Genesee HEALTH SYSTEM
Hope and health in the community

MAIN CAMPUS
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November 2, 2021

RE: Non-Medicare Retiree Options
Retired Prior to 11/20/2007

2022 Retiree Open Enrollment is under way 11/08/2021 through 11/19/2021. For the 2022 Plan Year, GHS is offering two plans: Health Alliance Plan (HAP) High Deductible Health Plan HMO (HAP HDHP HMO) and Health Alliance Plan High Deductible Health Plan PPO (HAP HDHP PPO). Open Enrollment information and other reference documents are listed on the GHS website at www.genhs.org under the Useful Pages heading, CMH/GHS Retirees tab.

Due to the ongoing Covid Pandemic, we are asking that you return enrollment forms by email or by using the self-addressed stamped envelope included with this letter. For anyone needing enrollment assistance you may utilize email, tplantz@genhs.org, or reach out to Tami directly at (810) 496-5603.

Critical: Review the page titled CMH/GHS Retiree Options. This document describes how the healthcare selection made by the retiree affects the plan selections available to your eligible spouse or dependent, if applicable.

Please review the Healthcare Options Under "65" Retirees benefit comparison sheet (located on the GHS retiree website), as well as all other information located on the GHS retiree website to assist you in making your decision in selecting the plan that best meets your needs. The HAP HDHP PPO is a national plan, and the HAP HDHP HMO plan is available to MI residents only.

Please ensure that you complete and return the GHS Enrollment Form and other forms and documents as are appropriate by **Monday, November 22, 2021.** We have provided additional information on the GHS retiree website which you may find informative and beneficial. Dental and Vision coverage options remain the same as in 2021.

As a final reminder, if you will be eligible for an HSA contribution, your HSA account must be open and active.

If you have any questions or concerns, you may contact Tami Plantz at (810) 496-5603 or Sandy Sweet at (810) 496-5759.

Sincerely,

Sandra Sweet

Sandra Sweet, Accounting Manager
Genesee Health System
Enclosures

GENESEE HEALTH SYSTEM

Retiree Under 65– Retired Prior to 11/20/2007

2022 INSURANCE ENROLLMENT

Enrollment/Change Status: Open Enrollment ☐ Other Period ☐

Retiree Name:	Social Security #			
Address:	Telephone #			
City, State ZIP:	Date of Birth			

MEDICAL INSURANCE OPTIONS ***HAP=Health Alliance Plan***	**Single**	**Two-Party**	**Family**	Effective Date:	GHS Initials
*HAP High Deductible Health Plan (PPO)	☐	☐	☐	(For Official Use Only)	
*HAP High Deductible Health Plan (HMO) (**Base Plan** is HMO version)	☐	☐	☐		
OPTICAL/DENTAL INSURANCE					
Blue Cross Blue Shield of Michigan	☐	☐	☐	Effective Date:	GHS Initials:
Delta Dental of Michigan	☐	☐	☐	Effective Date:	GHS Initials

CONTRACT CONTINUATION □ ***ADDITION*** □ ***DELETION*** □

Last Name (Print)	**First Name**	**Relation**	**F/M**	**SSN**	**DOB**	**Primary Care Physician**
		SELF				
		SPOUSE				
		DEPEND				
		DEPEND				

Please Note: Initial spouse and dependent coverage is subject to verification of eligibility. Eligibility documents include a copy of marriage license and social security card for spouse; and birth certificate and social security card for dependent. Provisions and penalties described in the "No Dual Hospital/Medical Coverage Certification" form apply. Please see the CMH/GHS Retiree Options document included in the packet for further explanation of insurance selections.

I certify that I have read and understand the information on this form. The statements and answers given are complete and correct to the best of my knowledge and belief. No information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the insurance carriers will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made false statements or misrepresentations, or have failed to disclose any material fact, the carriers will be entitled to declare the health care contract void and refuse all allowance of the benefits to any person under the contract. I understand that anyone listed above, seeking enrollment into a GHS sponsored health plan is prohibited from being enrolled in any other hospital/medical coverage, including Medicare.

Please contact Tami Plantz (810) 496-5603 or Sandy Sweet (810) 496-5759 for questions.

Retiree's Signature (Do Not Print)	Date	Employer's Signature	Date

NO DUAL HOSPITAL / MEDICAL COVERAGE CERTIFICATION

I have exercised my option to enroll in one of the Genesee Health System sponsored Hospital/Medical Plans. I understand that anyone enrolled in a High Deductible Health Plan (HDHP) covered under a Health Savings Account (HSA) is prohibited from participating in the plan if any one of those enrolled has other hospital/medical insurance. All enrollees are prohibited from having dual hospital/medical insurance due to federal requirements for participation in a HDHP w/ HSA. In addition, GHS prohibits retirees and anyone else on their hospital/medical policy from maintaining dual insurance coverage. Medicare Part A and/or Part B are still considered dual insurance unless enrolled into a Medicare Advantage (MA) plan sponsored by GHS. It is the responsibility of the retiree to notify the GHS Payroll Department within 30-days of being eligible or enrolled into Medicare, and provide this information annually during the annual open enrollment period. Failure to notify GHS of your (or your family members') Medicare eligibility and/or enrollment could result in negative federal tax implications for the retiree.

In accordance with the GHS prohibition against dual hospital/medical coverage, I hereby certify that neither I, my spouse, nor any dependent under age 19, nor any qualified adult child aged 19-26 listed on the enrollment application form have any other hospital/medical coverage. Regarding the possible enrollment of a qualified adult child aged 19-26, the child is governed by the rules associated with plans which qualify to be "grandfathered" or "not grandfathered". I also understand that if I have failed to disclose or falsified documentation regarding this paragraph, that GHS will bill me the amount overpaid by GHS for myself, spouse, dependent or qualified adult child aged 19-26 that was inappropriately dual covered. Falsification of documents constitutes fraud and is subject to termination.

I understand that GHS will require documentation of involuntary termination of coverage if I am transferring either my spouse, dependent, or qualified adult child aged 19-26 to a GHS hospital/medical plan from another employer paid source, outside the GHS open enrollment period.

I understand that I must notify the Payroll Department within 30 days of any qualifying event, which would require a spouse, dependent, or qualified adult child aged 19-26 to be removed from my insurance. I also understand that if I do not comply with this rule that GHS will bill me the amount overpaid by GHS for a spouse, dependent, or qualified adult child aged 19-26 that should have been removed from my insurance. Charges will become effective as of the last day of the month in which the qualifying event occurs.

I understand that I must notify the Payroll Department within 30 days of any qualifying event, which would require a spouse, dependent, or qualified adult child aged 19-26 to be added to my insurance. I also understand that if I do not comply with this rule, the spouse, dependent, or qualified child aged 19-26 must wait until the GHS open enrollment period to be added to my insurance.

If adult child is eligible to enroll in your group hospital/medical health plan, then coverage <u>will terminate on the last day of the month in which the child turns 26</u>, or child becomes otherwise ineligible.

_____
Name Printed

_____ _____ _____
Signature Date GHS INITIALS

Designation of Beneficiary Form

Employer/Group Section (To be completed by the employer/plan administrator. Required fields are marked with an asterisk(*).)

*Employer/Group Name: Genesee Health System	Group ID: G000B2R2

Employee/Member Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name:	*First Name:	MI:
*Social Security Number:	*Birth Date (MM/DD/YYYY):	*Gender:	*Marital Status:
*Street Address:	Email Address:
*City:	*State:	*ZIP Code:	Telephone: ( ) -

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

Subject to the terms of the group contract(s), between Mutual of Omaha or a company affiliated with Mutual of Omaha and said employer, I request that the following beneficiary (beneficiaries) be substituted under said contract(s) as my designated beneficiary (beneficiaries), in lieu of any and all beneficiaries previously named by me.

If more than one beneficiary is named, the beneficiaries shall share benefits equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Unless otherwise expressly provided, if any beneficiary designated below predeceases me, the share which such beneficiary would have received if such beneficiary had survived me shall be payable equally to the remaining designated beneficiary or beneficiaries. If no designated beneficiary survives me, the beneficiary shall be determined as prescribed in the group contract(s).

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	Address of Beneficiary (Address, City, State, ZIP)	Benefit Percentage (%)
				Percentage Total:	100%

Agreement and Signature

I understand that this Designation of Beneficiary shall apply to all insurance contracts issued to me by Mutual of Omaha or a company affiliated with Mutual of Omaha, unless I make a separate designation for each coverage, either on or after the date of this designation. I also understand that this Designation of Beneficiary is subject to change as provided in the group contract(s).

By signing below, I acknowledge that (a) I understand and agree to the terms of this form as noted above; and (b) this Designation of Beneficiary is effective as of the date submitted.

SIGNATURE OF EMPLOYEE/MEMBER _____ **DATE**_____/_____/_____

CMH/GHS RETIREE OPTIONS

2022 Retiree Healthcare Enrollment Drives Options Available to Spouse

IMPORTANT - Please read carefully! As a Retiree from CMH/GHS, you are the reason and the *pathway* for your potentially eligible spouse and/or child(ren) to enroll in a GHS sponsored healthcare plan. The selection of a healthcare plan made by the Retiree *drives the options* an eligible spouse/child might be enrolled into. What follows are several examples of healthcare enrollment decisions a Retiree might make and the corresponding result of that decision for their spouse/child as potential enrollees via GHS sponsored plans:

Please Note that HAP Medicare Advantage plans only provide coverage (other than emergency services) in Michigan.

Retiree Under 65 Non-Medicare Eligible; w/ Spouse Under 65 Non-Medicare Eligible

- Retiree elects ***HAP HDHP HMO**, spouse may only enroll in **HAP HDHP HMO** version
- Retiree elects ****HAP HDHP PPO***, spouse may only enroll in ***HAP HDHP PPO*** version

Both under 65 Non-Medicare; Must be enrolled into the **same** Health Alliance Plan

Retiree Under 65 Non-Medicare Eligible; w/ Spouse 65+ Medicare Eligible

- Retiree elects **HAP HDHP HMO**, spouse may only enroll in **HAP MA HMO** version or *****BC-MA**
- Retiree elects **HAP HDHP PPO**, spouse may only enroll in **HAP MA PPO** version or **BC-MA**

Retiree Over 65 Medicare Eligible; w/ Spouse Under 65 Non-Medicare Eligible

- Retiree elects **HAP MA HMO or BC-MA**, spouse may only enroll in **HAP HDHP HMO** version
- Retiree elects **HAP MA PPO or BC-MA**, spouse may only enroll in **HAP HDHP PPO** version

Retiree Over 65 Medicare Eligible; w/ Spouse Over 65 Medicare Eligible

- Retiree elects **HAP MA HMO**, spouse may only enroll in **HAP MA HMO** version
- Retiree elects **HAP MA PPO**, spouse may only enroll in **HAP MA PPO** version
- Retiree elects **BC-MA**, spouse may only enroll in **BC-MA**

Both Medicare Eligible (Retiree and Spouse); Must be enrolled into the **same** plan design selected by the retiree

If you have any questions or concerns, you may contact:
Tami Plantz (tplantz@genhs.org) or phone (810) 496-5603
Sandy Sweet (**ssweet@genhs.org**) or phone (810) 496-5759 or fax (810) 496-5755

*Health Alliance Plan High Deductible Health Plan HMO
**Health Alliance Plan High Deductible Health Plan PPO
***Blue Cross Blue Shield Medicare Plus Blue Group

Healthcare Options

Under "65" Retirees

Retired Prior to 11/20/2007

January 1, 2022 - December 31, 2022

Benefit	H+ HDHP PPO	H+ HDHP HMO*
Deductible	$1,400 Single/$2,800 Double, Family (Agency to fund into HSA Account $1,000 Single; or $2,000 Family)	$1,400 Single/$2,800 Double, Family (Agency to fund into HSA Account $1,250 Single; or $2,500 Family)
Co-insurance (after deductible is met)	$1,000 per single or $2,000 per family	$1,000 per single or $1,000 per family (Agency to Reimburse 80% of Expenses)
Prescription Co-pay	$10 Generic / $50 Brand (After Deductible is met)	$10 Generic / $50 Brand (After Deductible is met)
Office Co-pay	$25 co-pay (After Deductible is met)	$15 co-pay (After Deductible is met)
Comments Questions? Please call 810-496-5603		Must reside in Michigan and receive Primary Care services in the 20 county service area.

HEALTHCARE ENROLLMENT CHECKLIST
Non Medicare Retiree-Retired Prior to 11/20/2007

Please note the following deductibles apply to the HAP HD HMO and PPO Plans:
Individual Plan/$1,400
Family Plan/$2,800

If you are making no changes to healthcare:

- ☐ Review your prefilled GHS Enrollment Form. If it is correct, sign, date and return.
- ☐ Sign and return the No Dual Hospital/Medical Coverage Certification
- ☐ Complete and return the Mutual of Omaha Beneficiary Form

STOP HERE: Please mail your documents in the self-addressed, stamped envelope.

If you are changing your healthcare plan:

- ☐ Complete the enclosed, blank GHS Enrollment Form in its entirety (available on the GHS Retiree website)

  Attach a copy of the applicable items listed below:

  - ☐ "No Dual Hospital/Medical Coverage Certification" form – Signed
  - ☐ Completed Mutual of Omaha Beneficiary Form
  - ☐ Marriage Certificate
  - ☐ Birth Certificates & Social Security cards of dependents

Please return all required documentation by **Monday, November 22, 2021** in the self-addressed, stamped envelope. Thank you.

Tami Plantz
Accountant
Genesee Health System
420 W. Fifth Avenue, Flint, MI 48503
Phone 810.496.5603 Fax 810.496.5755

Sandy Sweet
Accounting Manager
Genesee Health System
420 W. Fifth Avenue, Flint, MI 48503
Phone 810.496.5759 Fax 810-496-5755

Administered by Alliance Health and Life Insurance Company

Health Alliance Plan of Michigan

Alliance Health and Life Insurance Company (AHLIC) Self-Funded-HMO

Summary of Benefits

AA000072 / XR002348 QR-32270

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,400 Individual ; $2,800 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	10%	N/A	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$2,400 Individual ; $3,800 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	N/A	These values do not accumulate: premiums, balance-billed charges, health care this plan doesn't cover. All other cost sharing accumulates.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$15 Copay after Deductible	N/A	
Telehealth Visit	$15 Copay after Deductible	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	$15 Copay after Deductible	N/A	
Audiology Office Visit	$15 Copay after Deductible	N/A	One routine hearing exam per benefit period at no cost share
Eye Exam Office Visit	$15 Copay after Deductible	N/A	One routine eye exam per benefit period at no cost share
Allergy Treatment	10% Coinsurance after deductible	N/A	
Allergy Injections	10% Coinsurance after deductible	N/A	
Laboratory & Pathology	10% Coinsurance after deductible	N/A	Some services require preauthorization
Imaging MRI, CT & PET Scans	10% Coinsurance after deductible	N/A	Services require preauthorization
Radiology (X-ray)	10% Coinsurance after deductible	N/A	Some services require preauthorization
Radiation Therapy & Chemotherapy	10% Coinsurance after deductible	N/A	
Dialysis	10% Coinsurance after deductible	N/A	
Chiropractic Services	10% Coinsurance after deductible	N/A	Manipulation of the spine for subluxation only - 10 visits per benefit year
Outpatient Surgical Services			
Outpatient Surgery	10% Coinsurance after deductible	N/A	
Ambulatory Surgical Center	10% Coinsurance after deductible	N/A	
Professional Surgical and Related Services	10% Coinsurance after deductible	N/A	
Emergency/Urgent Care			
Urgent Care	$50 Copay after Deductible		
Emergency Room Care	$100 Copay after Deductible		Copay will be waived if admitted
Emergency Medical Transportation	10% Coinsurance after deductible		Emergency transport only
Inpatient Hospital Services			
Facility Fee	10% Coinsurance after deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	10% Coinsurance after deductible	N/A	
Bariatric Surgery and Related Services	10% Coinsurance after deductible	N/A	One procedure per lifetime
Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services.
Postnatal Office Visits	$15 Copay after Deductible	N/A	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	

Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	$15 Copay after Deductible	N/A	
Other Services			
Home Health Care	10% Coinsurance after deductible	N/A	Unlimited
Hospice Care	10% Coinsurance after deductible	N/A	Up to 210 days per lifetime.
Skilled Nursing Care	10% Coinsurance after deductible	N/A	Covered for authorized services; Up to 730 days, renewable after 60 days
Durable Medical Equipment; Prosthetics & Orthotics	50% Coinsurance after deductible	N/A	Covered for approved equipment only
Hearing Aid Hardware	Not Covered	N/A	
Vision Hardware	Not Covered	N/A	
Rehabilitation Services: Physical, Occupational, and Speech Therapy	10% Coinsurance after deductible	N/A	May be rendered at home; Up to 60 combined visits per benefit period
Habilitation Services	10% Coinsurance after deductible	N/A	Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only. See Outpatient Mental Health for ABA cost sharing amount.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy
Voluntary Termination of Pregnancy	10% Coinsurance after deductible	N/A	Voluntary abortions performed during first trimester only. Limited to 1 episode within a 24 month period.
Infertility Services	50% Coinsurance after deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Assisted Reproductive Technologies	50% Coinsurance after deductible	N/A	1 attempt per lifetime
Temporomandibular Joint Disorder	10% Coinsurance after deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$10 Copay 30-day supply, $20 Copay 90-day supply		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. 50% Coinsurance after deductible for Infertility Drugs
Non-Preferred Generic Drugs	$10 Copay 30-day supply, $20 Copay 90-day supply		
Preferred Brand Drugs	$50 Copay 30-day supply, $100 Copay 90-day supply		
Non-Preferred Brand Drugs	$50 Copay 30-day supply, $100 Copay 90-day supply		
Preferred Specialty Drugs	$50 Copay 30-day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	$50 Copay 30-day supply at specialty pharmacy only		

Template Rev 06/2017

Benefit Riders: HS0001,HS0009,HS000T,HS0078,HS0114,HS0115,HS0116,HS0117,HS0118,HS0119,HS0120,HS0152,XMHP,HS0121

- Elective hospital admissions require that AHLIC be notified prior to the admission. Failure to notify AHLIC within 48 hours could result in a reduction of benefits, or nonpayment.
- Students away at school are covered for acute illness and injury related services according to AHLIC criteria.
- In cases of conflict between this summary and your Self-Funded Benefit Guide, the terms and conditions of the Self-Funded Benefit Guide govern.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.

Administered by Alliance Health and Life Insurance Company

Health Alliance Plan of Michigan
Alliance Health and Life Insurance Company (AHLIC) Self-Funded Preferred Provider Organization (PPO)
Summary of Benefits

AS000069 / XR002347 QR-32273

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,400 Self-only ; $2,800 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	$2,500 Self-only ; $5,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	Deductible does not include copays or coinsurance. In and Out-of-Network deductibles accumulate separately. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	10%	30%	Coinsurance applies towards the Annual Out-of-Pocket Maximum
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$2,400 Self-only ; $4,800 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	$3,500 Self-only ; $7,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	These values do not accumulate: premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates. In and Out-of-Network Out-of-Pocket Maximums accumulate separately.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	Not Covered	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	Not Covered	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	Not Covered	
Immunizations	Covered - Deductible does not apply	Not Covered	
Outpatient & Physician Services			
Primary Care Office Visit	$25 Copay after deductible	30% Coinsurance after deductible	
Telehealth Visit	$25 Copay after deductible	Not Covered	Through our contracted telehealth services provider.
Specialist Office Visit	$25 Copay after deductible	30% Coinsurance after deductible	
Audiology Office Visit	$25 Copay after deductible	30% Coinsurance after deductible	One routine hearing exam per benefit period at no cost share (In-Network only).
Eye Exam Office Visit	$25 Copay after deductible	30% Coinsurance after deductible	One routine eye exam per benefit period at no cost share (In-Network only).
Allergy Treatment	10% Coinsurance after deductible	30% Coinsurance after deductible	
Allergy Injections	10% Coinsurance after deductible	30% Coinsurance after deductible	
Laboratory & Pathology	10% Coinsurance after deductible	30% Coinsurance after deductible	Some services require preauthorization
Imaging MRI, CT & PET Scans	10% Coinsurance after deductible	30% Coinsurance after deductible	Services require preauthorization
Radiology (X-ray)	10% Coinsurance after deductible	30% Coinsurance after deductible	Some services require preauthorization
Radiation Therapy & Chemotherapy	10% Coinsurance after deductible	30% Coinsurance after deductible	
Dialysis	10% Coinsurance after deductible	30% Coinsurance after deductible	Out of Network benefits are not covered unless Prior Authorized.
Chiropractic Services	$25 Copay after deductible	30% Coinsurance after deductible	Manipulation of the spine for subluxation only; Up to 38 visits per benefit period.
Outpatient Surgical Services			
Outpatient Surgery	10% Coinsurance after deductible	30% Coinsurance after deductible	
Ambulatory Surgical Center	10% Coinsurance after deductible	30% Coinsurance after deductible	
Professional Surgical and Related Services	10% Coinsurance after deductible	30% Coinsurance after deductible	
Emergency/Urgent Care			
Urgent Care	10% Coinsurance after deductible		
Emergency Room Care	10% Coinsurance after deductible		Copay will be waived if admitted
Emergency Medical Transportation	10% Coinsurance after deductible		Emergency transport only
Inpatient Hospital Services			
Facility Fee	10% Coinsurance after deductible	30% Coinsurance after deductible	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	10% Coinsurance after deductible	30% Coinsurance after deductible	
Bariatric Surgery and Related Services	Not Covered	Not Covered	
Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	Not Covered	Covered under Preventive Services.
Postnatal Office Visits	$25 Copay after deductible	30% Coinsurance after deductible	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	See Inpatient Hospital Services	

Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	See Inpatient Hospital Services	
Outpatient Services	10% Coinsurance after deductible	30% Coinsurance after deductible	
Other Services			
Home Health Care	10% Coinsurance after deductible	30% Coinsurance after deductible	Does not include Rehabilitation Services.; Up to 100 visits per benefit period (Combined In and Out-of-Network),
Hospice Care	10% Coinsurance after deductible	30% Coinsurance after deductible	Up to 210 days per lifetime (Combined In and Out-of-Network),
Skilled Nursing Care	10% Coinsurance after deductible	30% Coinsurance after deductible	Covered for authorized services; Up to 120 days per benefit period (Combined In and Out-of-Network),
Durable Medical Equipment; Prosthetics & Orthotics	10% Coinsurance after deductible	30% Coinsurance after deductible	Covered for approved equipment only
Hearing Aid Hardware	Not Covered	Not Covered	
Vision Hardware	Not Covered	Not Covered	
Rehabilitation Services: Physical, Occupational, and Speech Therapy	$25 Copay after deductible	30% Coinsurance after deductible	May be rendered at home; Up to 60 combined visits per benefit period (Combined In and Out-of-Network),
Habilitation Services	$25 Copay after deductible	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only. See Outpatient Mental Health for ABA cost sharing amount.
Voluntary Sterilizations	See Outpatient Surgical Services	30% Coinsurance after deductible	Limited to vasectomy
Infertility Services	10% Coinsurance after deductible	30% Coinsurance after deductible	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Assisted Reproductive Technologies	10% Coinsurance after deductible	30% Coinsurance after deductible	1 attempt per lifetime
Temporomandibular Joint Disorder	Not Covered	Not Covered	
Organ Transplant and Related Services	10% Coinsurance after deductible	Not Covered	
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$10 Copay 30-day supply, $20 Copay 90-day supply		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply.
Non-Preferred Generic Drugs	$10 Copay 30-day supply, $20 Copay 90-day supply		
Preferred Brand Drugs	$50 Copay 30-day supply, $100 Copay 90-day supply		
Non-Preferred Brand Drugs	$50 Copay 30-day supply, $100 Copay 90-day supply		
Preferred Specialty Drugs	$50 Copay 30-day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	$50 Copay 30-day supply at specialty pharmacy only		

Template Rev 06/2017

Benefit Riders: AS0001,AS000T,AS0017,AS0019,AS0020,AS0042,AS0081,AS0082,AS0119,AST1,AST3,X00P,X145,X146,XMHP,AS0083

- In cases of conflict between this summary and your Self-Funded Benefit Guide and Riders, the terms and conditions of the Self-Funded Benefit Guide and Riders will govern. This plan includes a network of health care providers through which services are covered at the In-Network level of benefits. If you receive covered services from a provider that is not part of the plan's network, they will be processed at the lower Out-of-Network benefit level.
- Elective hospital admissions require that AHLIC be notified prior to the admission. AHLIC must be notified within 48 hours of any emergency hospital admission. Failure to notify AHLIC could result in a reduction of benefits, or nonpayment.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.

HAP Preventive Services Guidelines

hap.org

Routine Preventive Services for Infants and Children (Birth - 24 Months)

Screening	Females	Males
Newborn metabolic screening and screening for congenital hearing loss	Prior to hospital discharge (over 24 hours of age)	Prior to hospital discharge (over 24 hours of age)
Health, developmental, parental education, and risk assessments	Every three months (11 visits)	Every three months (11 visits)
Blood lead testing	As indicated	As indicated
Immunizations*	See*	See*

Routine Preventive Services for Children and Adolescents (Ages 2 - 18)

Screening	Females	Males
Health, developmental and risk assessments with parental and child education and counseling	Yearly	Yearly
Weight assessment	Yearly	Yearly
Cholesterol	Yearly	Yearly
Tobacco	Yearly	Yearly
Vision	Once before beginning school, and every two years after that	Once before beginning school, and every two years after that
Sexually transmitted infection (sexually active adolescents)	Yearly	Yearly
Cervical cancer screening (sexually active females)	Yearly	
Immunizations*	See*	See*

Adult Preventive Services (Ages 18 – 49)

Screening	Females	Males
Health assessment screening, history and counseling	Yearly	Yearly
Routine Prenatal office visits	ACOG** recommended frequency	
Blood pressure	Yearly	Yearly
Daily aspirin use		Age 45 - 79 years
Cholesterol and lipid	Yearly	Yearly
Diabetes mellitus	Yearly	Yearly
Colorectal cancer screening	Ask your doctor	Ask your doctor
Cervical cancer screening (sexually active females)	Yearly	
Sexually transmitted infection/HIV	Yearly	Yearly
Breast cancer screening	Yearly	
Immunizations*	See*	See*

Adult Preventive Services (Ages 50 and up)

Screening	Females	Males
Health assessment screening, history and counseling	Yearly	Yearly
Blood pressure	Yearly	Yearly
Daily aspirin use		Age 45 – 79 years
Cholesterol and lipid	Yearly	Yearly
Diabetes mellitus	Yearly	Yearly
Colorectal cancer	Annual Fecal Occult Blood Test (FOBT), sigmoidoscopy every 5 years combined with high-sensitivity FOBT every 3 years, or screening colonoscopy every 10 years	Annual Fecal Occult Blood Test (FOBT), sigmoidoscopy every 5 years combined with high-sensitivity FOBT every 3 years, or screening colonoscopy every 10 years
Cervical cancer screening	Yearly	
Sexually transmitted infection/HIV	Yearly	Yearly
Breast cancer screening	Yearly	
Immunizations*	See*	See*
Osteoporosis	Every two years, beginning at age 65	

This does not apply to grandfathered groups under the federal health care reform law that will not have to comply until a future date. Check with your employer to find out if your plan is grandfathered.

*Centers for Disease Control (CDC) recommended immunizations are always considered preventive and are recommended for all HAP members.

** ACOG is the American Congress of Obstetricians and Gynecologists

Additional information about covered services, authorization requirements and criteria can be found on the following resources available on https://www.hap.org/

Medicare Advantage Members:

- Procedure Reference lists – Medicare Preventive list
- Benefit Administration Manual policy: Preventive Services for Medicare Advantage Members

Non-Medicare Advantage Members:

- Procedure Reference lists – Preventive Services Procedures Codes list
- Benefit Administration Manual policy: Preventive Services for Members other than Medicare Advantage Members

Blue Cross Blue Shield of Michigan

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

GENESEE HEALTH SYSTEM
0070003700021 - 05CRY
Effective Date: 01/01/2021

Vision Coverage

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

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

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

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

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	$5 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 $45 less $5 copay (member responsible for any difference)
	One eye exam in any period of 24 **consecutive** months	

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	$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 24 **consecutive** months	

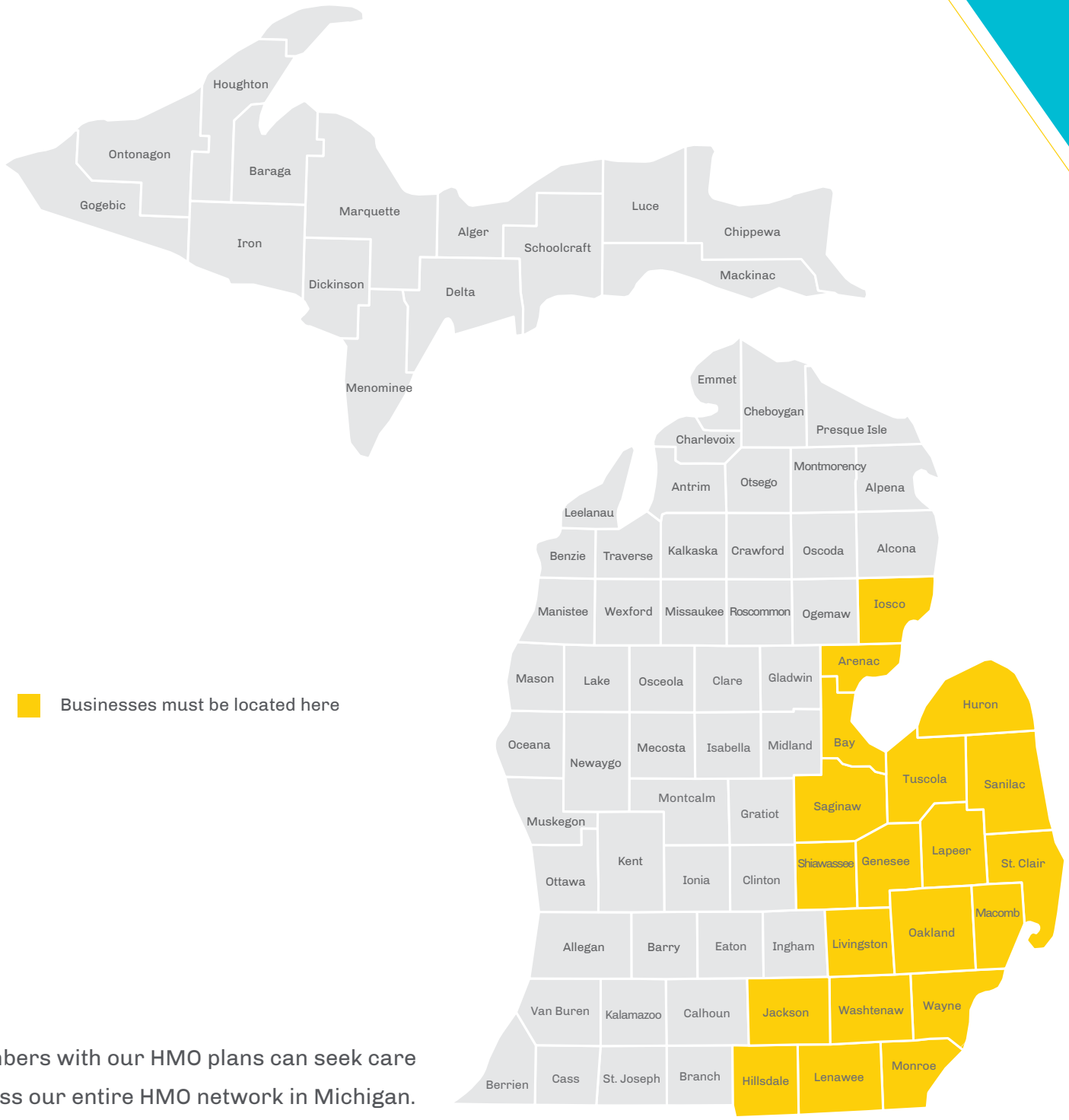
ADM PLANYR JAN;BLUE VISION;BVFLE;BVPP CHOICE NET

Benefits	VSP network doctor	Non-VSP provider
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 24 **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 24 **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 24 **consecutive** months	

2021
Large Group HMO service area



Businesses must be located here

Members with our HMO plans can seek care across our entire HMO network in Michigan.

HAP and its subsidiaries do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.