Non-Union Employee Benefits Guide

2025

This benefit guide provides an overview of Non-Union benefit options for full time, eligible employees. Please review it carefully before making your benefit selections.

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The details in this booklet are intended as an easy to read summary and provide only a general overview of the plan. It is not intended to be a contract. Additional limitations and exclusions may apply. If there is a discrepancy between this booklet and the applicable plan documents, the plan documents will prevail.

ELIGIBLE EMPLOYEES

Non-Union employees, other than GSRP, working 6 hours per day five days per week shall be eligible to enroll in district provided medical, vision, dental and life as determined by the district. Employees must work 37.5 hours/week to receive the full district subsidy. If the employee works less than 37.5 hours/week, they will be responsible for a prorated portion of the district subsidy.

GSRP Teachers are eligible for single subscriber health benefits if the grant funds allow. If coverage is waived, they are not eligible for cash in lieu or other applicable district paid benefits.

NEW HIRE COVERAGE

As a new employee you have 30 days from your start date to make your benefit elections. It is important you review the benefit information and enroll in benefits during your initial new hire eligibility period. If you do not enroll by that deadline, you will not be eligible for coverage until the following open enrollment period unless you experience a qualifying event.

Please complete the paper enrollment form and return to Human Resources as soon as possible. If you have any questions, please contact Shelley Devers at sdevers@ioniaisd.org.

DISTRICT PAID COVERAGE - All eligible employees will be enrolled in the following coverage at NO COST:

- Life & Accidental Death & Disbursement Insurance for $30,000
- **ADMINISTRATORS ONLY:** Long Term Disability (LTD) Insurance

WAIVING MEDICAL INSURANCE

- Full time employees waiving medical coverage will be eligible for Cash in Lieu of (CILO) Insurance payments based on the equivalent of the single subscriber hard cap; currently $321.59 payable on the 1st & 2nd payrolls of the month for 2025.
- If the employee works less than 37.5 hours/week, the CILO will be prorated.

MEDICAL INSURANCE OPTIONS - Insurance premiums are paid a month in advance and may need to be double withheld until caught up. Premiums are withheld on the 1st & 2nd payrolls of the month. Refer to page 3 for plan comparison and pricing.

- Enhanced 250 - A traditional lower deductible plan ($250/$500) with 10% coinsurance; not eligible for HSA
- Enhanced 500 – A traditional lower deductible plan ($500/$1000) with 10% coinsurance; not eligible for HSA
- Enhanced Level - A high deductible plan ($1650/$3300) with optional Health Savings Account (HSA)

DENTAL & VISION COVERAGE – Available at no cost to full time, eligible employees IF enrolled in a medical plan only.

OTHER OPTIONAL INSURANCE – Variable options available at full cost to the employee through American Fidelity annually during open enrollment.

MEDICAL PLAN COMPARISON AND PER PAYROLL PREMIUMS

	Non-Union/GSRP Plans - Western Michigan Health Insurance Pool		
	Plan# 1	Plan# 2	Plan# 3
	BCBS Enhanced 250 001	BCBS Enhanced 500 0008	BCBS Enhanced Level
Plan Highlights	In-Network	In-Network	In-Network
Individual Deductible	$250.00	$500.00	$1,650.00
Family Deductible	$500.00	$1,000.00	$3,300.00*
Coinsurance (Employee Pays)	10%	10%	0%
Individual Coinsurance Max	$1,000.00	$1,000.00	N/A
Family Coinsurance Max	$2,000.00	$2,000.00	N/A
Individual Out of Pocket Max	$2,500.00	$3,000.00	$2,650.00
Family Out of Pocket Max	$5,000.00	$6,000.00	$5,300.00
Covered Benefits			
Preventative Care	100%	100%	100%
Primary Care Physician Office Visit	$10 Copay	$20 Copay	100% after deductible
Specialist Office Visit	$10 Copay	$20 Copay	100% after deductible
Online Visit	$10 Copay	$20 Copay	100% after deductible
Urgent Care Visit	90% after deductible	90% after deductible	100% after deductible
Emergency Room	$50 Copay, then 90% after deductible	$50 Copay, then 90% after deductible	100% after deductible
Chiropractic	90% after deductible	90% after deductible	100% after deductible
PT/OT/ST Combined	90% after deductible	90% after deductible	100% after deductible
Massage Therapy	90% after deductible	90% after deductible	N/A
Prescription Drugs			
Generic/Preferred Specialty Generic	$10 Copay	$10 Copay	$10 Copay after deductible
Preferred or Non-Preferred Brand/Specialty Brand	$40 Copay	$40 Copay	$40 Copay after deductible
Mail Order Prescriptions (90 Days)	2x	2x	2x
Employee Per Payroll Premiums (Withheld on the 1st & 2nd pay of the month for 24 Pays)			
Employee	$77.90	$66.72	$46.21
2-Person	$226.31	$201.16	$155.00
Family	$241.51	$210.20	$152.77

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 001
Division Code(s): 1010, 1110
PPO - ENHANCED 250 001, Rx1, Hearing
Effective Date: 01/01/2025
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. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

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

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

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$250 per member $500 per family	$500 per member $1,000 per family
Copays • Fixed Dollar Copays	$10 copay for : • Professional Urgent care services • Office visits $50 copay for • Facility medical emergency	$50 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	10% up to a maximum of: $1,000 per member $2,000 per family	30% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$2,500 per member $5,000 per family Includes Deductible, Coinsurance and Copays	$2,500 per member $5,000 per family Excludes Deductible and Includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered

Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year Includes 3D Mammography	Covered - 100%	Covered - 70% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 70% after deductible
Well Child Care • 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	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $10 copay	Covered - 70% after deductible
Telemedicine Visits	Covered - 100% after $10 copay	Covered - 70% after deductible
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered	Covered - 100% after $10 copay	Not Covered
Office Consultations	Covered - 100% after $10 copay	Covered - 70% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered - 70% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - $50 copay then 90% after deductible; copay waived if admitted or for an accidental injury	Covered - $50 copay then 90% after deductible; copay waived if admitted or for an accidental injury
Non Emergency use of the Emergency Room	Covered - $50 copay then 90% after deductible	Covered - $50 copay then 70% after deductible
Facility Urgent Care Services	Covered - 90% after deductible	Covered - 70% after deductible
Physician Urgent Care Services	Covered - 100% after $10 copay	Covered - 70% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 90% after deductible	Covered - 90% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 90% after deductible	Covered - 70% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 90% after deductible	Covered - 70% after deductible
Radiation Therapy and Chemotherapy	Covered - 90% after deductible	Covered - 70% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 70% after deductible
Delivery and Nursery Care	Covered - 90% after deductible	Covered - 70% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care Hospital Services and Supplies	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Medical Care	Covered - 90% after deductible	Covered - 70% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 90% after deductible	Covered - 90% after deductible
Home Health Care	Covered - 90% after deductible	Covered - 90% after deductible
Skilled Nursing Limited to 120 days per calendar year	Covered - 90% after deductible	Covered - 90% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 90% after deductible	Covered - 70% after deductible
Bariatric Surgery	Covered - 90% after deductible	Covered - 70% after deductible
Oral Surgery Wisdom teeth extractions	Covered - 90% after deductible	Covered - 90% after in-network deductible
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 90% after deductible	Covered - 70% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 70% after deductible
Expanded Abortion Services	Not Covered	Not Covered

Note: Abortions are not covered if rendered in a location where abortions are not legal.

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 90% after deductible	Covered - 70% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Substance Use Disorder Treatment	Covered - 90% after deductible	Covered - 90% after deductible
Outpatient Mental Health Care	Covered - 100% after $10 copay	Covered - 70% after deductible
Telemedicine Mental Health Care	Covered - 100% after $10 copay	Covered - 70% after deductible
Virtual Care - Online Mental Health Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 100% after $10 copay	Not Covered
Outpatient Substance Use Disorder Treatment	Covered - 100% after $10 copay	Covered - 90% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Pre-authorization required 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)	Covered - 90% after deductible	Covered - 70% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 90% after deductible	Covered - 70% after deductible
Nutritional Counseling	Covered - 90% after deductible	Covered - 70% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 90% after deductible	Covered - 70% after deductible
Chiropractic Spinal Manipulation Services Limited to a maximum of 24 visits per member per calendar year	Covered - 90% after deductible	Covered - 70% after deductible
Durable Medical Equipment	Covered - 90% after deductible	Covered - 70% after deductible
Prosthetic and Orthotic Devices	Covered - 90% after deductible	Covered - 70% after deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 90% after deductible	Covered - 70% after deductible
Private Duty Nursing Care	Covered - 90% after deductible	Covered - 90% after deductible
Allergy Testing and Therapy	Covered - 90% after deductible	Covered - 70% after deductible
Facility Clinic Visit	Covered - 90% after deductible	Covered - 70% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 90% after deductible	Covered - 70% after deductible

Massage Therapy Limited to a maximum of 24 visits per calendar year	Covered - 90% after deductible	Covered - 70% after deductible

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 001
Division Code(s): 1010, 1110
Hearing Care Coverage
Effective Date: 01/01/2025
Benefits-at-a-glance

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Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 001
Division Code(s): 1010, 1110
Prescription Drugs
Effective Date: 01/01/2025
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30-day supply	$10 copay - Generic drugs $40 copay - Brand drugs $0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay
Retail and Mail Order - 90-day supply	$20 copay - Generic drugs $80 copay - Brand drugs
Specialty Drugs **Exclusive Specialty Network**. We only cover specialty drugs when obtained from our exclusive specialty pharmacy network. Covered drugs will be subject to the member's cost-share requirements. If a member obtains specialty drugs from any other provider, they may be responsible for the total cost	Retail 30-day $10 copay - Generic drugs $40 copay - Brand drugs Members are restricted to a 30-day supply and certain specialty drugs are limited to only a 15-day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a 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 with your true out-of-pocket costs.
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 PPACA	Covered - 100%

Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • "Preferred" devices will be covered at 100% of our approved amount. "Nonpreferred" devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies. Also see *Other Covered Services* for Test Strips, Lancets, Needles and Syringes

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 prior authorization) 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. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 008
Division Code(s): 1010, 1110
PPO - ENHANCED 500 008, Rx25, Hearing
Effective Date: 01/01/2025
Benefits-at-a-glance

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Note: A list of services that require approval before they are provided is available online at (https://www.bcbsm.com/important-info). Select **Approving covered Services**

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

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$500 per member $1,000 per family	$1,000 per member $2,000 per family
Copays • Fixed Dollar Copays	$20 copay for : • Professional Urgent care services • Office visits $50 copay for : • Facility medical emergency	$50 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	10% up to a maximum of $1,000 per member $2,000 per family	30% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$3,000 per member $6,000 per family Includes Deductible, Coinsurance and Copays	$3,000 per member $6,000 per family Excludes Deductible and Includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered

Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year Includes 3D Mammography	Covered - 100%	Covered - 70% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 70% after deductible
Well Child Care • 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	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $20 copay	Covered - 70% after deductible
Telemedicine Visits	Covered - 100% after $20 copay	Covered - 70% after deductible
Virtual Care - Online Medical Visits Note: Online Medical visits by a non BCBSM selected vendor are not covered	Covered - 100% after $20 copay	Not Covered
Office Consultations	Covered - 100% after $20 copay	Covered - 70% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered - 70% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - $50 copay then 90% after deductible; copay waived if admitted or for an accidental injury	Covered - $50 copay then 90% after deductible, copay waived if admitted or for an accidental injury
Non-Emergency use of the Emergency Room	Covered - $50 copay then 90% after deductible	Covered - $50 copay then 70% after deductible
Facility Urgent Care Services	Covered - 90% after deductible	Covered - 70% after deductible
Physician Urgent Care Services	Covered - 100% after $20 copay	Covered - 70% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 90% after deductible	Covered - 90% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 90% after deductible	Covered - 70% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 90% after deductible	Covered - 70% after deductible
Radiation Therapy and Chemotherapy	Covered - 90% after deductible	Covered - 70% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 70% after deductible
Delivery and Nursery Care	Covered - 90% after deductible	Covered - 70% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Medical Care	Covered - 90% after deductible	Covered - 70% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 90% after deductible	Covered - 90% after deductible
Home Health Care	Covered - 90% after deductible	Covered - 90% after deductible
Skilled Nursing Limited to 120 days per calendar year	Covered - 90% after deductible	Covered - 90% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 90% after deductible	Covered - 70% after deductible
Bariatric Surgery	Covered - 90% after deductible	Covered - 70% after deductible
Oral Surgery Wisdom teeth extractions	Covered - 90% after deductible	Covered - 90% after in-network deductible
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 90% after deductible	Covered - 70% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 70% after deductible
Expanded Abortion Services	Not Covered	Not Covered

Note: Abortions are not covered if rendered in a location where abortions are not legal.

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 90% after deductible	Covered - 70% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care	Covered - 90% after deductible	Covered - 70% after deductible
Inpatient Substance Use Disorder Treatment	Covered - 90% after deductible	Covered - 90% after deductible
Outpatient Mental Health Care	Covered - 100% after $20 copay	Covered - 70% after deductible
Telemedicine Mental Health Care	Covered - 100% after $20 copay	Covered - 70% after deductible
Virtual Care - Online Mental Health Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered	Covered - 100% after $20 copay	Not Covered
Outpatient Substance Use Disorder Treatment	Covered - 100% after $20 copay	Covered - 90% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Pre-authorization required **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 evaluat on can be performed at an approved autism evaluation center (AAEC).	Covered - 90% after deductible	Covered - 70% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 90% after deductible	Covered - 70% after deductible
Nutritional Counseling	Covered - 90% after deductible	Covered - 70% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 90% after deductible	Covered - 70% after deductible
Chiropractic Spinal Manipulation Services Limited to a maximum of 24 visits per member per calendar year	Covered - 90% after deductible	Covered - 70% after deductible
Durable Medical Equipment	Covered - 90% after deductible	Covered - 70% after deductible
Prosthetic and Orthotic Devices	Covered - 90% after deductible	Covered - 70% after deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 90% after deductible	Covered - 70% after deductible
Private Duty Nursing Care	Covered - 90% after deductible	Covered - 90% after deductible
Allergy Testing and Therapy	Covered - 90% after deductible	Covered - 70% after deductible
Facility Clinic Visit	Covered - 90% after deductible	Covered - 70% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 90% after deductible	Covered - 70% after deductible

Massage Therapy Limited to a maximum of 24 visits per calendar year	Covered - 90% after deductible	Covered - 70% after deductible

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 008
Division Code(s): 1010, 1110
Hearing Care Coverage
Effective Date: 01/01/2025
Benefits-at-a-glance

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Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid.	Covered - 100%	Not Covered
Hearing Aid Conformity Test	Covered - 100%	Not Covered

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 008
Division Code(s): 1010, 1110
Prescription Drugs
Effective Date: 01/01/2025
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30-day supply	$10 copay - Generic drugs $40 copay - Brand drugs $0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Retail and Mail Order - 90-day supply	$20 copay - Generic drugs $80 copay - Brand drugs
Specialty Drugs **Exclusive Specialty Network:** We only cover specialty drugs when obtained from our exclusive specialty pharmacy network. Covered drugs will be subject to the member's cost-share requirements. If a member obtains specialty drugs from any other provider, they may be responsible for the total cost.	Retail 30-day: $10 copay - Generic drugs $40 copay - Brand drugs Members are restricted to a 30-day supply and certain specialty drugs are limited to only a 15-day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a 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 with your true out-of-pocket costs.
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 PPACA	Covered - 100%

Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • "Preferred" devices will be covered at 100% of our approved amount "Nonpreferred" devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies. Also see *Other Covered Services* for Test Strips, Lancets, Needles and Syringes

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 prior authorization) 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. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 036, 037
Division Code(s): 3000, 3100
PPO – ENHANCED LEVEL HSA 036, 037, RX6, HEARING
Effective Date: 01/01/2025
Benefits-at-a-glance

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

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

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract	$1,650 per member $3,300 per family	$3,300 per member $6 600 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	0%	20% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums The full family out of pocket maximum must be met before it is considered satisfied	$2,650 per member $5,300 per family Includes Deductible, Coinsurance and Copays	$5,300 per member $10,600 per family Excludes Deductible and includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered

Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 80% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 80% after deductible
Well Child Care • 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	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after deductible	Covered - 80% after deductible
Telemedicine Visits	Covered - 100% after deductible	Covered - 80% after deductible
Virtual Care - Online Medical Visits Note: Online Medical visits by a non BCBSM selected vendor are not covered	Covered - 100% after deductible	Not Covered
Office Consultations	Covered - 100% after deductible	Covered - 80% after deductible
Pre Surgical Consultations	Covered - 100% after deductible	Covered - 80% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after deductible	Covered - 100% after deductible
Non-Emergency use of the Emergency Room	Covered - 100% after deductible	Covered - 80% after deductible
Facility Urgent Care Services	Covered - 100% after deductible	Covered - 80% after deductible
Physician Urgent Care Services	Covered - 100% after deductible	Covered - 80% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 100% after deductible	Covered - 100% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 100% after deductible	Covered - 80% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 100% after deductible	Covered - 80% after deductible
Radiation Therapy and Chemotherapy	Covered - 100% after deductible	Covered - 80% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 80% after deductible
Delivery and Nursery Care	Covered - 100% after deductible	Covered - 80% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 100% after deductible	Covered - 80% after deductible
Inpatient Medical Care	Covered - 100% after deductible	Covered - 80% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100% after deductible	Covered - 100% after deductible
Home Health Care	Covered - 100% after deductible	Covered - 100% after deductible
Skilled Nursing Limited to a maximum of 90 days per calendar year	Covered - 100% after deductible	Covered - 100% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 100% after deductible	Covered - 80% after deductible
Bariatric Surgery	Covered - 100% after deductible	Covered - 80% after deductible
Oral Surgery Wisdom teeth extractions	Covered - 100% after deductible	Covered - 100% after In-network deductible
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 100% after deductible	Covered - 80% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 80% after deductible
Expanded Abortion Services Note: Abortions are not covered if rendered in a location where abortions are not legal.	Not Covered	Not Covered

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 100% after deductible	Covered - 80% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100% after deductible	Covered - 80% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100% after deductible	Covered - 80% after deductible
Telemedicine Mental Health Care	Covered - 100% after deductible	Covered - 80% after deductible
Virtual Care - Online Mental Health Care	Covered - 100% after deductible	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network

Applied Behavior Analysis (ABA) Pre-authorization required **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).	Covered - 100% after deductible	Covered - 80% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 100% after deductible	Covered - 80% after deductible
Nutritional Counseling	Covered - 100% after deductible	Covered - 80% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 100% after deductible	Covered - 80% after deductible
Chiropractic Spinal Manipulation Services Limited to a maximum of 24 visits per member per calendar year	Covered - 100% after deductible	Covered - 80% after deductible
Durable Medical Equipment	Covered - 100% after deductible	Covered - 80% after deductible
Prosthetic and Orthotic Devices	Covered - 100% after deductible	Covered - 80% after deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 100% after deductible	Covered - 80% after deductible
Private Duty Nursing Care	Covered - 80% after deductible	Covered - 80% after deductible
Allergy Testing and Therapy	Covered - 100% after deductible	Covered - 80% after deductible
Facility Clinic Visit	Covered - 100% after deductible	Covered - 80% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 100% after deductible	Covered - 80% after deductible

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 036, 037
Division Code(s): 3000, 3100
Hearing Care Coverage
Effective Date: 01/01/2025
Benefits-at-a-glance

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Member's responsibility (coinsurance)

Benefits	Participating Provider	Non-Participating Provider
Coinsurance	No Coinsurance	Not Covered

Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Participating Provider	Non-Participating Provider
Frequency Limitation	Once every 36 months	
Audiometric Exam	Covered - 100%	Not Covered
Hearing Aid Evaluation	Covered - 100%	Not Covered
Hearing Aid	Covered - 100%	Not Covered
Member may be responsible for the difference in cost between our approved amount and the charge of the hearing aid		
Hearing Aid Conformity Test	Covered - 100%	Not Covered

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 036, 037
Division Code(s): 3000, 3100
Prescription Drugs
Effective Date: 01/01/2025
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Deductible	$1,650 per member $3,300 per family
Retail - 30-day supply	$10 copay after deductible - Generic drugs $40 copay after deductible - Brand drugs $0 copay after deductible – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 80% of the approved amount, less the member's copay.
Retail and Mail Order - 90-day supply	$20 copay after deductible - Generic drugs $80 copay after deductible - Brand drugs
Specialty Drugs **Exclusive Specialty Network**: We only cover specialty drugs when obtained from our exclusive specialty pharmacy network. Covered drugs will be subject to the member's cost-share requirements. If a member obtains specialty drugs from any other provider, they may be responsible for the total cost.	Retail 30-day: $10 copay after deductible - Generic drugs $40 copay after deductible - Brand drugs Members are restricted to a 30-day supply and certain specialty drugs are limited to only a 15-day supply for each fill.
High Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a 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 with your true out-of-pocket costs.

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 PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered
Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • "Preferred" devices will be covered at 100% of our approved amount "Nonpreferred" devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies. Also see *Other Covered Services* for Test Strips, Lancets, Needles and Syringes prescription drug plan will not pay for the same diabetic supplies.

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 prior authorization) 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. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Mandatory maximum allowable cost drugs	If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug **plus** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a non-preferred brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, you pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.

ADN ADMINISTRATORS

PO Box 610
Southfield, MI 48037
248-901-3705

IONIA COUNTY ISD Dental Benefits Plan — Group #9708

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**Plan year January 1 through December 31**
Annual Maximum	$1500 per eligible individual for covered class I, II and III services
Class I Preventive Services – 100%	
Oral Examinations	Twice per plan year
Prophylaxis/Perio Maintenance (Cleaning)	Twice per plan year
Topical Application of Fluoride	Once per plan year to age 18
Space Maintainers	Once per area per lifetime, up to age 19
Class II Restorative Services – 100%	
Bitewing X-Rays	Twice per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 36 months
All Other X-Rays	
Composite and Amalgam fillings**	Once per tooth surface per 12 months
Root Canal Therapy	
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery*	Once per quadrant per 36 months
Oral Surgery and Extractions*	
General Anesthesia or IV Sedation	Medically necessary and with covered oral surgery
Class III Major Services – 75%	
Inlays, Onlays, Crowns**	Once per permanent tooth in 60 months
Complete and Partial Removable Dentures**	Once per arch per 60 months
Fixed Partial Dentures (Bridges)**	Once per area per 60 months
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch
Addition of Teeth to Partial Dentures	
Occlusal Guards	Once per lifetime
Not Covered	
Sealants	
Implants	
TMJ/TMD Treatment	
Orthodontics	

*Certain Oral and Periodontal Surgery covered on Medical Plan first

Deductible – None
Missing Tooth Clause – None
12 Month Billing Limitation
Waiting Periods – None
COB – Standard

**Composite, porcelain and ceramic not covered for posterior teeth, alternate benefit applies
**Prosthetics are considered on seat/delivery date

****Note – Quotes of benefits do not constitute a guarantee of payment. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitation. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $200.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

National Vision Administrators, L.L.C.

Your NVA Vision Benefit Summary

Ionia County ISD
Effective 03/01/2022
Group Number #51141

Schedule of Vision Benefits

Examination Once Every Plan Year	• Covered 100% After $6.50 Copay	Reimbursed Amount • Up to $28.50 (OD) • Up to $38.50 (MD)
Lenses Once Every Plan Year	Standard Glass or Plastic	
• Single Vision	• Covered 100% After $18 Copay	• Up to $29
• Bifocal		• Up to $51
• Trifocal		• Up to $63
• Lenticular		• Up to $75
• Solid/Gradient Tint	• Covered 100%	
Single Vision		• Up to $6
Bifocal		• Up to $10
Trifocal		• Up to $12
Lenticular		• Up to $14
• Standard Transition	• Covered 100%	• Up to $33
• Photogrey(Glass)	• Covered 100%	• Up to $8
• Polarized	• Covered 100%	
Single Vision		• Up to $18
Bifocal		• Up to $30
Trifocal		• Up to $38
Lenticular		• Up to $44
Frame Once Every Plan Year	Retail Allowance • Up to $65 (20% discount off balance)*	• Up to $44
Contact Lenses Once Every Plan Year	In lieu of Lenses & Frame	In lieu of Lenses & Frame
Elective Contact Lenses	• Up to $150 Retail⊙ (15% discount (Conventional) or 10% discount (Disposable) off balance)**	• Up to $150
Medically Necessary***	• Covered 100%	• Up to $200

How Your Vision Care Program Works

Eligible members and dependents are entitled to receive a vision examination and one pair of lenses and a frame or contact lenses once every plan year.

At the start of the program, if authorized by your employer you may receive identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, you must indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care professional, please visit our website at www.e-nva.com or download our mobile app by searching NVA Vision, or contact NVA's Customer Service Department toll-free at 1.800.672.7723 (TDD line 1-888-820-2990) or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 51141000001 or the group number on the identification card and enter in your search parameters. It's that easy!

*Does not apply to Wal-Mart / Sam's Club or LensCrafters locations or for certain proprietary brands. **Does not apply to Wal-Mart/Sam's Club, LensCrafters, Contact Fill (NVA Mail Order) or certain locations at: Target, Sears, Pearle, & K-Mart and may be prohibited by some manufacturers. ***Pre-approval from NVA required.

⊙Additional professional services related to contact lenses (also known as fitting fees) would be included in the contact lens allowance shown above.

Fixed prices/courtesy discount do not apply at Walmart/Sam's Club and LensCrafters locations.
Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below.

- $50 Progressive Lenses Standard
- $100 Progressive Lenses Premium
- $10 Standard Scratch Resistant Coating
- $12 Ultraviolet Coating
- $40 Standard Anti-Reflective
- $30 Polycarbonate (Multi-Focal)
- $25 Polycarbonate (Single Vision)
- $55 High Index
- $30 Blended Bifocal (Segment)

For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price. Fixed prices are available in-network only. Discounts are not insured benefits. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers. Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Get a Better View

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations: The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers

Hearing Discount: You will receive up to 60% savings at participating provider locations through NationsHearing®

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order, however, you may get even better pricing on contact lenses through Contact Fill

Your NVA EyeEssential® Plan Discount – In Network Only

Service	Participating Provider	Lens Options
	Member Cost:	
Eye Examination:	Retail Less $10	$12 Solid Tint/ Gradient Tint $50 Standard Progressive Lenses $75 Polarized Lenses $65 Transitions Single Vision Standard $70 Transitions Multi Focal Standard $15 Standard Scratch Coating $12 UV Coating $35 Polycarbonate $45 Standard Anti-Reflective
Contact Lens Fitting:	Retail Less 10%	
Lenses:	Glass or Plastic	
Single Vision	$35.00	
Bifocal	$55.00	
Trifocal or Lenticular	$70.00	
Frame:	Retail Less 35%	
Contact Lenses*:	**Member Cost:**	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U and C) price.

Wal-Mart / Sam's Club and Lenscrafters stores do not provide additional discounts

Some optometrist affiliated with Optical Retail locations (i.e. LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

At NVA, We Work Only for Our Clients.

The proposed vision insurance program is insured through Fidelity Security Life Insurance Company (FSL) Kansas City, MO. Fidelity Security Life Insurance Company brings over 45 years of underwriting experience in the insurance industry since 1969.

Fidelity Security Life Insurance Company has been rated A (Excellent), based on an analysis of financial position and operating performance, by A.M. Best Company, an independent analyst of the insurance industry. For the latest rating, access www.ambest.com.

Some provisions benefits, exclusions or limitations listed herein may vary depending on your state of residence
Exclusions: The following benefits are not payable under this Policy for services or materials connected with or charges arising from (unless otherwise indicated in the Proposed Schedule of Benefits) Aniseikonic Lenses; Subnormal visual aids, Orthoptics, vision training, and any associated supplemental testing; Broken, lost or stolen lenses, contact lenses, or frames will not be replaced except in the next Benefit Frequency when Vision Materials would next become available; Services or materials provide as a result of any Workers' Compensation law, or similar legislation or required by any governmental agency or program whether federal, state or subdivisions thereof; Services rendered after the date an insured Person ceases to be covered under the policy, except when Vision Materials ordered before coverage ended are delivered and the services rendered to the Insured Person are within 31 days from the date of such order; Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan; Medical and/or surgical treatment of the eye, eyes or supporting structures; Two pair of glasses in lieu of bifocals; Plano (non-prescription) lenses; non-prescription sunglasses

Limitations: Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider, such fees or materials are not covered under the Policy. For Contact Lenses, any remaining balance may be used within the same Benefit Frequency. Where the Insured Person previously utilized an In-Network Provider, the remaining balance must be used with the same or any other In-Network Provider. Where the Insured Person previously utilized an Out-of-Network Provider, the remaining balance must be used with the same or any other Out-of-Network Provider

National Vision Administrators, L.L.C. • PO Box 2187 • Clifton, NJ 07015
Web: www.e-nva.com • Toll-Free: 1.800.672.7723

This document is intended as a program overview only and is not a certified document of the individual plan parameters.

Policy Nos. VC-108, VC-109, VC-110; Form NOS. M-9142, M-9143, M 9144.

051514

Enrollment Form

THE POOL
Western Michigan Health Insurance

Name of employer/plan sponsor: WMHIP – Ionia ISD		**Group #:** 71565	**Plan choice:** ____ Enhanced 250 001 ____ Enhanced HSA Level 036/37 ____ Enhanced 500 008
Check one:	☐ Initial ☐ Change	☐ Termination	☐ Reinstatement
Reason for change (check all that apply): ☐ Initial Eligibility Following Hire ☐ Open Enrollment ☐ Status Change: _____ ☐ Other _____			**Date of hire:** **Occupation:** **Hours worked weekly:** **Effective date of coverage or change:**
Employee Name (last, first, middle initial):			**Gender:** ☐ Female ☐ Male **Date of Birth:** **Social Security Number:**
Street Address:			**Telephone (including area code):**
Email Address:			Work Home
City:			**State:** **ZIP Code:**

Dependent's Name	Relationship to Child	Birth Date	Social Security Number	Gender	Termination Date
Spouse:				☐ Female ☐ Male	
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	
Child:	☐ Natural ☐ Step			☐ Female ☐ Male	

Employee certification and signature:

- To the best of my knowledge and belief, the information I have provided on this form is correct. I hereby certify that the dependents listed above are my dependents within the definition contained in the group Plan of my employer. I agree to notify the Plan Administrator if and when there is a change in any dependent's status
- The current benefits have been explained to me thoroughly. I hereby request coverage as outlined above under the Plan offered by my employer for which I am or may become eligible, and I authorize my employer to deduct any required contribution from my earnings.
- I understand that under IRS regulations, I cannot change or revoke this election during the plan year unless I experience a "change in status" or other such events permitted by the Plan. I understand that it is my responsibility to notify the Human Resource Department of a Special Enrollment Event within 30 days of the Event taking place.
- **I understand that any person who knowingly and with intent to defraud submits an application or files a claim containing any materially false or misleading information commits a fraudulent act, which is a crime.**
- I understand that in the event of any discrepancy between this enrollment form and any policy in which I am enrolling, the terms of the policy shall apply.
- I understand my coverage begins on the effective date assigned by the Administrator, provided I have met all eligibility requirements

Employee signature:	**Date:**

Ionia County ISD

Health Equity HSA Payroll Deduction Form

Plan Year – January 1, 2025 thru December 31, 2025

2025 Annual HSA Contribution Maximums	
Coverage Type	**Total Annual Maximum Contribution***
Self-Only	**$4,300**
2 Person or Full Family	**$8,550**

***Catch-up contribution (age 55+): additional $1,000/year**

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your high deductible health plan. If you change from a qualifying high deductible plan to a non-qualifying low deductible plan, your HSA deductions will terminate.

For further information, please contact Health Equity Member Services at 866.346.5800.

Below is an <u>optional</u> chart to help you calculate the amount you would like withheld.

Total Elected Amount	Divided by	Number of pay periods	=	Amount to Withhold Per Pay **(write this amount below)**
	/		=	

Please complete this section *and* return it to the Business Office:

Employee's Name: _____

Please withhold $_____ from my bi-weekly payroll and apply the funds to my Health Equity HSA. I understand this amount will continue unless I complete a new form or change to a non-qualifying low deductible plan.

Employee's Signature: _____ **Date:** _____

IMPORTANT NOTIFICATIONS THAT APPLY TO ALL BENEFIT ELIGIBLE EMPLOYEES

Federal law requires that employers provide specific disclosures to employees about their benefit plans and enrollment rights that may be available. Please review the information contained in this packet.

Newborn's and Mother's Health Protection Act

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

Women's Health & Cancer Rights Act

If you receive plan benefits in connection with a mastectomy, you are entitled to coverage for the following under the plan:

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

These benefits will be provided subject to the same deductible and coinsurance applicable to her medical and surgical benefits provided under this plan.

Special Enrollment Events/Changes in Family Status

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

IMPORTANT NOTIFICATIONS THAT APPLY TO ALL BENEFIT ELIGIBLE EMPLOYEES

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP).

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1 855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child_health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

IMPORTANT NOTIFICATIONS THAT APPLY TO ALL BENEFIT ELIGIBLE EMPLOYEES

IOWA – Medicaid and CHIP (Hawki)	NEBRASKA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618- 5488 (LaHIPP)	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public- assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people we-serve/children-and- families/health-care/health-care-programs/programs-and- services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

IMPORTANT NOTIFICATIONS THAT APPLY TO ALL BENEFIT ELIGIBLE EMPLOYEES

MONTANA – Medicaid	OREGON – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800 699 9075
PENNSYLVANIA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP_Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

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	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

IMPORTANT NOTICE FROM IONIA COUNTY ISD
YOUR CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

Important Notice About Your Prescription Drug Coverage Under the Plan 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 under the Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current coverage will not be affected. Here is a summary of options for Medicare Eligible Employees (and/or Dependents):

- You can keep your existing medical and prescription drug Plan coverage and choose not to enroll in a Part D plan. In this case, your claims continue to be paid by the Plan.
- You can keep your existing medical and prescription drug Plan coverage and enroll in a Part D plan. In this case, as an active employee (or dependent of an active employee), your Plan coverage continues to pay primary on your claims (pays before Medicare Part D).

- You can drop this Plan's coverage and enroll in a Part D plan. In this case, Medicare is your primary coverage. If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may enroll back into the Plan during an open enrollment period under the Plan.
- Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

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 under this Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage... Contact your HR Department at 248-822-8111 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 your Employer 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).