Genesee HEALTH SYSTEM
Hope and health in the community

MAIN CAMPUS
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Flint, MI 48503
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Crisis Line: (877) 346-3648
www.genhs.org

October 2, 2018

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

2019 Retiree Open Enrollment is under way 10/29/18 through 11/16/2018. For the 2019 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.

We are asking that the following dates be utilized for those wishing to drop off their insurance forms or for those who need assistance and would like to meet in person to complete forms. A GHS representative will be available on October 30, November 7, and November 13, 2018 between 10:00 a.m. and 4:00 p.m. Please note that we are located at 420 W. Fifth Avenue on the 2nd Floor (main GHS building).

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 enclosed Healthcare Options Under "65" Retirees benefit comparison sheet, as well as all other information in this packet 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, to be received in my office by **Monday, November 19, 2018.** I have included additional information with this letter which you may find informative and beneficial. Dental and Vision coverage options remain the same as in 2018.

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 me directly at (810) 496-5759 or Tami Plantz at (810) 496-5603.

Sincerely,

Sandra Sweet

Sandra Sweet, Sr. Accountant
Genesee Health System

Enclosures

GENESEE HEALTH SYSTEM

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

2019 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 Sandy Sweet (810) 496-5759 or Tami Plantz (810) 496-5603 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

2019 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, 2019 - December 31, 2019

Benefit	H+ HDHP PPO	H+ HDHP HMO*
Deductible	**$1,350 Single/$2,700 Double, Family (Agency to fund into HSA Account $1,000 Single; or $2,000 Family)**	**$1,350 Single/$2,700 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		**Must reside in Michigan and receive Primary Care services in the 18 county service area.**

Questions? Please call 810-496-5759

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

If you are making no changes to healthcare:

- ☐ Review the enclosed, 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

  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 19, 2018** in the self-addressed, stamped envelope. Thank you.

Sandra Sweet
Senior Accountant
Genesee Health System
420 W. Fifth Avenue, Flint, MI 48503
Phone 810.496.5759 Fax 810.496.5755

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

AS000072 / XR002348

Health Care Services	Coverage	Limitations*
Benefit Period, Annual Deductible, and Annual Out of Pocket Maximum:		
Benefit Period:	Calendar Year	
Annual Deductible	$1,350 Individual ; $2,700 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	Deductibe dos not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum
Co-insurance (amount member pays)	10%	
Annual Out of Pocket Maximum	$2,350 Individual ; $3,700 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, health care this plan doesn't cover. All other cost sharing accumulates
Preventive Services:		
Preventive Office Visit / Physical Exam	Covered - Deductible does not apply	
Well Baby Office Visit	Covered - Deductible does not apply	
Routine Hearing Exam	Covered - Deductible does not apply	
Routine Eye Exam	Covered - Deductible does not apply	
Immunizations	Covered - Deductible does not apply	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	
Pap Smears and Mammograms	Covered - Deductible does not apply	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	$15 Copay after Deductible	
Telehealth	$15 Copay after Deductible	Through our contracted telehealth services provider
Specialty Physician Office Visit	$15 Copay after Deductible	
Gynecology Office Visit	$15 Copay after Deductible	
Audiology Office Visit	$15 Copay after Deductible	
Eye Exam Office Visit	$15 Copay after Deductible	
Allergy Treatment and Injections	Plan Pays 90% after Deductible	
Laboratory and Radiology Services	Plan Pays 90% after Deductible	
Dialysis	Plan Pays 90% after Deductible	
Chemotherapy	Plan Pays 90% after Deductible	
Radiation Therapy	Plan Pays 90% after Deductible	
Outpatient Surgery	Plan Pays 90% after Deductible	
Chiropractic Office Visit and Related Services	Plan Pays 90% after Deductible	Manipulation of the spine for subluxation only - 10 visits per benefit year
Emergency/Urgent Care:		
Emergency Room Services	$100 Copay after Deductible	
Urgent Care Facility Services	$50 Copay after Deductible	
Emergency Ambulance Services	Plan Pays 90% after Deductible	Emergency transport only
Inpatient Hospital Services:		
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Plan Pays 90% after Deductible	
Bariatric Surgery & Related Services	Plan Pays 90% after Deductible	One procedure per lifetime
Maternity Services:		
Initial Prenatal Office Visit	Covered - Deductible does not apply	Covered under Preventive Services
Subsequent Prenatal Office Visits	Covered - Deductible does not apply	Covered under Preventive Services
Postnatal Office Visits	$15 Copay after Deductible	
Labor, Delivery and Newborn Care	Plan Pays 90% after Deductible	
Mental /Behavioral Health:		
Inpatient Services	Plan Pays 90% after Deductible	
Outpatient Services	$15 Copay after Deductible	
Substance Use Disorder:		
Inpatient Services	Plan Pays 90% after Deductible	
Outpatient Services	$15 Copay after Deductible	
Other Services:		
Home Health Care	Plan Pays 90% after Deductible	Unlimited
Hospice Care	Plan Pays 90% after Deductible	Up to 210 days per lifetime
Skilled Nursing Care	Plan Pays 90% after Deductible	Covered for authorized services - Up to 730 days, renewable after 60 days
Durable Medical Equipment; Prosthetic & Orthotics	Plan Pays 50% after Deductible	Coverage provided for approved equipment based on AHLIC's guidelines
Hearing Aid Hardware	Not Covered	
Vision Hardware	Not Covered	
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Plan Pays 90% after Deductible	Up to 60 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Women: Covered Men: Plan Pays 90% after Deductible	Adult sterilization procedures are limited to vasectomy and tubal ligation whose sole intent is to prevent conception. **Women: Covered as Preventive Service**
Voluntary Termination of Pregnancy	Plan Pays 90% after Deductible	Voluntary abortions performed during first trimester only. Limited to 1 episode within a 24 month period.
Infertility Services	Plan Pays 50% after Deductible	Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with AHLIC's benefit, referral and practice policies
Assisted Reproductive Technologies	Plan Pays 50% after Deductible	One attempt of artificial insemination per lifetime
Pharmacy:		
Preferred Generic, Non-Preferred Generic / Preferred Brand, Non-Preferred Brand / Preferred Specialty, Non-Preferred Specialty	$10 / $50 / $50 Copay after Deductible 50% Coinsurance after Deductible for Infertility Drugs	**The following applies after the Deductible:** Retail: 30 day supply for non-maintenance drugs at 1 Copay; 90 day supply for eligible maintenance drugs at 2 Copays Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 Copays. Specialty drugs not available at 90 day or mail order.

Benefit Riders: XMHP,HS0001,HS000T,HS0009,HS0078, HS0114,HS0515, HS0116, HS0117,HS0118, HS0119, HS0120, HS0136,HS0121

* Hospital admissions require that AHLIC be notified within 48 hours of 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. Students away at school are not covered for routine physicals, non-emergency psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services while at school.

* In cases of conflict between this summary and your Self-Funded Benefit Guide, the terms and conditions of the Self-Funded Benefit Guide govern.

Administered by Alliance Health and Life Insurance Company

ALLIANCE HEALTH AND LIFE INSURANCE COMPANY (AHLIC)
HIGH DEDUCTIBLE HEALTH PLAN PREFERRED PROVIDER ORGANIZATION (HDHP PPO)
SCHEDULE OF BENEFITS

Administered by Alliance Health and Life Insurance Company

This Summary of Benefits is designed to provide an overview of the AHLIC High Deductible Health Plan PPO and is subject to the terms and conditions of the Self Funded Benefit Guide. In cases of conflict between this summary and the Self Funded Benefit Guide, the terms and conditions of the Self Funded Benefit Guide govern. This program features a network of health care providers through which the Participant and Dependents can receive services at the In-Network level of benefits. AHLIC High Deductible Health Plan PPO Participants and Dependents who do not seek services from a network provider, or who are not directed through a referral authorization by a network provider, will receive services at the **lower Out-of-Network benefit level**.

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Benefit Period	Calendar year		
Annual Deductible	$1,350 Self-only ; $2,700 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.	Deductibles do not include copays. In and Out-of-Network deductibles accumulate separately.
Coinsurance Percentage	10%	30%	Coinsurance applies towards the Annual Out-of-Pocket Maximum.
Annual Out-of-Pocket Maximum	$2,350 Self-only ; $4,700 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.	Annual Out-of-Pocket Maximums include deductibles, coinsurance, and copays. These values do not accumulate: Premiums, balance-billed charges, and health care this plan doesn't cover. In and Out-of-Network annual Out-of-Pocket Maximums accumulate separately.
Preventive Services	**(No annual dollar limit)**		Preventive Services are not subject to the deductible
Preventive Office Visit	Covered	Not Covered	
Periodic Physical Exam Office Visit	Covered	Not Covered	
Well Baby Office Visit	Covered	Not Covered	
Immunizations	Covered	Not Covered	
Routine Eye and Hearing Exam Office Visit	Covered	Not Covered	
Related Lab Tests and X-Rays	Covered	Not Covered	
Pap Smears and Mammograms	Covered	Not Covered	
Outpatient & Physician Services			
Personal Care Office Visit	$25 copay after deductible	Plan pays 70% after deductible	
Telehealth	$25 copay after deductible	Not Covered	Through our contracted telehealth services provider
Specialty Physician Office Visit	$25 copay after deductible	Plan pays 70% after deductible	
Gynecology Office Visit	$25 copay after deductible	Plan pays 70% after deductible	
Allergy Testing and Injections	Plan pays 90% after deductible	Plan pays 70% after deductible	
Other Injections	Plan pays 90% after deductible	Plan pays 70% after deductible	
Labs Tests & X-Rays	Plan pays 90% after deductible	Plan pays 70% after deductible	*****Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a denial in charges.
Dialysis	Plan pays 90% after deductible	Plan pays 70% after deductible	
Chiropractic Visit & Related Services	$25 copay after deductible	Plan pays 70% after deductible	Manipulation of the spine for subluxation only - 38 visits per benefit year
Outpatient Surgery & Related Svc	Plan pays 90% after deductible	Plan pays 70% after deductible	*****Some services require prior authorization
Radiation/Chemotherapy	Plan pays 90% after deductible	Plan pays 70% after deductible	
Eye Exam Office Visit	$25 copay after deductible	Plan pays 70% after deductible	
Audiology Office Visit	$25 copay after deductible	Plan pays 70% after deductible	
Emergency Services			
Emergency Room Services	Plan pays 90% after deductible		
Urgent Care Facility Services	Plan pays 90% after deductible		
Emergency Ambulance Services	Plan pays 90% after deductible		Emergency transport only
Inpatient Hospital Services			Unlimited days of care ******Admissions require AHLIC be notified within 48 hours of admission. Failure to notify AHLIC within 48 hours could result in a denial of charges. Unlimited days of care.
Semi-Private Room	Plan pays 90% after deductible	Plan pays 70% after deductible	
Intensive, Cardiac and Other Specialty Care Units as medically necessary	Plan pays 90% after deductible	Plan pays 70% after deductible	
Related Therapy Services	Plan pays 90% after deductible	Plan pays 70% after deductible	
Surgery and Related Services	Plan pays 90% after deductible	Plan pays 70% after deductible	******Some services require prior authorization
Related Lab Tests and X-Rays	Plan pays 90% after deductible	Plan pays 70% after deductible	
Physician/Professional Services	Plan pays 90% after deductible	Plan pays 70% after deductible	
Riders			**X00P, AS0001, AS000T, AS0017, AS0108, AS0081, AS0082, AS0042, AS0019, AS0020, AST1, AST3, X145, X146, AS0083**

HEALTH CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK	LIMITATIONS
Maternity Services			
Outpatient Prenatal Visits	Covered	Not Covered	Covered as Preventive Services. Not covered Out-of-Network
Outpatient Postnatal Visits	$25 copay after deductible	Plan pays 70% after deductible	
Labor, Delivery and Newborn Care	Plan pays 90% after deductible	Plan pays 70% after deductible	**Some services require prior authorization
Ancillary Services			
Home Health Care	Plan pays 90% after deductible	Plan pays 70% after deductible	The number of visits for Medically Necessary home health care shall not exceed 100 visits per Benefit Period. (Combined In and Out-of-Network) Does not include PT/OT/ST. See PT/OT/ST coverage.
Hospice Care	Plan pays 90% after deductible	Plan pays 70% after deductible	Up to 210 days per lifetime (Combined In and Out-of-Network)
Rehabilitation Services Physical, Speech and Occupational Therapy	$25 copay after deductible	Plan pays 70% after deductible	Up to 60 combined visits per benefit year - May be rendered at home (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. Services require prior authorization. *See outpatient Mental Health for ABA cost share amount.
Durable Medical Equipment (DME)	Plan pays 90% after deductible	Plan pays 70% after deductible	Must be an approved piece of equipment based on AHLIC guidelines
Prosthetics and Orthotics	Plan pays 90% after deductible	Plan pays 70% after deductible	Must be an approved piece of equipment based on AHLIC guidelines
Skilled Nursing Facility	Plan pays 90% after deductible	Plan pays 70% after deductible	Up to 120 days per benefit year (Combined In and Out-of-Network)
Mental/Behavioral Health Services			Services can be directly accessed by calling Coordinated Behavioral Health Management at 1-800-444-5755
Inpatient Services	Plan pays 90% after deductible	Plan pays 70% after deductible	**Some services require prior authorization
Outpatient Services	$25 copay after deductible	Plan pays 70% after deductible	Covered as medically necessary
Substance Use Disorder Services			Services can be directly accessed by calling Coordinated Behavioral Health Management at 1-800-444-5755
Inpatient Services	Plan pays 90% after deductible	Plan pays 70% after deductible	**Some services require prior authorization
Outpatient Services	$25 copay after deductible	Plan pays 70% after deductible	Covered as medically necessary
Transplant Services			*Some services require prior authorization
Organ Transplant and Related Services	Plan pays 90% after deductible	Not Covered	
Other Services			
Prescription Drugs	After the deductible is satisfied the following Copays apply - $10 Copay per Preferred Generic, Non-Preferred Generic; $50 Copay per Preferred Brand, Non-Preferred Brand; $50 Copay per Preferred Specialty, Non-Preferred Specialty	Not Covered	**Following applies after Deductible:** Does not include coverage of drugs for Infertility or Obesity. All prescriptions must meet AHLIC guidelines. Retail: 30 day supply for non-maintenance drugs at 1 Copay. 90 day supply for eligible maintenance drugs at 2 Copays. Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 Copays. Specialty Drugs are not available at 90 day or Mail Order.
Voluntary Sterilization	Women: Covered Men: Plan pays 90% after deductible	Women: Not Covered Men: Plan pays 70% after deductible	Adult sterilization procedures are limited to vasectomy and tubal ligation whose sole intent is to prevent conception. **Women: Covered as Preventive Services**
Voluntary Termination of Pregnancy	Plan pays 90% after deductible	Plan pays 70% after deductible	
Assisted Reproductive Technologies	Plan pays 90% after deductible	Plan pays 70% after deductible	One attempt of artificial insemination per lifetime
Infertility Services	Plan pays 90% after deductible	Plan pays 70% after deductible	Services for diagnosis, counseling and treatment of anatomical disorders causing infertility in accordance with Alliance's benefit, referral and practice policies. Does not include coverage of infertility drugs.

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

Blue Cross Blue Shield of Michigan

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

Blue Vision℠ with VSP Choice Network 24/24/24 Benefits-at-a-Glance

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

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.

	VSP network doctor	Non-VSP provider
Member's responsibility (copays)		
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		
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 $34 less $5 copay (member responsible for any difference)
	One eye exam in any period of 24 **consecutive** months	
Lenses and frames		
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. **Note:** Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	$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	
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 $38.25 less $10 copay (member responsible for any difference)
	One frame in any period of 24 **consecutive** months	
Contact lenses		
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)
	One pair of contact lenses 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)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	One pair of contact lenses in any period of 24 **consecutive** months	