2024 Employee **Benefits Guide**

MPHI

What's Inside...

We understand how important having a sound benefit package is, and that is why we are **committed** to providing you and your family with competitive benefits that meet your needs and keep you living well, while balancing our obligation to be financially responsible as a company. Your employee benefits are an important part of your total compensation.

This benefit guide includes important information describing your benefit plan offerings. Please read it thoroughly.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see pages 32-33 for more details.

IMPORTANT INFORMATION

Benefits Enrollment

We appreciate the hard work put forth by our employees, and together, we make MPHI a great place to work. An important part of being a great place to work is having a benefit program that helps protect you and your family. MPHI's benefit program allows you to select the level of coverage you need from a menu of benefit options.

This Guide will help you select your benefits for the upcoming plan year.

Eligibility

Newly hired Regular Full-Time employees working at least 30 hours per week are eligible for benefits on the first of the month following their date of hire, with the exception of the 403(b) plan, which begins on the date of hire.

For current employees, open enrollment changes are effective on January 1 each year, or upon the date of a qualified change in status (see *Making Mid-year Changes*).

Dependent Eligibility

Eligible employees may enroll certain dependents for coverage under our health, dental, vision and FSA plans. Eligible dependents include:

- Your legal spouse.
- Your children or your spouse's children by birth, legal adoption, or legal guardianship through the end of the year in which they turn 26.
- Your child over age 26 who was totally and permanently disabled prior to age 19 due to either a physical or mental disability; incapable of self-sustaining employment, unmarried and dependent on you for more than half of his or her support, and reported as a dependent on your most recent federal income tax return. We must be notified of the condition before the end of the year in which the dependent turns 26. The disability must be certified by a physician.

> Adult children may be enrolled on the BCBS High Deductible Health Plan; however, their claims may not be eligible for reimbursement from your HSA account unless the child qualifies as a tax dependent of the employee. Please contact your HSA administrator for more information.

Automatic Annual Re-enrollment

Prior to each plan year, there will be an open enrollment period available to employees to make benefit elections for the next plan year. Your current elections will automatically be continued unless you complete a new election form to during the open enrollment period. If you are required to contribute to the cost of coverage, you will be considered to have agreed to pay the appropriate premiums for the subsequent plan year for this coverage. If one or more of the current elections in which you are enrolled are not being offered during the subsequent plan year, you will be enrolled in the most similar option.

Automatic re-enrollment does not apply to the Medical and Dependent Care Flexible Spending Accounts under the Institute's Section 125 Cafeteria Plan. Therefore, you must complete a new election form to continue your participation in the Flexible Spending Accounts.

THE BASICS

IMPORTANT INFORMATION

Making Mid-Year Changes

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the qualified event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's loss or gain of coverage through our organization or another employer.
- Change in employment status.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 30 days.

2024 Employee Pre-Tax Contributions (monthly)

To participate in the medical, dental and vision plans, MPHI asks you to contribute a portion of the cost of coverage through payroll deduction. The 2024 monthly pre-tax costs are listed below.

	EMPLOYEE ONLY	TWO PERSON	FAMILY
BCBSM Simply Blue 500 PPO with RX, Dental and Vision	$74.00	$180.00	$224.00
BCBSM Simply Blue High Deductible Health Plan (HDHP) PPO with RX, Dental and Vision	$38.00	$90.00	$112.00

YOUR OPTIONS

MEDICAL

Medical coverage is one of the most significant parts of your overall benefits package with MPHI and it is important that you take the time to understand the details of the medical plan in which you enroll.

MPHI offers two comprehensive medical plan options through **Blue Cross Blue Shield of Michigan**:

- Simply Blue $500 PPO
- Simply Blue PPO High Deductible Health Plan (HDHP)

About Your Plans

All of your medical plan options use the same "PPO" network through Blue Cross Blue Shield of Michigan—so there is no difference in the provider network. PPO stands for Preferred Provider Organization, which is a group of doctors and hospitals who join together provide medical services at a discount to its membership. Since PPO providers agree to offer services at a discounted fee, each of the MPHI plans provide a higher benefit level if you use an in-network provider.

You can see out-of-network, or non-participating, providers but your benefits will be reduced and you'll pay more out-of-pocket. A participating provider must accept the BCBS *Allowed Amount* as payment in full—they can't balance bill you for more than your deductible and coinsurance. A non-participating provider can balance bill you for the difference between their charge and the BCBS Allowed Amount—plus your deductible and coinsurance. There's no limit to what you can be charged by a non-participating provider.

Although we encourage you to choose a primary care physician and establish a regular relationship with that doctor, you can see any provider you want, even a specialist. To search for in-network providers, visit www.bcbsm.com.

Deductible
The amount of expenses you pay each calendar year before the plan begins to pay for benefits that have a coinsurance.

Coinsurance
After you've met the deductible, the plan pays a major portion of the covered expenses, and you pay the remaining portion. This sharing of expenses is called "coinsurance." For example, if the plan pays 80% for a particular service, your coinsurance is 20%.

Out-of-Pocket Maximum
The out-of-pocket maximum provides you with financial protection by limiting the total amount you pay for covered expenses in a calendar year. If your out-of-pocket costs reach the out-of-pocket maximum for an individual or family, the plan will start to pay 100% of your remaining expenses for that individual or family for the remainder of the year. The out-of-pocket dollar maximum includes all medical and prescription drug out-of-pocket expenses, including the deductible, coinsurance and copays.

Important!
If your enrollment tier is employee + spouse, employee + child(ren) or family, then you are responsible for satisfying the full family deductible amount *before* you will begin to pay coinsurance. Unlike in a traditional PPO plan, there is not an "individual" deductible .

YOUR OPTIONS

MEDICAL SUMMARY

	Simply Blue PPO $500 Plan		Simply Blue PPO HDHP	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductibles and Coinsurance - calendar year				
Deductible	$500 Single $1,000 Family	$1.000 Single $2,000 Family	$2,000 Single $4,000 Family	$4,000 Single $8,000 Family
			The plan combines deductible amounts paid under your Simply Blue medical coverage and your Simply Blue prescription drug coverage. The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract, with the exception of in-network preventive care services.	
Coinsurance — Applies once deductible is met (waived for covered services performed in an in-network physician's office)	• 20% of approved amount for most other covered services • 50% of approved amount for private duty nursing care	• 40% of approved amount for most other covered services • 50% of approved amount for private duty nursing care	None	20% of approved amount for most covered services
Coinsurance out-of-pocket maximum	$2,500 Single $5,000 Family	$5,000 Single $10,000 Family	Not applicable	$2,000 Single $4,000 Family
	The family coinsurance requirement applies to a two-person or family contract.			
Annual out-of-pocket maximum – applies to deductibles, copays and coinsurance amounts for all covered services, including cost-sharing amounts for prescription drugs	$6,350 Single $12,700 Family	$12,700 Single $25,400 Family	$2,000 Single $4,000 Family	$6,000 Single $10,000 Family
Physician Services				
Office Visits medically necessary	$20 copay	60% after out-of-network deductible	100% after deductible	80% after out-of-network deductible
Specialist Office Visits	$40 copay	60% after out-of-network deductible	100% after deductible	80% after out-of-network deductible
Urgent Care medically necessary	$60 copay	60% after out-of-network deductible	100% after deductible	80% after out-of-network deductible
	Deductible and coinsurance apply for services outside of the exam			
Emergency Care				
Emergency Room	$250 copay		100% after deductible	80% after out-of-network deductible
Preventive Care				
Adult and childhood preventive services and immunizations	100% no deductible or copay	Not covered	100% no deductible or copay	Not covered
Hearing Care Benefits				
Audiometric exam – one every 36 months	100% of approved amount	Not covered	100% of approved amount after deductible	Not covered
Hearing aid evaluation – one every 36 months	100% of approved amount	Not covered	100% of approved amount after deductible	Not covered
Ordering and fitting the hearing aid – one every 36 months	100% of approved amount	Not covered	100% of approved amount after deductible	Not covered
Hearing aid conformity test – one every 36 months	100% of approved amount	Not covered	100% of approved amount after deductible	Not covered
	Hearing care services are not covered when performed by nonparticipating providers unless the services are performed outside of Michigan and the local Blue Cross and Blue Shield plan does not contract with providers for hearing care services. Simply Blue Hearing Care benefits, are subject to the same deductibles required under Simply Blue medical coverage. Benefits are not payable until after you have met the Simply Blue annual deductible.			

YOUR OPTIONS

Prescription Drugs

Simply Blue PPO High Deductible Health Plan—Prescription Drug Coverage

The Simply Blue PPO prescription drug benefits, including mail order drugs, are subject to the same deductibles, copays and annual copay dollar maximums required under the Simply Blue medical coverage.

- Prescription drug claims apply towards the Simply Blue annual deductible requirement.
- Prescription drug benefits are not payable until the applicable Simply Blue annual deductible has been met.

Simply Blue $500 PPO Plan—Prescription Drug Coverage

The Simply Blue 500 PPO prescription drug plan has three different categories, or tiers, of drugs.

	Network Retail Pharmacy Copay for up to a 30 day supply	**OptumRx Mail Order Copay for up to a 90 day supply**
Tier 1 Generic/Formulary Preferred	$15 copay for each drug	$30 copay for each drug
Tier 2 Formulary Brand	$30 copay for each drug	$60 copay for each drug
Tier 3 Non-formulary Brand	$60 copay for each drug	$120 copay for each drug

- **Generic:** a drug whose formula is equivalent to that of a brand name drug
- **Brand:** an original formula with no generic equivalent
- **Non-Formulary:** a drug for which there is either a generic alternative or a cost cost-effective preferred brand

Specialty Drugs

Specialty drugs are prescription medications that require special handling, administration, or monitoring. These drugs are used to treat complex, chronic, and often costly conditions, including asthma, cancer, multiple sclerosis, rheumatoid arthritis, infertility and other conditions.

If your medication is included in the Specialty Drug Guide, you can:

- Get your prescription drugs delivered to your home by mail ordering them through Walgreens Specialty Pharmacy. Download the Specialty Drug Brochure for ordering instructions, or call Walgreens Specialty Pharmacy at (866)515-1355 to order.
- Fill your prescription at a retail pharmacy. Not all pharmacies will dispense specialty drugs, so call your pharmacy to verify that they will fill your prescription.
- If filling your prescription at a retail pharmacy outside of Michigan, you must make sure the pharmacy you will be using participates in the out-of-state specialty pharmacy network.

YOUR OPTIONS

Prescription Drugs

High-Cost Drug Discount Optimization Program: Powered by PillarRx

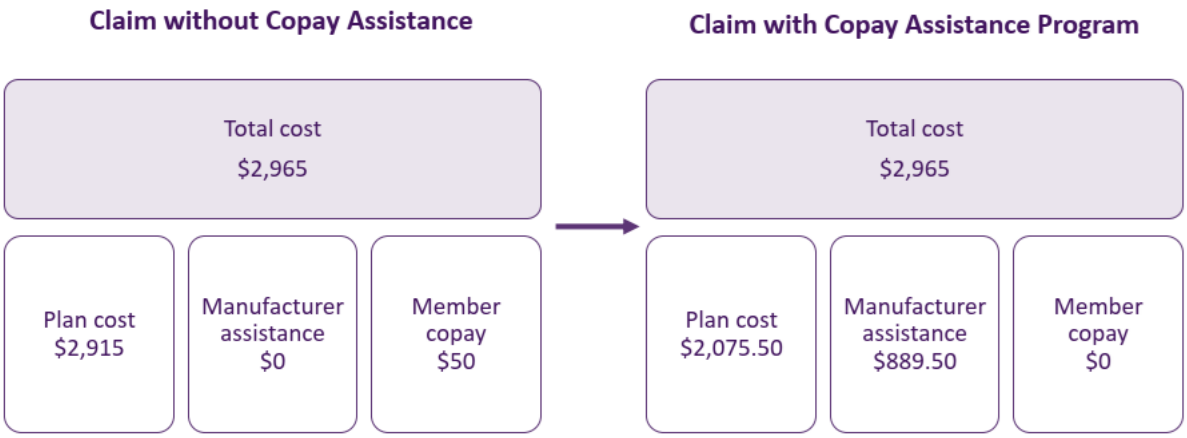
The PillarRx program will be in place for the Simply Blue 500 PPO Plan. The Simply Blue PPO HDHP with HSA is not included in the program. BCBSM will be mailing letters to those enrolled in the Simply Blue 500/1000 PPO Plan who will be impacted.

BCBSM partners with PillarRx in a program in which drug manufacturers will assist in paying most or all of the member's copay on approximately 300 high-cost drugs.

If a member currently takes one or more medications for which copay assistance is available, he or she can expect a phone call from a PillarRx copay assistance team representative. The representative will help the member to enroll in the discount program, as well inform them how the program works, what they should expect at the pharmacy and answer any questions. **Members who take medications included in this program are required to enroll.**

- **Members who enroll** will have all or a portion of their out-of-pocket costs (copay) for the drug covered by the drug manufacturer. Hence, in the example it shares a $0 copay to the member.
- **Members who ignore the letter / calls** and who do not enroll in the program will be responsible for a 30% coinsurance on the affected medication.

As such, there is a financial incentive for members to enroll in the program.



Members can call the PillarRx copay assistance team at (636)614-3126 for more information.

YOUR OPTIONS

Prescription Drugs

Important Coverage Provisions

Generic utilization is mandatory with this prescription plan. If you choose to fill your prescription with a name brand medication when a generic is available, you will pay the brand copay plus the difference in cost between generic and brand, even if your physician indicates "Dispense as Written." The only exception is if your physician requests and receives authorization from BCBSM, and then you will only pay the applicable copay.
You may need to get **prior authorization** for certain prescription drugs before they are dispensed, or they may not be covered under the plan. Your doctor should contact BCBSM directly for approval before he or she writes a prescription for a drug that is on the prior authorization or step therapy list.

Step therapy is a kind of prior authorization required for some drugs. BCBSM will not approve payment unless the patient has tried other medications first.

Convenient 90-Day Retail Option

You can purchase a 90-day supply of certain prescriptions for two copays, instead of three, from an approved pharmacy.

In order to qualify for the 90-day retail prescription drug program, state laws must approve the dispensing of a 90-day supply of your medication and your physician must write the prescription to be dispensed in this quantity. Nearly all chain and independent pharmacies are approved by BCBSM to participate in this program. Visit www.bcbsm.com to view a complete listing.

Mail Order Program

You may save money by having your prescriptions filled through the Mail Order Program with OptumRx.

Before placing your order, make sure you have at least a 14-day supply of that medication on hand to hold you over. Your medication will usually be sent 7 to 11 days after you submit your order.

Your doctor should provide you with two prescriptions, one to get an initial 14-day supply of the medication and a second to get a 90-day supply, with refill options, by mail.

Certain medications may be subject to dispensing limitations due to state or federal law.

Quantity Limits

BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days) once applicable deductible has been met.

Blue Cross limits all specialty drugs to a 30-day supply at each fill, whether they are obtained at a retail pharmacy or via mail order through Walgreens Specialty Pharmacy. One of the main reasons is to ensure that members are not paying for a 90-day supply of these highly expensive drugs when they may need to discontinue use before 90 days.

YOUR OPTIONS

Fertility, diabetes and Durable Medical Equipment

Fertility Benefit Coverage

Blue Cross' standard medical benefits cover testing to determine a diagnosis of infertility for an individual, as well as the specialist evaluation, corrective surgery or other therapies that serve to correct the cause of the infertility. As infertility becomes a more talked about benefit in our community MPHI offers enhanced fertility coverage for those in need and will be dependent on BCBSM's medical criteria.

Services that are payable include:

- A medical evaluation
- Diagnostic services, such as, laboratory studies, X-rays and ultrasounds
- Oral and injectable drugs
- Artificial insemination
- Assisted reproductive technology, such as In Vitro Fertilization (IVF)

Exclusions and limitations:

- Third-party reproductive services (e.g. donor eggs, sperm or embryos)
- Infertility services or treatments for female patients that are perimenopausal, menopausal or post menopausal.
- Assisted reproductive technology for fertile individuals
- Experimental treatment

Livongo Diabetes Management Program

Diabetes management helps you to develop healthy habits and get blood sugar levels under control. Once enrolled, a Welcome Kit arrives at your home with a smart device set up and ready for testing with the ability to order unlimited testing strips and lancets at no out-of-pocket cost. The Livongo cellular-connected meter offers real-time feedback on glucose readings, activity tracking and coaching by certified diabetes care and education specialists to help you understand the impact of your lifestyle habits. The cellular meter also captures glucose reading and produces reports that can easily be shared with care providers. Join today at www.join.livongo.com/BCBSM/register or call **(800)945-4355.**

Durable Medical Equipment Coverage

Blue Cross Blue Shield of Michigan uses to a tailored network managed by Northwood Inc. for durable medical equipment, prosthetic and orthotics (often referred to as DME POS) and medical supplies. DME POS and medical supplies can include things like crutches, wheelchairs, diabetic testing supplies and other items.

To find Northwood network DME POS provider, login into your Blue Cross member account and search using the"Find a Doctor" feature.

Otherwise visit www.bcbsm.com/dmesupplies and click on the Find a Doctor button. Look for the "Northwood" indicator in the search results.

If you do not use a Northwood provider, these services will be considered out-of-network and the out-of-network cost-share will apply which could be more expensive.

YOUR OPTIONS

Dental, Vision & Hearing

Dental

Our dental plan is insured by Blue Cross Blue Shield of Michigan (BCBSM). You may see any dentist you choose.
Blue Dental PPO: To find a PPO dentist near you, please visit www.mibluedentist.com or call (888)826- 8152.

When you receive services through the Blue Dental PPO network, you will usually have the lowest out-of-pocket costs because your copays are based on a discounted amount.

If you receive care from a nonparticipating dentist, you may be billed for the difference between the approved amount and the dentist's charge.

Vision

Our vision plan is insured by Blue Cross Blue Shield of Michigan (BCBSM).
Blue Vision benefits are provided by Vision Service Plan (VSP), one of the largest provider of vision care in the nation.

Benefits for exams, lenses and frames are available once per every 12 consecutive months. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.

Plus, members are eligible for discounts on additional prescription glasses and savings on lens extras when these are purchased from a VSP doctor.

Walmart and Sam's Club are now considered participating retail provider locations for our Blue Vision plans!

To find a VSP doctor, call (800)877-7195 or log onto the VSP Website at www.vsp.com.

Hearing

Both of our health plans include benefits for hearing services.
Covered benefits are payable every 36 months, with in network (BCBS PPO) providers only.

Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan **and** the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services.

See the benefit description located at the back of this guide.

YOUR OPTIONS

BCBSM Member Resources

With **Virtual Care by Teladoc Health**, you and everyone on your health plan can get virtual medical and mental health care from a smartphone, tablet or computer. Virtual Care is included with your BCBSM health care plan.

24/7 Care

Have a virtual visit with a U.S. board-certified doctor for minor illnesses such as colds, sore throats, urinary tract infections and pink eye. Visits are available for adults and children.
Medical visits are available 24/7, anywhere in the U.S., when your primary care provider isn't available. You don't need to make an appointment and the average wait time is 10 minutes. Prescriptions, if needed, can be sent to your preferred pharmacy.

Mental Health

With Virtual Care by Teladoc Health, you can have virtual visits with licensed therapists, psychologists, social workers and counselors, and U.S. board-certified psychiatrists from the comfort of your home at a convenient time. This option provides ongoing support for stressful situations or issues such as grief, anxiety and depression, This is in addition to the 24/7 virtual urgent care you have with Virtual Care.
Mental Health visits are available by appointment with many providers offering extended hours, including nights and weekends.

How does it work?

Create an account so you're ready whenever you need care. It doesn't take long, so don't wait until you're sick to set up your account.

- Visit www.bcbsm.com/virtualcare for a link to download the Teladoc Health app. You can also open the BCBSM mobile app, click "Find a Doctor" and then "Virtual Care" or call (800)835-2362.
- You will need your Blue Cross member ID card. Remember to choose your health plan and enter your member ID number when updating or creating your account so your coverage is applied correctly.
- Choose a service: 24/7 Care or Mental Health
- Meet with the doctor or therapist online and get a prescription sent to your preferred pharmacy, if needed.
- At the end of your visit, you'll get a full report to share with your family doctor or other health care providers.

Virtual Care by Teladoc

(previously Blue Cross Medical Online Visits)
Allows members to seek care for non-emergencies with board-certified physicians available 24/7/365 when your PCP is not available .

Telemedicine Medical Online Visits

Allows members to seek care with their providers on a virtual basis versus seeking care in a provider's office includes PCP and Specialists.

Start a visit or sign up today!
Download the Virtual Care by Teladoc app
Or
Visit www.bcbsm.com/virtualcare
You will need your Blue Cross ID card to sign up. Choose your health plan and enter your enrollee ID number

YOUR OPTIONS

BCBSM Member Resources

BCBSM Mobile App

BCBSM has a mobile app for its participants to use. The app mirrors the member portal but also provide on-the-go enhancements. In addition to 24/7 access, the app will offer participants:

- Access a virtual ID card
- On-the-spot doctor and hospital search
- A personal snapshot of your plan using easy to understand graphics that will provide a quick indication of your deductibles, coinsurance and claims.

As a registered BCBSM.com participant, you will use your current user name and password to login. Once you are logged in, you will be able to see all of your medical, dental, and vision benefits. In order to use the mobile app, you will need to register for web access at www.BCBSM.com. Once you are registered, your personal ID stays with you even if you change plans, jobs or retire.

Blue365

BCBSM members have the opportunity to save on a variety of healthy products and services in Michigan and across the United States.

Member discounts with Blue365 offer exclusive deals on things, such as:

- **Fitness and wellness:** Health magazines, fitness equipment and gym memberships
- **Healthy eating**: Cookbooks, classes, and weight-loss programs
- **Lifestyle:** Travel and recreation
- **Personal care:** Lasik and eye care services, dental care and hearing aids

View all of the savings in one place through your member account through the mobile app or by logging in at www.blue365deals.com/BCBSMI/join.

Blue Cross Blue Shield Global® Core - Healthcare coverage wherever you go

Through the Blue Cross Blue Shield Global Core, formerly BlueCard Worldwide Program, you have access to medical assistance services, doctors and hospitals around the world. You can even look up a provider directory before your trip!

If you need to locate a doctor or hospital, or need medical assistance services, call the BCBS Global Core Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. You can also email for assistance at customerservice@bcbsglobalcore.com.

An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

In most cases, you should not need to pay upfront for inpatient care at Blue Cross Blue Shield Global Core hospitals except for the out-of-pocket expenses (non-covered services, deductible, copayment and coinsurance) you normally pay. The hospital should submit your claim on your behalf.

YOUR OPTIONS

Additional Resources

Health Advocate

With Health Advocate, you will have access to a Personal Health Advocate, typically a registered nurse, supported by medical directors and benefits and claims specialists. You will have the confidence in knowing that the entire Health Advocate team is working on your behalf to help you and represent your needs.

Here is just a sample of the many services you will now have readily available to you with Health Advocate:

- Help finding the right doctors and hospitals
- Help obtaining services for your elderly parents and parents-in-law
- Help scheduling appointments, especially with hard-to-reach specialists
- Help when faced with serious illness or injury
- Help securing second opinions
- Help with insurance claims and billing issues

One of the other unique features of Health Advocate is that your extended family will be able to use their special services. In addition to you, your legal spouse, and dependent children, your parents and parents-in-law will also be covered under this program. To access Health Advocate services simply call 1-866-695-8622 (toll free) or visit www.healthadvocate.com/members, and you or covered family member will be connected to your own Personal Health Advocate. It's that easy!

Evaluating Benefit Plan Options with ALEX

There is a lot to consider when choosing a medical plan for you and your family. That's why we offer ALEX; a helpful online decisions support tool. ALEX is designed to evaluate your health care needs, crunch some numbers and point out what makes the most sense for you, so you can choose the best benefit plan for you and your family.

How long will it take and how should I prepare?

Most users spend about 7 minutes with ALEX, but it really depends on how much guidance you would like. ALEX can save your place, so you don't have to re-enter your information. You can pick up from where you left off. ALEX will ask you to estimate what type of medical care you and your dependents might need throughout the year. These include doctor's visits, surgeries, ER visits and prescriptions.

You will want to think about what you and your family have experienced in the past and use that information to help you answer the questions. If you are having a hard time coming up with estimate, ALEX can help you with that as well.

How does ALEX know what is best and can I trust ALEX with the information I give?

ALEX applies the contribution amounts for each plan and adds the estimated out-of-pocket expenses you would incur based on the information you give ALEX. ALEX will then recommend the least expensive plan for your needs and additional benefits that will help you save money. Your ALEX experience is completely anonymous and private. ALEX does not maintain personal information so he cannot pass it back to anyone, including MPHI.

How can I access ALEX?

You can access ALEX by using any tablet, computer or Smartphone.

YOUR OPTIONS

FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) lets you pay for health and/or daycare expenses with **tax-free** dollars. You save money because you pay for those expenses with pre-tax money—how much you save depends on how much you pay in income tax. You choose how much to contribute (FSA elections do not rollover from year-to-year). Your contributions are withheld, in equal amounts, from your paychecks throughout the year. As you incur expenses you can file a claim to be **reimbursed** from your account.

If you enroll in a FSA, you will also receive a **debit card** that you can use at the point of service so you have immediate access to your funds. You may still have to substantiate your expenses by providing proof that they are eligible, though, so be sure to keep all documentation. This includes Explanation of Benefits (EOBs), prescription drug slip, or an itemized statement from the provider.

There are two Health Care (HC) FSA options:

- **Full Scope**: use this FSA to pay for eligible medical, dental or vision expenses. *You cannot enroll in this option if you are contributing towards an HSA* .
- **Limited Purpose**: this FSA can be used to pay for eligible dental or vision expenses, and medical expenses *after* you have met your deductible. You are eligible to enroll in this option if you are covered by the Simply Blue HSA HDHP . You are not eligible to enroll in this option if you are covered by the Simply Blue 500 PPO.

2024 CONTRIBUTION LIMIT	$3,050

Dependent Care FSA

The Dependent Care (DC) FSA lets you pay eligible dependent care expenses with pre-tax dollars. Most childcare, eldercare and companion services are eligible expenses. Your dependents must be:

- Under age 13 or mentally or physically unable to care for themselves
- Spending at least 8 hours per day in your home
- Eligible to be claimed as a dependent on your federal income tax return
- Receiving care when you are at work and your spouse (if married) is at work, searching for work, is in school full-time or is mentally or physically disabled and unable to provide the care.

If both you and your spouse work, the IRS limits your contribution to a DC FSA:

- If you file separate income tax returns, the annual contribution limit is $2,500 each for you and your spouse
- If you file a joint tax return and your spouse also contributes to a DC FSA, your combined limit is $5,000
- If your spouse is disabled or a full-time student, special limits apply
- If you or your spouse earn less than $5,000, the maximum is limited to earnings under $5,000.

With a DC FSA, you can be reimbursed up to the amount that you have in your account. If you file a claim for more than your balance, you will be reimbursed as new deposits are made.

Eligible dependent care expenses can either be reimbursed through the DC FSA or used to obtain the federal tax credit. You can't use both options to pay for the same expenses. Usually, the DC FSA will save you more money than the tax credit, but to find out what is best for you and your family, talk to your tax advisor or take a look at IRS Publication 503.

If you contribute to a DC FSA, you must file an IRS Form 2441 with your federal income tax return. Form 2441 is simply an informational form on which you report the amount you paid and who you paid for day care.

YOUR OPTIONS

FLEXIBLE SPENDING ACCOUNTS

If your health coverage choice is	You can enroll in the following accounts	Use the accounts to pay for the following	How is the account administered?
Simply Blue PPO HDHP	Health Savings Account (HSA)	Qualified health expenses (for yourself and your tax dependents) that are not covered by the High Deductible (HSA) Plan.	You will be set up with an H SA through WEX. You submit requests for reimbursement to your bank, and keep your receipts for tax records.
	Limited Purpose Medical FSA	Qualified dental and vision expenses (for yourself and your dependents) that are not covered by an insurance plan.	WEX administers these accounts on behalf of MPHI. MPHI deducts the money from your paycheck on a pre-tax basis and forwards it to WEX. File a claim form with your itemized receipt to receive reimbursement. You can also claim the money in your Medical and Dependent Care FSA by using the WEX debit card.
	Dependent Care Reimbursement Account (DCRA)	Qualified dependent care expenses, such as day care.	
	If not contributing to an HSA: Medical Flexible Spending Account (FSA)	Qualified medical, dental, and vision expenses (for yourself and your dependents) that are not covered by an insurance plan.	
Simply Blue $500 PPO **Or** **Waiving coverage**	Medical Flexible Spending Account (FSA)	Qualified medical, dental, and vision expenses (for yourself and your dependents) that are not covered by an insurance plan.	WEX administers these accounts on behalf of MPHI. MPHI deducts the money from your paycheck on a pre-tax basis and forwards it to WEX. File a claim form with your itemized receipt to receive reimbursement. You can also claim the money in your Medical and Dependent Care FSA by using the WEX debit card.
	Dependent Care Reimbursement Account (DCRA)	Qualified dependent care expenses, such as day care.	

FSA or HSA participants are able to use funds to cover over-the-counter medical products without a prescription. This provision also adds menstrual care products to the definition of “qualified medical expenses”.

What are examples of over-the-counter medical products that are eligible to be reimbursed?

- Cold and flu medications
- Nasal spray or drops
- Pain relievers
- Allergy medication
- Menstrual care products as defined as a tampon, pad, liner, cup, sponge, or similar products used with respect to menstruation
- And more!

YOUR OPTIONS

Health Savings Account

When you enroll the Simply Blue PPO High Deductible Health Plan, you have the option to open a Health Savings Account with WEX (formerly Discovery Benefits). A HSA is a tax-advantaged medical savings account. Similar to a Health Care Flexible Spending Account (FSA), you pay no federal taxes on your contributions (and, in most states, contributions are also tax-exempt).

You can use funds in your HSA to pay for eligible expenses incurred after the date the HSA is opened. It is possible for this date to be later than your benefits effective date if you delay opening your HSA. Unused funds roll over in your account year over year, so there is no "use it or lose it" requirement with a HSA.

You decide when to withdraw money from your HSA to reimburse yourself for qualified medical expenses. You can either request a disbursement from your account, transfer funds into a personal bank account, or use the debit card that is provided to HSA participants to receive immediate access to funds at the point of service. Or, you can choose to pay for your care out-of-pocket until you reach your deductible and/or out-of-pocket maximum—this approach will let your HSA balance grow and earn interest toward future qualified expenses.

There does not need to be a qualifying event in order to make a change to your HSA contribution. **To change your election amount, log onto Employee Self-Service (ESS) anytime of the year, as often as you would like.**

If you enroll in the Simply Blue PPO High Deductible Plan, you may be eligible to contribute to an HSA <u>if</u>:

- You are not enrolled in Medicare
- You are not covered by other health insurance that is not subject to the HDHP limits (such as a spouse's traditional medical plan)
- You have not received VA benefits or certain Indian Health Services at any time over the past three months
- You are not claimed as a dependent on someone else's tax return

2024 HSA Contribution Limits

Your total maximum, including the company contribution and any wellness incentives paid by the company on your behalf, cannot exceed the IRS indexed statutory maximums below.

	INDIVIDUAL COVERAGE	FAMILY COVERAGE
Employee Maximum Annual Contribution (minimum $100)	$4,150	$8,300
Catch-up (55 or older)	$1,000	$1,000

YOUR OPTIONS

Health Savings Account

How Does it Work?

Open an HSA

When you enroll in the HDHP, you may open an HSA.

You can contribute

You are encouraged to contribute to your HSA through payroll deductions, online or by sending a check and contribution form.

Use your HSA

You decide when to withdraw money from your HSA to pay for qualified medical expenses, including your deductible and coinsurance payments. It works just like a bank account!

Or let it grow tax-free

If you'd rather let your HSA grow and earn interest for future qualified expenses, you can let it grow and just pay for your medical costs out-of-pocket.

Rollover unused funds

At the end of the year, your HSA balance will carry over for use to cover future eligible expenses or to grow into an investment.

Key Advantages of an HSA

- Triple tax savings – contributions to an HSA are not taxed, your savings grow tax-free, and the money is tax-free when used to pay for qualified health expenses today or in the future.
- Savings for retirement – start growing the balance in your HSA to help pay for health care expenses during retirement. It's going to cost far more than you imagined.
- Investment opportunities – You can invest your contributions in stocks, mutual funds and other investment vehicles.
- Use your HSA to pay for eligible medical expenses including deductibles, co-insurance, prescriptions, vision, and dental care.
- Unused funds will roll over year to year. There's no "use it or lose it" penalty.
- After age 65, funds can be withdrawn for any purpose without penalty, but may be subject to income tax if not used for IRS-qualified medical expenses.

YOUR OPTIONS

LIFE/AD&D

Basic Life/AD&D

Life and Accidental Death and Dismemberment (AD&D) insurance offers financial protection in the event of your death. MPHI provides Basic Life/AD&D coverage for eligible employees at no cost through UNUM.

The below items are part of your Basic Life/AD&D benefit.

- For You: 2x your annual salary up to a benefit amount, with a minimum of $50,000 and a maximum of $450,000
- For Your Spouse: $10,000
- For Your Child(ren) (6 months to age 19, 23 if full-time student): $2,000

Your Basic Life and Optional Life insurance benefits reduce to 65% at 65, then 50% at age 70.

Coverage effective dates and increases in coverage may be delayed if you and/or your dependents are disabled or hospital confined on the date coverage is scheduled to take effect.

Optional Life

Voluntary Life insurance is additional life insurance that you can purchase from Unum for yourself and your dependents at a discounted group rate. The chart below provides an overview of the voluntary benefits being offered.

WHO CAN HAVE IT?	WHAT'S THE BENEFIT AMOUNT?	HOW LONG CAN THEY KEEP IT?
Employee Any full time employee that is benefit eligible; during the first 30-days of eligibility or open enrollment	In increments of $10,000 of 5x's your annual salary up to a benefit amount of $500,000. **Amounts over $150,000 are subject to medical underwriting**	You can keep the coverage as long as you would like, even if you leave MPHI the coverage can be ported. However, the benefit does reduce at ages 70 and 75.
Spouse Available with purchase of employee coverage during the first 30 days or open enrollment;	In increments of $5,000 up to 100% of the employee benefit amount. **Amounts over $25,000 are subject to medical underwriting**	Your spouse can keep coverage as long as you keep yours, no matter where (or if) you work.
Child Available with purchase of employee coverage for eligible dependent children, which may include stepchildren and legally adopted children, age birth through 23 years.	In increments of $2,000 up to $10,000,	Ends when employee policy ends or when children turn 19 (or 23 if full-time students). At that time, children can purchase an individual policy, not to exceed the original children's benefit amount

YOUR OPTIONS

Long Term Disability

Long Term Disability

MPHI offers a Long Term Disability plan to provide income to employees who are disabled for an extended period of time. This coverage is insured through Unum. MPHI pays the full cost of this coverage.

FEATURE	DESCRIPTION
Amount	60% of your monthly covered earnings to a maximum monthly benefit of $11,000 per month
Elimination Period	Benefits for approved claims begin after 90 days for illness or injury.
Benefit Duration	Benefits are payable up to age 65 or longer in some cases. Benefits are limited to 24 months in a person's lifetime for mental/nervous or substance abuse conditions.
Definition of Disability	You are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and ● You have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury. ● You must be under the regular care of a physician in order to be considered disabled.
Pre-existing Condition Definition	You have a pre-existing condition if: ● You received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; ***and*** ● The disability begins in the first 12 months after your effective date of coverage.

Are Your Beneficiaries Up to Date?
Beneficiaries are individuals or entities that you select to receive benefits from your policy. You can change your beneficiary designation at any time. You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.

YOUR OPTIONS

Long Term Care

Long Term Care

This coverage is insured through Unum. Base coverage for the employee is fully paid by MPHI. Employees may also purchase additional protection for themselves, and for family members. Evidence of Insurability may be required for buy up coverage. Please see the Unum flyers for more details.

FEATURE	DESCRIPTION
Elimination Period	Benefits for approved claims begin after 90 days.
Benefit Period	Three years
Definition of Disability	Loss of two or more Activities of Daily Living (bathing, dressing, eating, toileting, continence, and transferring) or Cognitive Impairment.
Employer Paid Base Plan	• Monthly Benefit $3,000 • Assisted Living Facility Benefit $1,800 • Professional Home Care Benefit $1,500 • Facility Benefit Duration 3 years
Employee Paid Buy-Up Options	• Facility Monthly Benefit up to $6,000, in $1,000 increments Guaranteed Issue—no medical questions if you enroll when first eligible • Total Home Care Benefit 50% of the home care benefit • Compound Inflation Protection
Medically Underwritten Buy-Up Options	• Facility Monthly Benefit $7,000 or $8,000 • Unlimited Facility Benefit Duration

This is only a brief summary of some of the key terms and conditions found in the insurance policy with Unum. It is not a guarantee of benefits. See the UNUM contract for details. If there are any discrepancies between this Guide and your Unum contract, the policy terms will govern.

YOUR OPTIONS

FMLA

FMLA Administration

Unum manages our leaves under the Family and Medical Leave Act (FMLA), state leave laws and corporate leave policies.

We have chosen Unum because they have a dedicated team of highly-trained specialists who are well-versed in claims management, FMLA regulations and state leave laws. Unum is committed to excellent customer service and makes the process of reporting an absence simple by allowing you to report a claim or leave by telephone.

When to Call UNUM:

- When you are unable to work due to illness, injury or pregnancy.
- When you need to be absent from work to care for a family member who has a serious health condition.
- When you need to care for a child due to birth, adoption or foster care placement.
- When you need to be absent from work for a qualifying exigency leave because your spouse, son, daughter or parent is on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces.
- When you need to care for your spouse, child, parent or next of kin undergoing medical treatment, recuperation, or therapy, is in outpatient status, or is on the temporary disability retired list for a serious illness or injury incurred or aggravated in the line of duty on active duty in the Armed Forces (includes the National Guard or Reserves). This includes a veteran who was discharged from the Armed Forces for reasons other than dishonorable within the 5 year period before the employee's first day of leave.
- When you need any other type of leave that may be covered by applicable state leave laws.
- Thirty days before a planned leave based on prescheduled medical treatment related to a serious health condition for you or your family member, or the expected birth, adoption or foster care placement of a child.

What to do Next:

- Notify your manager or supervisor of your absence from work.
- **Contact Human Resources directly by phone or by emailing HR@MPHI.org.** You will receive detailed instructions on how to submit your FMLA claim with UNUM as well as additional instructions.

Please be prepared to provide the following information to UNUM when you submit your claim/leave:

- Name of the company where you work
- Your name and Social Security number or employee ID number
- Complete address and phone number
- Date of birth
- Marital status
- Occupation (or job title)

Please be prepared, if filing for a leave, your employer must provide you a minimum of 15 days from the date the leave is filed to complete the certification of healthcare provider form. If eligible, this form will be mailed in your initial leave packet within 2 business days of filing your leave.

YOUR OPTIONS

ADDITIONAL BENEFITS

Retirement Savings Plan

The 403(b) Plan was established to provide employees the potential for future financial security for retirement. Eligible employees may contribute and direct the investment of a portion of their income into their 403(b) account.

MPHI will automatically contribute 6% of the employee's gross wages into their 403(b) account regardless of whether or not the employee elects to make their own contributions.

MPHI will also match the first 2% of the employee's contribution at 100%, allowing for a combined 8% employer contribution maximum.

MPHI partners with Fidelity to administer our 403(b) plan. Currently, the IRS allows employees to contribute up to $20,500 on an annual basis (does not include employer contribution). The 2024 maximum catch-up contribution for participants age 50 and over is $6,500.

Complete details of the 403(b) Plan, including eligibility requirements, are described in the Summary Plan Description provided to eligible employees.

Tuition Reimbursement

MPHI will provide tuition reimbursement to all Regular Full-Time employees immediately upon hire. To maintain eligibility, employees must remain on the active payroll and remain classified as a Regular Full-Time employee.

A Request for Tuition Reimbursement Funds form must be completed in advance and must be approved by the Human Resources and Payroll & Benefits departments.

Seventy five percent of the eligible expenses will be reimbursed, upon documented successful completion (i.e. grade "C" or better, or "pass" if a pass/fail course), up to $4,000 per calendar year per employee.

For classes that overlap calendar years, these expenses are applied to the year in which the class ends. Individual course or courses that are part of a degree must be related to the employee's current job duties or a foreseeable future position in the organization in order to be eligible for tuition reimbursement.

Please refer to the Summary Plan Description for additional information.

Employee Assistance Program (EAP)

MPHI offers two EAP options, Unum and HelpNet. They both provide similar services, helping you to manage stress and deal with personal and family issues ranging from everyday to severe.

- **Health Resources**
- **Financial Issues**
- **Child Care and Elder Care**
- **Education & Schooling**
- **Legal Issues**
- **Addiction & Recovery**

Both the HelpNet and Unum WorkLife Balance programs are available to you and your family members at no additional cost.

YOUR OPTIONS

ADDITIONAL BENEFITS

HelpNet

HelpNet is available to help you or your family members resolve any personal problem. There are many types of personal problems that affect employees. Some may require only a phone call to the EAP to resolve them. Others may require that you meet in person with a professional for one or more sessions. Contact HelpNet at (800)969-6162.

Your HelpNet EAP Work-Life Website

Your work-life service provides online access to a wide range of resources regarding the work and life topics of interest to you and your family—all available on one website. **Just login to www.bronsonhealth.com/helpnet, click: "WorkLife Login" and enter "MPHI123" for the company code**. You can navigate through articles, links, interactive content, self-searches, self-assessments and much more".

- Self-search provider databases for summer camps, education resources, pet sitters, attorneys, financial advisors, volunteer opportunities, and more
- Legal and medical encyclopedias
- Financial and daily living calculators
- Savings Center providing 25 to 70 percent discounts on name-brand merchandise

Legal, Financial, and ID Recovery Resource and Referrals

When a legal issue, financial matter, or an instance of identity fraud disrupts your life, it can create substantial stress for you and your family. To help minimize the impact, your work-life service offers programs to assist you with managing the many complexities of these events. Through professional consultation, these programs can save you time, while providing valuable information and peace of mind.

Legal Assist:

Provides a free half-hour consultation with an attorney on most legal issues. In most cases, discounted rates are available if further legal representation is required.

Financial Assist:

Provides a free telephonic consultation with a financial professional qualified to advise on a range of financial issues.

ID Recovery:

Provides a free telephonic consultation with an ID recovery professional. The program also provides a 25% discount on Enhanced ID Recovery, whereby the specialist not only provides a consultation, but also handles the paperwork and negotiations on your behalf.

YOUR OPTIONS

ADDITIONAL BENEFITS

Calm.com

We've partnered with Calm to provide you with tools that can help you meditate, relax, focus, and improve sleep. Now more than ever, it's important that we continue to find ways to manage stress and stay strong in the face of uncertainty. Whether you have 30 seconds or 30 minutes every day, Calm's resources are designed to seamlessly integrate with your schedule and needs.

Your Calm subscription gives you unlimited access to their full library of resources at www.calm.com and in the Calm app.

Here's a sneak peek as to what you can expect:

- Calm's Masterclasses taught by world-renowned experts
- Guided breathing exercises such as the Breathe Bubble
- Music tracks designed to promote focus, relaxation, and sleep
- 100+ guided meditations that cover anxiety, stress, gratitude, and much more
- Brand new daily meditations and movement sessions as part of their Dailies series
- The entire library of Sleep Stories which contains soothing bedtime tales that's suitable for both grown-ups and children (new stories added every week!)

Activate Your Calm Subscription in 4 Steps!

1. Visit this link: www.calm.com/b2b/mphi/subscribe
2. Sign up with your personal email address (or log in to an existing account)
3. Validate your work email address
4. Download Calm on your iOS or Android devices. Alternatively, you can access the web-based version of Calm at www.calm.com!

Care.com

Finding the right care for your family can be hard, especially when you are balancing your personal and work life. MPHI has partnered with Care.com to help working families find and manage care for kids, adults, pets, homes and more. Your premium with Care.com provides you access to the world's largest network of vetted caregivers.

With your membership, employees will have the opportunity to:

- Message caregivers they may be interested in interviewing and hiring, including the private calling feature
- Access to background check options
- Post jobs for the specific services they are looking for
- Through your Care.com membership you also have access to exclusive discounts to goods and services with LifeMart

Activate your Care.com account by visiting www.care.com/yourbenefits. Once you create your account you can download the Care app from the Apple or Google Play store.

YOUR OPTIONS

ADDITIONAL BENEFITS

Unum Work-Life Balance EAP

When you have questions, concerns or emotional issues surrounding either your personal or work life, there are resources that can help you. Through MPHI's Unum policies, you have unlimited access to consultants by telephone, resources and tools online, and up to three face-to-face visits with counselors for help with a short term problem.

Master's level consultants can assist you when you need confidential information to:

- Locate childcare and eldercare services.
- Speak with financial experts by phone regarding budgeting, controlling debt, teaching children to manage money, investing for college and preparing for retirement.
- Work through complex sensitive issues such as personal or work relationships, depression and substance abuse.
- Get advice on how to deal with a conflict between you and a co-worker.
- Get a referral to a local attorney for a free, 30-minute in-person or telephonic legal consultation. You'll have access to an attorney for state-specific legal information and services. (If you decide to retain the attorney, you may be eligible to receive a 25% discount on additional services.)

You may contact a professional ***confidentially,*** 24 hours a day. You can also log onto the Work-Life Balance website, to view or request printed information on a variety of topics.

Call (800)854-1446 ***confidentially*** 24 hours a day for assistance or log on to www.lifebalance.net (Username: lifebalance, Password: lifebalance).

Travel Assistance

Travel Assistance through Assist America is also part of the Unum Long Term Disability Insurance benefit.

Travel Assistance offers medical assistance to people traveling 100 miles or more away from home. If you, your spouse or dependents experience a medical emergency while traveling, Travel Assistance can help. Services are available for simple to extreme travel emergencies:

- Hospital admission coordination
- Emergency medical evacuation
- Critical care monitoring
- Medical repatriation
- Emergency message service
- Transportation for a friend or family member to join the hospitalized patient
- Care of minor children
- Emergency trauma counseling
- Prescription assistance
- Assistance in the return of a vehicle
- Legal and interpreter referrals

All services are arranged by Assist America. Medical expenses such as care and treatment in a hospital are paid for by you or your health insurance policy if care received is covered in your policy. Visit www.assistamerica.com or call (**800)872-1414** to get more detailed information regarding their services. You can download their mobile app off the website so that you have that with you while you travel. If you need their assistance outside of the USA, you can reach them by phone at (**609)986-1234.** Reference number for MPHI employees: **01-AA-UN-762490.**

YOUR OPTIONS

PAID TIME OFF

MPHI Recognized Holidays

• New Year's Day	• Veterans Day
• Martin Luther King Day	• General Election Day (Observed in even numbered years only)
• President's Day	• Thanksgiving Day
• Memorial Day	• Friday Following Thanksgiving
• Juneteenth	• Day before Christmas Day
• Fourth of July	• Christmas Day
• Labor Day	• Day before New Year's Day

Employees shall receive holiday pay, provided the employee works their scheduled work day immediately prior to and following the holiday. Any employee working less than 40 hours per week will be paid on a prorated basis, based on their full- time equivalency (FTE), as stated in their current appointment letter.

Vacation Leave

Years Worked	**Vacation Leave Accrued**	**Maximum Number of**
0 - 2 years	2 weeks per year – 3.08 hours/pay	160
After 2 years	3 weeks per year – 4.62 hours/pay	160
After 4 years	4 weeks per year – 6.15 hours/pay	160
After 15 years	4.5 weeks per year - 6.92 hours/pay	180
After 20 years	5 weeks per year - 7.69 hours/pay	200
After 25 years	5.5 weeks per year - 8.46 hours/pay	220
After 30 years	6 weeks per year - 9.23 hours/pay	240

Regular Full-Time employees working less than 40 hours per week will accumulate Vacation Leave on a pro-rata basis. Please reference the MPHI Employee Handbook for additional information regarding Paid Time Off.

YOUR OPTIONS

PAID TIME OFF, CONT.

Sick Time

MPHI provides paid sick leave benefits for periods of temporary absence due to illness or injury. Regular Full-Time employees working 40 hours per week shall accumulate 2.16 hours of sick leave per bi-weekly pay period.

Regular Full-Time employees working less than 40 hours a week will accumulate Sick Leave on a pro-rata basis. A maximum of 520 hours may be accumulated. See MPHI Employee Handbook for additional information.

Paid Medical Leave Benefits

Full-time and part-time (working at least 25 hours per week) regular employees will receive 40 hours of paid medical leave benefits on January 1st of each calendar year. Newly hired employees or employees who transfer into an eligible position during the year will earn a pro-rated number of paid medical leave benefit hours for the first year.

Hired of Transferred	**Paid Medical Leave Allotted through 1st Year**
January 1st—March 31st	40 Hours
April 1st—June 30th	30 Hours
July 1st—September 30th	20 Hours
October 1st—December 30th	10 Hours

Paid medical leave benefits can be used for the following reasons; 1) the employee's personal illness, injury, health condition or preventative care; 2) a family member's illness, injury, health condition or preventative care; 3) the employee's or family member's victimization by domestic violence or sexual assault; and 4) the closure of the employee's primary workplace or his/her child's school/place of care due to a public health emergency. See MPHI Employee Handbook for additional information.

Personal Leave Time

Regular Full-Time employees working 40 hours per week who are active on payroll as of December 31st will be granted 3 days of Personal Leave for the following calendar year, credited on January 1st.

New employees are granted Personal Leave on a prorated basis based on their month of hire.

- Employees hired between January 1st and April 30th receive 2 Personal Leave days.
- Employees hired between May 1st and August 31st receive 1 Personal Leave day.
- Employees hired on or after September 1st will be eligible for Personal Leave days as of January 1st of the following year.

Regular Full-Time employees working less than 40 hours per week will accumulate Personal Leave on a pro-rata basis.

Please reference the MPHI Employee Handbook for additional information regarding Paid Time Off.

YOUR OPTIONS

PAID TIME OFF, CONT.

Parental Leave

Twelve weeks of paid parental leave will be available to regular full-time employees, who have completed 12 months of continuous employment, immediately after the birth or placement of a child (17 years or younger) for adoption. Regular full-time employees employed less than 12 months will receive four weeks of paid parental leave immediately after the birth or placement of a child (17 years or younger) for adoption. Employees may be asked to provide documentation of the birth or adoption.

Full time regular employees working less than 40 hours per week as specified in their current appointment letter shall be allowed parental leave time proportional to the amount of time regularly employed. All other employment categories are not entitled to parental leave.

This benefit runs concurrently with FMLA and may only be used once per a 12-month period. Intermittent leave requires advance supervisor approval and may be an option for paternal/adoption leave, or if the employee has been released to return to work by their doctor. Adoption of children related by marriage is not a qualifying event for this benefit.

Jury Duty

All MPHI employees are eligible for jury duty pay. To receive jury duty pay, employees must show the jury duty summons to their supervisor as soon as possible so the supervisor may make arrangements to accommodate their absence. Employees are expected to report for work whenever the court schedule permits.

If the employee is serving over 80 hours of jury duty, the employee will be required to submit the jury duty fee, less mileage, with the Payroll & Benefits Department in order to receive jury duty pay. Either MPHI or the employee may request an excuse from jury duty if, in the MPHI's supervisor's judgment, the employee's absence would create serious operational difficulties.

*Any employee working less than 40 hours per week will be paid on a prorated basis, based on their full- time equivalency (FTE), as stated in their current appointment letter.

Bereavement Leave

A maximum of five days of paid bereavement leave may be utilized per event, in addition to sick time, for attendance at the funeral of an employee's: father; mother; step-parent; spouse; child; or step-child. Three days of paid bereavement leave may be utilized per event, in addition to sick time, for attendance at the funeral of an employee's: sister; brother; grandparent; grandchild; father-in-law; and mother-in-law. Bereavement leave must generally be taken in the days leading up to and immediately following the funeral.

A maximum of five days of sick leave may be utilized per event for attendance at a non-immediate family member's funeral, only upon specific permission from the supervisor in each case. Additional unpaid time off may be granted at the discretion of the supervisor. The supervisor is to be notified immediately of a death in the family and the extent of the employee's expected absence.

*Any employee working less than 40 hours per week will be paid on a prorated basis, based on their full- time equivalency (FTE), as stated in their current appointment letter.

LEGAL NOTICES

IMPORTANT NOTICES

Qualified Changes in Status/Changing Your Pre-Tax Contribution Amount Mid-Year

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. With this program, contributions are deducted from your paycheck before federal, state and Social Security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation.

These programs are regulated by the Internal Revenue Service (IRS). The IRS requires you to make your pre-tax elections before the start of the plan year January 1 – December 31. The IRS permits you to change your pre-tax contribution amount mid-year only if you experience a change in status, which includes the following:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child.
- Marriage, legal separation, annulment or divorce.
- Death of a dependent.
- A change in employment status that affects eligibility under the plan.
- A change in election that is on account of, and corresponds with, a change made under another employer plan.
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan.

The change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. If your spouse's employment terminates and he/she loses employer-sponsored coverage, you may elect coverage for yourself and your spouse under our program. However, the change must be requested within 30 days of the change in status. If you do not notify Human Resources within 30 days, you must wait until the next annual enrollment period to make a change.

These rules relate to the program allowing you to pay for certain benefits using pre-tax dollars. Please review the medical booklet and other vendor documents for information about when those programs allow you to elect or cancel coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ from the pre-tax program.

HIPAA Notice of Special Enrollment Rights

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

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

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact the Payroll and Benefits Department.

LEGAL NOTICES

Important Notices

Protecting Your Privacy

The Michigan Public Health Institute Welfare Benefits Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Payroll and Benefits Department.

Women's Health and Cancer Rights Act of 1998

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

Summary of Material Modification

The information in this document and in the benefit guide applies to the Michigan Public Health Institute Welfare Benefit Plan, Plan Number 501.This information meets the requirements for a Summary of Material Modification as required by the Employee Retirement Income Security Act (ERISA).

Benefit Enrollment Communications Disclosure

The benefit enrollment communications (the Benefit Guide, the Health and Welfare Benefits Notices, etc.) contain a general outline of covered benefits and do not include all the benefits, limitations and exclusions of the benefit programs. If there are any discrepancies between the illustrations contained herein and the benefit proposals or official benefit plan documents, the benefit proposals or official benefit plan documents prevail. See the official benefit plan documents for a full list of exclusions. Michigan Public Health Institute reserves the right to amend, modify or terminate any plan at any time and in any manner.

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

LEGAL NOTICES

MEDICARE PART D NOTICE

Important Notice from MPHI About Your Prescription Drug Coverage and Medicare

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

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

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

2. Michigan Public Health Institute has determined that the prescription drug coverage offered by the Michigan Public Health Institute Welfare Benefits Plan, 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 while enrolled in Michigan Public Health Institute coverage as an active employee, please note that your Michigan Public Health Institute coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Michigan Public Health Institute coverage as a former employee.

You may also choose to drop your Michigan Public Health Institute coverage. If you do decide to join a Medicare drug plan and drop your current Michigan Public Health Institute coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Michigan Public Health Institute and don't

MEDICARE PART D NOTICE

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 Michigan Public Health Institute 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:	June 2023
Name of Entity/Sender:	MPHI
Contact--Position/Office	Payroll and Benefits Department
Address:	2436 Woodlake Circle, Suite 300 Okemos, MI 48864
Phone Number:	(517) 324-8300

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).

LEGAL 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 July 31, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447**ALASKA – Medicaid**
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/
flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2
INDIANA – Medicaid
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: https://www.in.gov/medicaid/
Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
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
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-867-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

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PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 1-617-886-8102
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178
NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 1-603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 1-919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669
VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 1-304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, 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. Dept. of Health and Human Services , Centers for Medicare & Medicaid Services, www.cms.hhs.gov/
  Phone: 1-877-267-2323, Menu Option 4, Ext. 61565

LEGAL NOTICES

BCBSM Privacy Notice

Blue Cross® Blue Shield® of Michigan

NOTICE OF PRIVACY PRACTICES

FOR MEMBERS OF OUR NONGROUP AND UNDERWRITTEN GROUP PLANS INCLUDING MEDICARE ADVANTAGE AND PRESCRIPTION BLUE OPTIONS A AND B

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.

Affiliated entities covered by this notice

This notice applies to the privacy practices of the following affiliated covered entities that may share your protected health information as needed for treatment, payment and health care operations.

- Blue Cross Blue Shield of Michigan
- Blue Care Network of Michigan
- Blue Care of Michigan Inc.
- Blue Cross Complete of Michigan
- BCN Service Company

Our commitment regarding your protected health information

We understand the importance of your Protected Health Information (hereafter referred to as "PHI") and follow strict polices (in accordance with state and federal privacy laws) to keep your PHI private. PHI is information about you, Including demographic data, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health, the provision of health care to you or the payment for that care. Our policies cover protection of your PHI whether oral, written or electronic.

In this notice, we explain how we protect the privacy of your PHI, and how we will allow it to be used and given out ("disclosed"). We must follow the privacy practices described in this notice while it is in effect. This notice takes effect September 23, 2013, and will remain in effect until we replace or modify it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. These revised practices will apply to your PHI regardless of when it was created or received. Before we make a material change to our privacy practices, we will provide a revised notice to our subscribers.

Where multiple state or federal laws protect the privacy of your PHI, we will follow the requirements that provide greatest privacy protection. For example, when you authorize disclosure to a third party, state laws require BCBSM to condition the disclosure on the recipient's promise to obtain your written permission to disclose your PHI to someone else.

Our uses and disclosures of protected health information

We may use and disclose your PHI for the following purposes without your authorization:

- **To you and your personal representative:** We may disclose your PHI to you or to your personal representative (someone who has the legal right to act for you).
- **For treatment:** We may use and disclose your PHI to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) who request it in connection with your treatment. For example, we may disclose your PHI to health care providers in connection with disease and case management programs.

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- **For payment:** We may use and disclose your PHI for our payment-related activities and those of health care providers and other health plans, including:
    - Obtaining premium payments and determining eligibility for benefits
    - Paying claims for health care services that are covered by your health plan
    - Responding to inquiries, appeals and grievances
    - Coordinating benefits with other insurance you may have
- **For health care operations:** We may use and disclose your PHI for our health care operations, including for example:
    - Conducting quality assessment and improvement activities, including peer review, credentialing of providers and accreditation
    - Performing outcome assessments and health claims analyses
    - Preventing, detecting and investigating fraud and abuse
    - Underwriting, rating and reinsurance activities (although we are prohibited from using or disclosing any genetic information for underwriting purposes)
    - Coordinating case and disease management activities
    - Communicating with you about treatment alternatives or other health-related benefits and services
    - Performing business management and other general administrative activities, including systems management and customer service

We may also disclose your PHI to other providers and health plans who have a relationship with you for certain health care operations. For example, we may disclose your PHI for their quality assessment and improvement activities or for health care fraud and abuse detection.

- **To others involved in your care:** We may, under certain circumstances, disclose to a member of your family, a relative, a close friend or any other person you identify, the PHI directly relevant to that person's involvement in your health care or payment for health care. For example, we may discuss a claim decision with you in the presence of a friend or relative, unless you object.
- **When required by law:** We will use and disclose your PHI if we are required to do so by law. For example, we will use and disclose your PHI in responding to court and administrative orders and subpoenas, and to comply with workers' compensation laws. We will disclose your PHI when required by the Secretary of the Department of Health and Human Services and state regulatory authorities.
- **For matters in the public interest:** We may use or disclose your PHI without your written permission for matters in the public interest, including for example:
    - Public health and safety activities, including disease and vital statistic reporting, child abuse reporting, and Food and Drug Administration oversight
    - Reporting adult abuse, neglect or domestic violence
    - Reporting to organ procurement and tissue donation organizations
    - Averting a serious threat to the health or safety of others
- **For research:** We may use and disclose your PHI to perform select research activities, provided that certain established measures to protect your privacy are in place.
- **To communicate with you about health-related products and services:** We may use your PHI to communicate with you about health-related products and services that we provide or are included in your benefits plan. We may use your PHI to communicate with you about treatment alternatives that

BCBSM Privacy Notice

may be of interest to you. These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees and add value to your benefits plan.

- **To our business associates:** From time to time, we engage third parties to provide various services for us. Whenever an arrangement with such a third party involves the use or disclosure of your PHI, we will have a written contract with that third party designed to protect the privacy of your PHI. For example, we may share your information with business associates who process claims or PHI. For example, we may share your information with business associates who process claims or conduct disease management programs on our behalf.
- **To group health plans and plan sponsors:** We participate in an organized health care arrangement with our underwritten group health plans. These plans, and the employers or other entities that sponsor them, receive PHI from us in the form of enrollment information (although we are prohibited from using or disclosing any genetic information for underwriting purposes). Certain plans and their sponsors may receive additional PHI from BCBSM and BCN. Whenever we disclose PHI to plans or their sponsors, they must follow applicable laws governing use and disclosure of your PHI including amending the plan documents for your group health plan to establish the limited uses and disclosures it may make of your PHI.

You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Some uses and disclosures of your PHI require a signed authorization:

- **For marketing communications:** Uses and disclosures of your PHI for marketing communications will not be made without a signed authorization except where permitted by law.
- **Sale of PHI:** We will not sell your PHI without a signed authorization except where permitted by law.
- **Psychotherapy notes:** To the extent (if any) that we maintain or receive psychotherapy notes about you, disclosure of these notes will not be made without a signed authorization except where permitted by law.

Any other use or disclosure of your protected health information, except as described in this Notice of Privacy Practices, will not be made without your signed authorization.

Disclosures you may request

You may instruct us, and give your written authorization, to disclose your PHI to another party for any purpose. We require your authorization to be on our standard form. To obtain the form, call the customer service number on the back of your membership card or call 1-313- 225-9000.

Individual rights

You have the following rights. To exercise these rights, you must make a written request on our standard forms. To obtain the forms, call the customer service number on the back of your mem-bership ID card or call 1-313-225-9000. These forms are also available online at www.bcbsm.com.

- **Access:** With certain exceptions, you have the right to look at or receive a copy of your PHI contained in the group of records that are used by or for us to make decisions about you, including our enrollment, payment, claims adjudication, and case or medical management notes. We reserve the right to charge a reasonable cost-based fee for copying and postage. You may request that these materials be provided to you in written form or, in certain circumstances, electronic form. If you request an alternative format, such as a summary, we may charge a cost-based fee for preparing the summary. If we deny your request for access, we will tell you the basis for our decision and whether you have a right to further review.

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- **Disclosure accounting:** You have the right to an accounting of certain disclosures of your PHI, such as disclosures required by law, except that we are not obligated to account for a disclosure that occurred more than six years before the date of your request. If you request this accounting more than once in a 12-month period, we may charge you a fee covering the cost of responding to these additional requests.
- **Restriction requests:** You have the right to request that we place restrictions on the way we use or disclose your PHI for treatment, payment or health care operations. We are not required to agree to these additional restrictions; but if we do, we will abide by them (except as needed for emergency treatment or as required by law) unless we notify you that we are terminating our agreement.
- **Amendment:** You have the right to request that we amend your PHI in the set of records we described above under Access. If we deny your request, we will provide you with a written explanation. If you disagree, you may have a statement of your disagreement placed in our records. If we accept your request to amend the information, we will make reasonable efforts to inform others, including individuals you name, of the amendment.
- **Confidential communication:** We communicate decisions related to payment and benefits, which may contain PHI, to the subscriber. Individual members who believe that this practice may endanger them may request that we communicate with them using a reasonable alternative means or location. For example, an individual member may request that we send an Explanation of Benefits to a post office box instead of to the subscriber's address. To request confidential communications, call the customer service number on the back of your membership ID card or 1-313- 225-9000.
- **Breach notification:** In the event of a breach of your unsecured PHI, we will provide you with notification of such a breach as required by law or where we otherwise deem appropriate.

Questions and complaints

If you want more information about our privacy practices, or a written copy of this notice, please contact us at:

Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd., MC 1302
Detroit, MI 48226-2998
Attn: Privacy and Security Official
Telephone: 1-313- 225-9000

For your convenience, you may also obtain an electronic (downloadable) copy of this notice online at www.bcbsm.com.

If you are concerned that we may have violated your privacy rights, or you believe that we have inappropriately used or disclosed your PHI, call us at 1-800- 552-8278. You also may complete our Privacy Complaint form online at www.bcbsm.com.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with their address to file your complaint upon request. We support your right to protect the privacy of your PHI. We will not retaliate in any way if you file a complaint with us or with the U.S. Department of Health and Human Services.

Effective Date: Sep 2013

BENEFIT SUMMARIES

This is a general outline of covered benefits and does not include all the benefits, limitations, and exclusions of the policy. If there are any discrepancies between the illustrations contained herein and the insurance carrier proposal or contract, the insurance carrier materials prevail. See insurance company contract for full list of exclusions.

Blue Cross Blue Shield of Michigan

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

MICHIGAN PUBLIC HEALTH INSTI
Simply Blue℠ $500 PPO
Effective Date: On or after January 2024
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.

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 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.

ADM PLANYR JAN;BLUE DENTAL;BLUE VISION;BVFL;DO-PPO;HC (A) LG;INFS LG;PDRX LG;PK023;SB BHOV LG;SB LG;SB-EA-1 LG;SB-ECM-IN$2.5KL;SB-ECM-ON $5K L;SB-OCSM-24 LG;SB-OT-60 LG;SBD-ON 1K/2K LG;SBDIN 500/1K LG;SBOPMIN 6350 LG;SBOPMON12.7K LG;SBTCP204060250L;TTC153060RXCMLG

000019261648

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	$500 for one member, $1,000 for the family (when two or more members are covered under your contract) each calendar year	$1,000 for one member, $2,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $20 copay for office visits and office consultations with a **primary care physician** • $20 copay for **virtual primary care** visits • $40 copay for office visits and office consultations with a **specialist** • $20 copay for medical online visits • $20 copay for chiropractic and osteopathic manipulative therapy • $250 copay for emergency room visits • $60 copay for urgent care visits	• $250 copay for emergency room visits
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	• 30% of approved amount for private duty nursing care • 20% of approved amount for most other covered services	• 50% of approved amount for private duty nursing care • 40% of approved amount for most other covered services
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but **does not** apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	$2,500 for one member, $5,000 for the family (when two or more members are covered under your contract) each calendar year	$5,000 for one member, $10,000 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.
Annual out-of-pocket maximums - applies to deductibles, flat-dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	$6,350 for one member, $12,700 for the family (when two or more members are covered under your contract) each calendar year	$12,700 for one member, $25,400 for the family (when two or more members are covered under your contract) each calendar year **Note:** Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
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), two per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization of female reproductive organs	100% (no deductible or copay/coinsurance)	60% 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)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and Well-child 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	60% 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	

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Benefits	In-network	Out-of-network
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note:** Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary **Note: Virtual Primary Care** visits by a non-BCBSM selected vendor are not covered.	• $20 copay for each office visit with a **primary care physician** (in person or virtual) • $20 copay for each **virtual primary care** visit for members 18 years of age or older, by a BCBSM selected vendor • $40 copay for each office visit with a **specialist** **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible
Online visits - by physician must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered. Not all services delivered virtually are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	$20 copay per online visit	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	• $20 copay for each office consultation with a **primary care physician** • $40 copay for each office consultation with a **specialist** **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible

Urgent care visits

Benefits	In-network	Out-of-network
Urgent care visits	$60 copay for each urgent care visit **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	$250 copay per visit (copay waived if admitted)	$250 copay per visit (copay waived if admitted)
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% 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)	60% after out-of-network deductible
Postnatal care	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% 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 **Note:** Nonemergency services must be rendered in a **participating** hospital.	80% after in-network deductible Unlimited days	60% after out-of-network deductible
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible

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Benefits	In-network	Out-of-network
Chemotherapy	80% after in-network deductible	60% 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	80% after in-network deductible	80% after in-network deductible
	Limited to a maximum of 120 days per member per calendar year	
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
	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	80% after in-network deductible	80% 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	80% after in-network deductible	80% 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	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization of male reproductive organs **Note:** For voluntary sterilization of female reproductive organs, see **"Preventive care services."**	80% after in-network deductible	60% after out-of-network deductible
Elective abortions	80% after in-network deductible	60% 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% (no deductible or copay/coinsurance)	100%(no deductible or copay/coinsurance) in designated facilities **only**
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible

Benefits	In-network	Out-of-network
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	80% after in-network deductible	60% after out-of-network deductible
Cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit or medical online visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit or medical online visit, we will process the claim under your office visit or medical online visit benefit.

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance use disorder treatment	80% after in-network deductible	60% 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	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	80% after in-network deductible	80% after in-network deductible in participating facilities **only**
• Online visits **Note:** Online visits by a non-BCBSM selected vendor are not covered.	80% after in-network deductible	60% after out-of-network deductible
• Physician's office	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	80% after in-network deductible	60% 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 behavior analysis (ABA) treatment - when rendered by an approved licensed behavior analyst - subject to preauthorization **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	80% after in-network deductible	80% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

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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.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	$20 copay per visit **Note:** Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam	60% 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	80% after in-network deductible	60% 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:** Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. **Note:** DME items 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. For a list of covered DME items required under PPACA, call BCBSM.	80% after in-network deductible	60% after out-of-network deductible
Prosthetic and orthotic appliances **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	80% after in-network deductible	60% after out-of-network deductible
Private duty nursing care	70% after in-network deductible	50% after out-of-network deductible
Approved infertility services - including medical evaluation, diagnostic services and assisted reproductive technology treatment to manage infertility.	80% after in-network deductible	60% after out-of-network deductible

MICHIGAN PUBLIC HEALTH INSTITUTE
Simply Blue $500 PPO Rx Plan
Effective Date: On or after January 2024
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/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.

Prescription Drug Discount Program - Prescription drug manufacturers provide coupon programs for certain medications. Your benefit plan requires you to take advantage of BCBSM-approved coupon programs for select medications. This benefit may lower the cost-sharing typically required for these drugs. Your out-of-pocket expense will be no more than your benefit cost-sharing. When a manufacturer coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.

NOTE: Adjustments may be required to accurately reflect your annual out-of-pocket maximum to reflect your true out-of-pocket cost.

This program may be discontinued at any time if it is no longer supported by the vendor.

Specialty Pharmaceutical Drugs - The pharmacy for **specialty drugs** is AllianceRx Walgreens Pharmacy, 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. You may also obtain specialty drugs through a Walgreens retail pharmacy as long as the drug is available at that location. You may want to call ahead to confirm availability at the location. ***If you go to a non-AllianceRx Walgreens Pharmacy, you may be responsible for 100% of the cost of the specialty drug.*** A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call AllianceRx Walgreens Pharmacy 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". 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)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

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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
Generic or select prescribed over-the-counter drugs	1 to 30-day period	You pay $15 copay	You pay $15 copay	You pay $15 copay	You pay $15 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $30 copay	No coverage	No coverage
	84 to 90-day period	You pay $30 copay	You pay $30 copay	No coverage	No coverage
Preferred brand-name drugs	1 to 30-day period	You pay $30 copay	You pay $30 copay	You pay $30 copay	You pay $30 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $60 copay	No coverage	No coverage
	84 to 90-day period	You pay $60 copay	You pay $60 copay	No coverage	No coverage
Nonpreferred brand-name drugs	1 to 30-day period	You pay $60 copay	You pay $60 copay	You pay $60 copay	You pay $60 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay $120 copay	No coverage	No coverage
	84 to 90-day period	You pay $120 copay	You pay $120 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	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
State-controlled drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
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	75% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

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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
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	75% of approved amount
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	75% of approved amount
Other FDA-approved **brand-name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the 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.	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

* 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. • **Generic drug tier** - This tier 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. • **Preferred brand-name drug tier** - This tier includes non-specialty preferred brand-name drugs. These drugs are more expensive then generic and members pay more for them. • **Nonpreferred brand-name drug tier** - This tier includes non-specialty brand-name drugs for which there's either a generic alternative or a more cost-effective preferred brand-name drug available. Members pay more for these nonpreferred brand-name drugs.

Features of your prescription drug plan

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**.
Maximum allowable cost drugs	When you receive a generic maximum allowable cost (MAC) drug from an in-network pharmacy, you pay your cost share as noted in your coverage. However, if you request a brand-name drug and the prescriber did not write "Dispense as Written" or "DAW" on the prescription, you must pay the difference between the maximum allowable cost and the Blue Cross Blue Shield of Michigan approved amount for the brand-name drug, plus your copayment. If the prescriber wrote "Dispense as Written" or "DAW" on the prescription, we will pay the pharmacy the approved amount for the brand-name drug, after deduction of your copayment.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

Blue Cross Blue Shield of Michigan

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

MICHIGAN PUBLIC HEALTH INSTITUTE
Simply Blue HDHP PPO
Effective Date: 01/01/2024

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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 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.

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.

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 until the end of the year in which they turn age 26

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 or $4,000 for a family contract (two or more members) each calendar year **(no 4th quarter carry-over)**	$4,000 for a one-person contract or $8,000 for a family contract (two 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	$2,000 for a one-person contract $4,000 for a family contract (two or more members) each calendar year	$5,000 for a one-person contract $10,000 for a family contract (two 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), two per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

Benefits	In-network	Out-of-network
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	80% coinsurance 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% coinsurance after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% coinsurance 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% coinsurance 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% coinsurance after out-of-network deductible
	One routine colonoscopy per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	100% after in-network deductible	80% coinsurance after out-of-network deductible

Benefits	In-network	Out-of-network
Online visits - must be medically necessary **Note:** Online visits by a non-BCBSM selected vendor are not covered	100% after in-network deductible	80% coinsurance after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% coinsurance after out-of-network deductible
Office consultations - must be medically necessary	100% after in-network deductible	80% coinsurance after out-of-network deductible
Urgent care visits - must be medically necessary	100% after in-network deductible	80% coinsurance after out-of-network deductible

Emergency medical care

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

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	80% coinsurance after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% coinsurance after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% coinsurance 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% coinsurance after out-of-network deductible
Postnatal care	100% (no deductible or copay/coinsurance)	80% coinsurance after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% coinsurance 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 **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% after in-network deductible Unlimited days	80% coinsurance after out-of-network deductible
Inpatient consultations	100% after in-network deductible	80% coinsurance after out-of-network deductible

Benefits	In-network	Out-of-network
Chemotherapy	100% after in-network deductible	80% coinsurance 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% coinsurance after in-network deductible
	Limited to a maximum of 90 days per member per calendar year	
Hospice care	100% after in-network deductible	100% coinsurance 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% coinsurance 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% coinsurance 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% coinsurance after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% coinsurance 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% coinsurance after out-of-network deductible
Elective abortions	100% after in-network deductible	80% coinsurance 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% coinsurance 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% coinsurance after out-of-network deductible

Benefits	In-network	Out-of-network
Specified oncology clinical trials **Note:** BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% coinsurance after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% coinsurance 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 use disorder treatment	100% after in-network deductible	80% coinsurance 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% coinsurance after out-of-network deductible
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% coinsurance after in-network deductible in participating facilities **only**
• Online visits **Note:** Online visits by a non-BCBSM selected vendor are not covered	100% after in-network deductible	80% coinsurance after out-of-network deductible
• Physician's office	100% after in-network deductible	80% coinsurance after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities **only**	100% after in-network deductible	80% coinsurance 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 behavior analysis (ABA) treatment - when rendered by an approved licensed behavior analyst - 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.	100% after in-network deductible	100% coinsurance after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	100% after in-network deductible	80% coinsurance after out-of-network deductible
	Physical, speech and occupational therapy **with an autism diagnosis** is unlimited	
Other covered services, including mental health services, for autism spectrum disorder	100% after in-network deductible	80% coinsurance after out-of-network deductible

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% coinsurance after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% coinsurance after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible	80% coinsurance 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% coinsurance 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:** Reference the Find A Doctor tool at bcbsm.com for in-network Durable Medical Equipment providers. **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	80% coinsurance after out-of-network deductible
Prosthetic and orthotic appliances **Note:** Reference the Find A Doctor tool at bcbsm.com for in-network Prosthetics/Orthotics providers.	100% after in-network deductible	80% coinsurance after out-of-network deductible
Private duty nursing care	100% after in-network deductible	80% coinsurance after out-of-network deductible
Approved infertility services - including medical evaluation, diagnostic services and assisted reproductive technology treatment to manage infertility.	100% after in-network deductible	80% coinsurance after out-of-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 Pharmacy, 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 Pharmacy will handle mail order prescriptions only for specialty drugs. You may obtain specialty drugs through a Walgreens retail pharmacy as well as long as the drug is available at that location. You may want to call ahead to confirm availability at the location. ***If you go to a non-AllianceRx Walgreens Pharmacy, you may be responsible for 100% of the cost of the specialty drug.*** 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 Pharmacy 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 required 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
Copay/Coinsurance	1 to 30-day period	After deductible is met, you pay nothing	After deductible is met, you pay nothing	After deductible is met, you pay nothing	After deductible is met, you pay nothing
	31 to 83-day period	No coverage	After deductible is met, you pay nothing	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay nothing	After deductible is met, you pay nothing	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
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

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
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

Clinical 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.
Prescription drug preferred therapy	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications **before** prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication. Before filling your **initial** prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at **bcbsm.com/pharmacy, along with the preferred medications.** If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect **all** targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.
Maximum allowable cost drugs	When an in-network pharmacy fills a prescription with a MAC drug, we will pay the pharmacy the maximum allowable cost of the drug after minus your cost share.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

Blue Cross Blue Shield of Michigan

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MICHIGAN PUBLIC HEALTH INSTITUTE
Dental Coverage
Effective Date: On or after January 2024
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.

Dentist information
With Blue Dental PPO, you can choose any licensed dentist anywhere. However, you'll get the best coverage and save the most money when you choose a Tier 1 PPO (in-network) dentist.

You have outstanding access to thousands of Tier 1 PPO dentists across the country through the Blue Dental PPO network. Tier 1 PPO dentists agree to accept our PPO approved amount as full payment for covered services, so you'll pay your applicable coinsurance and deductible amounts. To find a Tier 1 PPO dentist near you, log into your member account at **bcbsm.com** or call **1-888-826-8152.**

If you go to a non-PPO dentist, you can still save money by choosing a Tier 2 participating non-PPO (out-of-network) dentist. Tier 2 dentists participate with us on a "per claim" basis through our Blue Par Select (BPS) arrangement. They accept our BPS approved amount as full payment for covered services, so you'll pay your applicable coinsurance and deductible amounts. To find a Tier 2 participating non-PPO dentist near you, log into your member account at **bcbsm.com**. You should ask your dentist if they participate with BCBSM before every treatment.

Note: If you go to a nonparticipating dentist, you 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	25%
• Class III services	50%
• Class IV services	50%
Dollar maximums • Annual maximum for Class I, II and III services	$2,000 per member
• Lifetime maximum for Class IV services	$2,000 per member

ADM PLANYR JAN;BLUE DENTAL;BLUE VISION;BVFL;DO-PPO;HC (A) LG;INFS LG;PDRX LG;PK023;SB BHOV LG;SB LG;SB-EA-1 LG;SB-ECM-IN$2.5KL;SB-ECM-ON $5K L;SB-OCSM-24 LG;SB-OT-60 LG;SBD-ON 1K/2K LG;SBDIN 500/1K LG;SBOPMIN 6350 LG;SBOPMON12.7K LG;SBTCP204060250L;TTC153060RXCMLG

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. This period begins on the date of the member's first treatment.
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	75% of approved amount **Note:** Replacement fillings covered after 24 months or more after initial filling
Fillings - primary (child) teeth	75% 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	75% of approved amount **Note:** Once every 60 months per tooth
Recementation of crowns, veneers, inlays, onlays and bridges	75% of approved amount **Note:** Three times per tooth per calendar year after six months from original restoration
Oral surgery	75% of approved amount
Root canal treatment	75% of approved amount **Note:** Once per tooth per lifetime; retreatment of previous root canal therapy once per tooth per lifetime.
Scaling and root planing	75% of approved amount **Note:** Once every 24 months per quadrant
Limited occlusal adjustments	75% of approved amount **Note: Limited** occlusal adjustments covered up to five times in any 60 consecutive months
Occlusal biteguards	75% of approved amount **Note:** Once every 12 months
General anesthesia or IV sedation	75% of approved amount **Note:** When medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	75% of approved amount **Note:** Six months or more after denture is delivered
Relining or rebasing of a partial or complete denture	75% of approved amount **Note:** Once per arch in any 36 consecutive months
Tissue conditioning	75% of approved amount **Note:** Once per arch in any 36 consecutive months

ADM PLANYR JAN;BLUE DENTAL;BLUE VISION;BVFL;DO-PPO;HC (A) LG;INFS LG;PDRX LG;PK023;SB BHOV LG;SB LG;SB-EA-1 LG;SB-ECM-IN$2.5KL;SB-ECM-ON $5K L;SB-OCSM-24 LG;SB-OT-60 LG;SBD-ON 1K/2K LG;SBDIN 500/1K LG;SBOPMIN 6350 LG;SBOPMON12.7K LG;SBTCP204060250L;TTC153060RXCMLG

Class III services

Benefits	Coverage
Removable dentures (complete and partial)	50% of approved amount **Note:** Once every 60 months
Bridges (fixed partial dentures) - for members age 16 and older	50% 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	50% 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	50% of approved amount
Minor treatment to control harmful habits	50% of approved amount
Interceptive and comprehensive orthodontic treatment	50% of approved amount
Post-treatment stabilization	50% of approved amount
Cephalometric film (skull) and diagnostic photos	50% 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

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MICHIGAN PUBLIC HEALTH INSTITUTE
Vision Coverage
Effective Date: On or after January 2024
Benefits-at-a-glance

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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

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	$10 copay	Member responsible for difference between approved amount and provider's charge, after $10 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 copay	Reimbursement up to $50 less $5 copay (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	

ADM PLANYR JAN;BLUE DENTAL;BLUE VISION;BVFL;DO-PPO;HC (A) LG;INFS LG;PDRX LG;PK023;SB BHOV LG;SB LG;SB-EA-1 LG;SB-ECM-IN$2.5KL;SB-ECM-ON $5K L;SB-OCSM-24 LG;SB-OT-60 LG;SBD-ON 1K/2K LG;SBDIN 500/1K LG;SBOPMIN 6350 LG;SBOPMON12.7K LG;SBTCP204060250L;TTC153060RXCMLG

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.	$10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $10 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.	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $10 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $70 less $10 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)	$10 copay	Reimbursement up to $210 less $10 copay (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)	$130 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	

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Blue Cross Blue Shield of Michigan

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

MICHIGAN PUBLIC HEALTH INSTITUTE
Hearing Care Coverage
Effective Date: On or after January 2024
Benefits-at-a-glance

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Member's responsibility (deductible and copay)

Benefits	Participating provider	Nonparticipating provider
Deductible	None	Not applicable
Copay	None	Not applicable

Covered services

You **must** receive the following services from **a hearing participating provider**. Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan **and** the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services. In this case, BCBSM will pay the approved amount for hearing aids and related covered services obtained from a nonparticipating provider. You may be responsible for charges that exceed our approved amount.

Benefits	Participating provider	Nonparticipating provider
Audiometric exam - one every 36 months	100% of approved amount	Not covered
Hearing aid evaluation- one every 36 months	100% of approved amount	Not covered
Ordering and fitting the hearing aid (a monaural or binaural hearing aid)- one every 36 months	100% of approved amount	Not covered
Hearing aid conformity test- one every 36 months	100% of approved amount	Not covered

Note: You **must** obtain a medical evaluation (sometimes called a medical clearance exam) of the ear performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. **This evaluation is not covered under your hearing care coverage, so you must pay for this exam unless your medical coverage includes coverage for office visits.**
A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified or in the process of being board certified as an otolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.

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Contact Information

Provider	Benefit	Contact Information	
BCBSM	Medical	Claim and eligibility questions	(877) 354-2583 www.bcbsm.com
		To find PPO providers	(800) 810-2583 www.bcbsm.com
		Virtual Care by Teladoc	(844) 606-1608 www.bcbsm.com/virtualcare
		General Pharmacy Questions	(877) 354-2583 OptumRx: (855) 811-2223
		PillarRx	(636) 614-3126
	Dental	General info / finding a provider	(888) 826-8152 www.bcbsm.com
	Vision	To locate VSP providers	(800) 877-7195 www.vsp.com
WEX	Flexible Spending Accounts Health Savings Account	All issues	(866) 451-3399 (Phone) (866) 451-3245 (Fax) www.wexinc.com
Unum	Life / AD&D Disability Long Term Care	Claim and service questions	(800) 421-0344 www.unum.com
Unum	FMLA	Claim and service questions	(888) 673-9940 www.unum.com
Health Advocate	Health Advocacy Program	All Issues	(866) 695-8622 www.HealthAdvocate.com membersanswers@healthadvocate.com
Unum LifeBalance	Employee Assistance Program (EAP)	All issues	(800) 854-1446 www.unum.com/worklifebalance
HelpNet	Employee Assistance Program (EAP)	All issues	(800) 969-6162 www.bronsonhealth.com/helpnet
Calm.com	Employee Resource	All issues	www.calm.com www.calm.com/b2b/mphi/subscribe
Care.com	Employee Resource	All issues	www.care.com
Unum Assist America	Travel Assistance Program	Travel planning and assistance: Within the U.S.A. Outside the U.S.A. Email address Website	Reference #: 01-AA-UN-762490 (800) 872-1414 (609) 986-1234 medservices@assistamerica.com www.assistamerica.com
Fidelity	403(b)	Customer Service	(800) 343-0860 www.fidelity.com