need It Most

To qualify for extended benefits, the employee must qualify as totally disabled under your LTD policy, be receiving disability benefits AND be unable to safely and completely perform two or more of the Activities of Daily Living as listed below without assistance.

- eating/feeding
- dressing
- bathing
- transferring (moving in and out of a bed or chair)
- toileting;

OR

Be cognitively impaired and need another person's direct assistance or verbal direction to function;

AND

Be confined as an inpatient in a skilled nursing home, rehabilitation facility or rehabilitation hospital;

OR

Be receiving home health care or hospice care.

Benefits will continue up to five years, as long as these requirements are met.

Five Years of Precious Time

During the five years of extended benefits, families have less financial burden to distract them from the care of a disabled loved one. By helping to meet ongoing expenses, this benefit may help defer difficult financial decisions.

There's No Alternative to Peace of Mind

The Extended Disability Benefit can provide significant emotional and financial benefits. To understand how vital this coverage is, ask yourself what happens without it.

Social Security and Medicare may not provide adequate assistance, and many people do not purchase long-term care insurance.

For more information about the Extended Disability Benefit or any of Reliance Standard's other coverages, talk with your RSL sales representative.

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

www.reliancestandard.com

This brochure is solely intended as a summary of the Extended Disability Benefit and is not an offer of coverage. For a complete description of the benefits and features, please see policy form LRS-6564 Ed. 4/06. Not available in all states and subject to underwriting guidelines. Some provisions may vary by state. For more details, please contact your RSL sales representative.

The Extended Disability Benefit is not a Long-Term Care Insurance Plan.

Reliance Standard Life Insurance Company is licensed in all states (except New York), the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam. In New York, insurance products and services are provided through First Reliance Standard Life Insurance Company, Home Office: New York, NY.

RS-2035 (4/13)

Reimbursement Account Services

At A Glance - Reimbursement Accounts

Bloomfield Hills Schools offers you the opportunity to participate in Health Care and Dependent Care Reimbursement Accounts, and Health Savings Accounts. A Reimbursement Account is a tax-free way of paying for eligible out-of-pocket health care and dependent care expenses. By participating in these accounts you have the opportunity to pay for these expenses using **pretax** dollars — you do not pay federal, state or Social Security taxes on the dollars you contribute. As a reimbursement participant, you will have access to a reimbursement administration system. The NGE and Health Equity systems will provide services to help you manage your reimbursement account(s).

- Review election information and manage your account using the Benefit Center. Representatives will be able to assist you with your Reimbursement Account questions. For FSA call toll free **888-266-1732** -Access detailed FSA account information online at: **https://plansource.wealthcareportal.com**— Your Employer ID is NGE4965.
- Access detailed HSA account information at www.healthequity.com**.** For HSA call toll free 1-866-346-5800.
- Print your personalized FSA Health Care or Dependent Care Flexible Spending Reimbursement Form and link to contribution and reimbursement schedules.
- View a detailed Explanation of Benefits for FSA reimbursements, including line-by-line detail of each claim submitted, status of each claim processed, and denial information.

How to Enroll with FSA and HSA Accounts

Enrollment in the Reimbursement Account(s) is part of your annual ***Educated Choices*** online enrollment process outlined in this workbook.

Planning Carefully

The following IRS regulations apply to Reimbursement Accounts:

- Once you decide to participate in the Health Care and/ or the Dependent Care Reimbursement Account(s), your enrollment must remain in effect until the end of the plan year. Each year you will have an opportunity to enroll again.
- **The "Use it or Lose It" rule applies to both Health Care and Dependent Care Reimbursement Account(s). Any balance in the Reimbursement Account(s) that is not used for eligible expenses must be forfeited. You will have 60 days after the end of the plan year or the date you are no longer enrolled in the plan (whichever comes first) to submit eligible expenses incurred during that same year for reimbursement.**
- You may change your payroll deduction amount for your Health Care and/or Dependent Care Reimbursement Account(s) during the plan year, only if you have a life status change. **IRS-approved changes include a change in marital status, death of spouse or child, birth or adoption of a child and termination of employee's or spouse's employment.**
- As you know, the benefit you may receive from the Social Security program is based in part on the amount of Social Security tax you pay. With any Reimbursement Account, you will pay slightly lower Social Security taxes. The effect on the benefits you or your family may receive from Social Security should be minimal.

Reimbursement Account Services

Health Savings Accounts

How Does It Work?

Step 1: Enroll in an HSA-eligible health plan – Your Employer will offer you an HSA-eligible health plan. This is a health care plan that does not pay for health care expenses until you pay a set amount as a deductible. Your plan will cover you after you meet your deductible.

Step 2: Access your HSA – Once you've selected your health plan, you will receive a welcome kit with information on how to access and use your Healthy Blue HSA.

Step 3: Contribute to your HSA – Contributions to your HSA can be made by you, your employer or both. Relatives and friends can also contribute to your HSA. The maximum HSA contribution allowed for 2022 is $3,650 for single coverage and $7,300 for family coverage. These dollar amounts are adjusted annually by the federal government. If you are 55 or older, you are eligible for an additional $1,000 catch-up contribution each year until you enroll in Medicare. The money in your account will automatically roll-over from year to year and remain in your account until you use it. Those staff age 65 or older and enrolled with Medicare are not eligible for participation in a health savings account.

Step 4: Use your money – You control how the money in your HSA is spent. You may use the money to cover your copayment and deductible requirements for services covered through your health plan or to pay for qualified medical expenses not covered by your health plan. It's important to know what is considered a qualified medical expense. It's also important to keep your receipts, in case you need to defend your spending for a tax audit. If you use money in your HSA for something other than a qualified medical expense, you'll have to pay income taxes on that amount. You'll also have to pay a 20 percent tax penalty (unless you are disabled or have attained age 65). If you are age 65 or older and enrolled in Medicare, you are not eligible to participate in the HSA.

Step 5: Invest your money – You may invest the money in your account if you choose. The same types of investments permitted for an individual retirement account are allowed for an HSA. You can grow your savings by investing in a wide variety of mutual funds.

How Do Flexible Spending Reimbursement Accounts Work?

- *You* determine the amount you want to contribute to each account for the plan year on an annual basis. A minimum contribution of $150 is required. Contributions for the plan year are limited to a maximum of $2,750 for the Health Care Reimbursement Account and a maximum of $5,000 for the Dependent Care Reimbursement Account.
- Your per-pay deposit/contribution is withheld from each paycheck before taxes are calculated.
- You pay expenses at the time of purchase with your Benefits MasterCard; or
- You incur and submit expenses for reimbursement via fax or mail. The reimbursement is tax free.

Flexible Spending Account (FSA)

Employees who enroll into the HDHP and the HSA are not eligible to enroll into the FSA plan.

REMINDER: You must re-enroll annually for your Health Care Reimbursement and Dependent Care Reimbursement account(s); elections do not automatically rollover.

IMPORTANT INFORMATION ABOUT TURNING AGE 65 AND YOUR HEALTH SAVINGS ACCOUNT

BHS will presume that all employees have enrolled in Medicare during the month in which they turn 65. Contributions into the HSA will cease in the month in which you turn 65 unless you have informed BHS in writing that you have waived completely out of all Medicare coverage. An employee who has delayed Medicare enrollment is required to inform BHS when enrollment into Medicare occurs. Always seek guidance from your tax advisor.

Reimbursement Account Services

FSA Plan Year

Our FSA plan year is January 1 through December 31.

Retirement, Leave of Absence and Termination — Based upon IRS rulings, should your employment terminate mid-plan year, you have 60 days from your date of termination to submit eligible expenses. These claims must be incurred prior to your termination date, for both health care and dependent care reimbursement. Claims received after the 60-day period will be denied. The current plan year ends December 31. If you have not terminated employment, you have 60 days from the end of the plan year to submit eligible expenses for the current plan year.

Mid-plan year life status changes require a meeting with the Benefits Coordinator. Please contact the Benefits Coordinator within 30 days of the life event to schedule an appointment.

Benefits MasterCard

The Benefits MasterCard works like a debit card against your Flexible Spending Account and streamlines the reimbursement process so you do not have to wait to be reimbursed. It is accepted at most large retailers. You will not be required to submit receipts when using the Benefits MasterCard but for recordkeeping purposes you should retain all receipts.

If you are currently enrolled into the flexible spending account and already have a debit MasterCard, please retain your current card for use during the new plan year. Your new election will be loaded onto that card. If your current card is expiring this year, you will receive a new card in the mail prior to the start of the plan year. If you are new to the flexible spending account this year, a card will be ordered for you and will arrive at your home shortly before the start of the plan year, however please be aware that it will not be effective until the start of the plan year. If you would like to order a card for your spouse, you may do so during your enrollment. Your Benefits MasterCard will arrive at your home address in a plain white envelope. Also, you will not have to activate your card, it will automatically activate on the first swipe.

NOTE: If you enroll into the Flexible Spending Account you will receive a Benefits MasterCard. If you enroll into the Health Savings Account you will receive the HSA Visa® Debit card.

PLAN SOURCE CUSTOMER SERVICE: 888-266-1732 Option 2 for Reimbursement Account Support. Hours of operation 8 am—8 pm EST.

How to Receive Reimbursement

1. Use your Benefits MasterCard to pay for eligible expenses at the time of purchase; no receipt submission for reimbursement is required at the time of purchase.
2. If you do not use your Benefits MasterCard, once you pay an expense for health care or dependent care services you may request reimbursement.
3. To submit manual claims for reimbursement you may use the online system. You will complete and print the online form to include with your receipts.
4. **Access the PlanSource online system at https://plansource.wealthcareportal.com. If you have not registered on this site in the past, you will be required to register.**
5. You may submit expenses for reimbursement via fax, mail or by email to https://www.mywealthcareonline.com/PlanSource/
6. After your request is processed a reimbursement check will be mailed to your home. If you are enrolled for direct deposit, the reimbursement will be deposited to your bank account.
7. Each participant is responsible for keeping records to support these expenses, including those purchased with the Benefits MasterCard. You may be asked to substantiate Benefits MasterCard purchases with receipts. If you fail to do so upon request please note your account may be inactivated until such time you supply PlanSource with the required claim documentation.

Reimbursement Account Services

Dependent Care Reimbursement Account

This account will reimburse you for childcare or dependent care expenses to enable you and your spouse to work outside the home. This includes the cost of a childcare center, a babysitter or a person to care for a disabled dependent, spouse or parent. You can pay a relative to take care of your child(ren) or to care for a disabled spouse or parent. However, you cannot pay a dependent (a teenage daughter, for example) to take care of another dependent.

If you decide to utilize the Dependent Care Reimbursement Account, you cannot use the Federal Tax Credit for the same expenses.

Estimating Dependent Care Expenses

If you are or will be incurring Dependent Care expenses, the following examples may help to show you how the Dependent Care Reimbursement Account can save you tax dollars. **Please note the maximum amount you may contribute on an annual basis to the Dependent Care Reimbursement Account is $5,000 per household ($2,500 for married couples filing separately).**

Remember you may need to reduce the number of weeks you use day care by the number of holidays, vacation days and unscheduled days you have allotted each year.

Eligibility Requirements

A key criteria for eligibility is that you are employed and covered under this plan at the time your eligible dependent receives care.

You must also meet one of the following requirements for eligibility:

- Your spouse is working or looking for employment.
- You are a single parent or guardian.
- At a time when you are employed, your spouse is a full-time student at least five months during the year.
- Your spouse is mentally or physically disabled and unable to provide for his/her own care.
- You are legally separated or divorced and have custody of your child even though you may not be able to consider your child a dependent. For the period that the child resides with you, this Dependent Care Reimbursement plan can be used to pay for child-care services.

An Eligible Dependent is a qualifying individual spending at least eight hours a day in your home and is one of the following:

- Your dependent under age 13 for whom you claim an exemption on your income taxes. (If your dependent turns 13 during the plan year, expenses are no longer eligible for reimbursement). A child under the age of 13 for whom you have custody if divorced or legally separated.
- Your spouse if mentally or physically unable to provide self care.
- Your dependent, regardless of age, who is mentally or physically unable to provide self care even if you cannot claim an exemption for this dependent on your income taxes.

Eligible expenses for reimbursement include:

- Care received inside or outside your home by someone other than your spouse, a person listed as a dependent on your income tax return, or one of your children under age 19. The child-care provider must claim the payments they receive as income.
- Care received from a qualifying child day-care center or adult or dependent care center.
- Care provided by a housekeeper as long as the services provided, in part, are the care of a qualified dependent.
- Care provided through nursery, preschool, after-school, or summer day camp programs. Taxes for wages spent on eligible dependent care can also be submitted for reimbursement.

Ineligible Expenses

- Dependent care for a child age 13 or over.
- Non work-related babysitting.
- Schooling in kindergarten and beyond.
- Overnight camp.

All submitted receipts are processed and reviewed prior to reimbursement per the Internal Revenue Code Section 125 and 129.

Federal Notices

Newborn's 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 normal 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 physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, health plan providers may not require that a provider obtain authorization for prescribing a hospital length of stay of less than 48 hours (or 96 hours).

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits. 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 for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits under this plan. If you would like further information about the Women's Health & Cancer Rights Act, please contact your medical carrier or your employer.

Special Enrollment Events/Changes in Family Status

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

If you decline coverage for yourself and/or your dependents (including your spouse) now because you are covered by another health insurance plan, you may be able to enroll yourself or your dependents in this plan in the future. If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your dependents provided that you request enrollment within 30 days after the event. These events are referred to as changes in "family status." In addition, if you were to lose coverage, you must request enrollment within 30 days after the coverage ends and if the event qualifies as a "family status" change. When you become enrolled as the result of a Special Enrollment Event, coverage will be made effective on the date of the event.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Sarah Dare.

Primary Care Physician Requirements

The BCN plan require you to select a primary care physician (PCP) for you and your family members when enrolling. You will need a referral from your PCP in order to see a specialist. You do not need need a referral in order to obtain access for routine obstetrical or gynecological care from a health care professional in the BCN network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating providers, contact Blue Care Network.

Federal Notices

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_co nt.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)	NEBRASKA – 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://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – 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	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
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public- assistance/index.html Phone: 1-800-442-6003	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – 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: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

Federal Notices

PENNSYLVANIA – Medicaid	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

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

Important Notice from Bloomfield Hills Schools About Your CREDITABLE 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 BCBSM and BCN 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:

- 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.
- Bloomfield Hills Schools has determined that the prescription drug coverage offered by the Bloomfield Hills Schools health plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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 coverage may be affected.

Summary of Options for Medicare Eligible Employees (and/or Dependents):

- Continue medical and prescription drug coverage and do not elect Medicare D coverage. **Impact** – your claims continue to be paid by Bloomfield Hills Schools health plan.
- Continue medical and prescription drug coverage and elect Medicare D coverage. Impact - As an active employee (or dependent of an active employee) the Bloomfield Hills Schools health plan continues to pay primary on your claims (pays before Medicare D).
- Drop the coverage (including medical as they cannot be elected independently) and elect Medicare Part D coverage. Impact – Medicare is your primary coverage. You will not be able to rejoin the Bloomfield Hills Schools health plan unless you experience a family circumstance change or until the next open enrollment period.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back unless you experience a family status change or until the next open enrollment period.

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 Bloomfield Hills Schools 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 below 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 Bloomfield Hills Schools 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).

Date:	**9/15/21**
Name of Entity/Sender:	**Bloomfield Hills Schools**
Contact--Position/Office:	**Karen Healy Director of Human Resources and Payroll**
Address:	**7273 Wing Lake Road Bloomfield Hills MI 48304**
Phone Number:	**(248) 341-5432**

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).

Please contact us for more information:	**For more information about HIPAA or to file a complaint:**
Privacy Officer Karen Healy - Director, Human Resources and Payroll Bloomfield Hills Public Schools 7273 Wing Lake Road Bloomfield Hills, MI 48304 (248) 341-5432	The U.S. Department of Health & Human Services Office for Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 (202) 619-0257 Toll Free: 1-877-696-6775

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).

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include case management.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing a provider for an office visit.
Health care operations include the business aspects of running our health plan, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of non-routine disclosures of protected health information.
- We have the obligation to provide and you have the right to obtain a paper copy of this notice from us at least every three years.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 6, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:	For more information about HIPAA or to file a complaint:
Privacy Officer Karen Healy—Director, Human Resource and Payroll Bloomfield Hill Schools 7273 Wing Lake Road Bloomfield Hills, MI 48304 (248) 341-5432	The U.S. Department of Health & Human Services Office for Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 (202) 619-0257 Toll Free: 1-877-696-6775

Annual Open Enrollment

Annual Open Enrollment

Please be sure to check these points:

- Have you reviewed your medical benefit plan options carefully? Please review the **Considerations for Enrollment** in the **Medical** section of this workbook.
- Have you thought about purchasing Additional Employee Life Insurance or Optional Dependent Life Insurance? Please review the **Considerations for Enrollment** in the **Employee Life Insurance and Dependent Life Insurance** sections of this workbook.
- Is your annual deposit for the Health Care Reimbursement Account, Health Savings Account and/or Dependent Care Reimbursement Account displayed correctly for the upcoming plan year?

Once you are ready to enroll, please logon to the ***Educated Choices*** Web site to select your benefit options. Your elections will then be recorded and processed.

Benefits Confirmation Statement

Once you complete your enrollment, please remember to print off a confirmation statement for your records.

Please review this statement VERY CAREFULLY to ensure that your selections were processed correctly. If you have any questions regarding your benefit coverage or options described herein, please contact:

Sarah Dare
Benefits Coordinator
sdare@bloomfield.org
(248) 341-5431

Karen Healy
Director, Human Resources and Payroll
khealy@bloomfield.org
(248) 341-5432

Bloomfield Hills Schools

The contents of this booklet are intended for use as an easy to read summary only. It does not constitute a contract. Additional limitations and exclusions may apply. For an official description of benefits, please refer to each carrier's official certificate/benefit guide. For more information, please contact the Human Resources Department.

2022 Open Enrollment Schedule:

October 28 . . . . . Annual Enrollment Period Begins

November 5 . . . . . Annual Enrollment Period Ends

January 1 . . . . . Benefits effective

January 21, 2022. . . . . Full Plan Year Payroll Deductions/ Contributions Begin

Confirmation statements are available on-line.

Open enrollment assistance will be available. For more details please refer to the email sent in October regarding open enrollment.

This benefit summary prepared by

Arthur J. Gallagher & Co.

© 2017 Gallagher Benefit Services, Inc. All rights reserved.

BG\GBS\TK10