2024

Reimagine Education LLC

MICHIGAN INTERNATIONAL PREP SCHOOL

Employee Benefits Guide

General Agency Company

Insurance Since 1915

Knowledgeable. Committed. Trusted.

Table of Contents

Welcome

Your benefits are an important part of your overall compensation. This brochure was designed to answer some of the basic questions you might have about your benefits. Please read it carefully along with any supplemental materials you receive.

Eligibility

- Employees working 30 hours or more.
- Employees are benefit eligible the date of full-time employment.

Qualified Life Events

Elections you make at this time will remain in effect until next Open Enrollment period. In addition, if you decline coverage for yourself and/or your dependent(s) when first becoming eligible, you must wait until the next Open Enrollment period to enroll.

However, if you experience a qualified life event during the year, you may make changes to your elections at that time.

Qualified life events include:

- **Change in status:** Marriage, divorce, legal separation, annulment or death
- **Change in number of dependents**: Birth, death, divorce, adoption/placement for adoption or dependent reaching limiting age
- **Change in employment status** of employee, dependent or spouse that affects the individual's eligibility
- **Change in employee, spouse or dependent** coverage on spouse's plan during spouse's Open Enrollment period
- **Change in entitlement** to Medicare, Medicaid, or State Children's Health Insurance Program (CHIP) for employee, dependent or spouse
- **Change in eligibility for group health plan premium assistance** under Medicaid or CHIP for employee, dependent or spouse

It is **your responsibility** to notify Human Resources (HR) **within 30 days** of the event. If you fail to do so, you will not be able to enroll or make changes until the next Open Enrollment period. When you, your dependent(s) or your spouse become enrolled as a result of a qualified life event, coverage will be made effective retroactive to the date of the event. For more information, please contact HR.

Definitions

Deductible
- The amount you pay for certain covered healthcare services before your insurance plan starts to pay on your behalf.

Premium
- This is the cost you will pay to participate in the employer health plan. Your premium is separate from your deductible and out-of-pocket maximum.

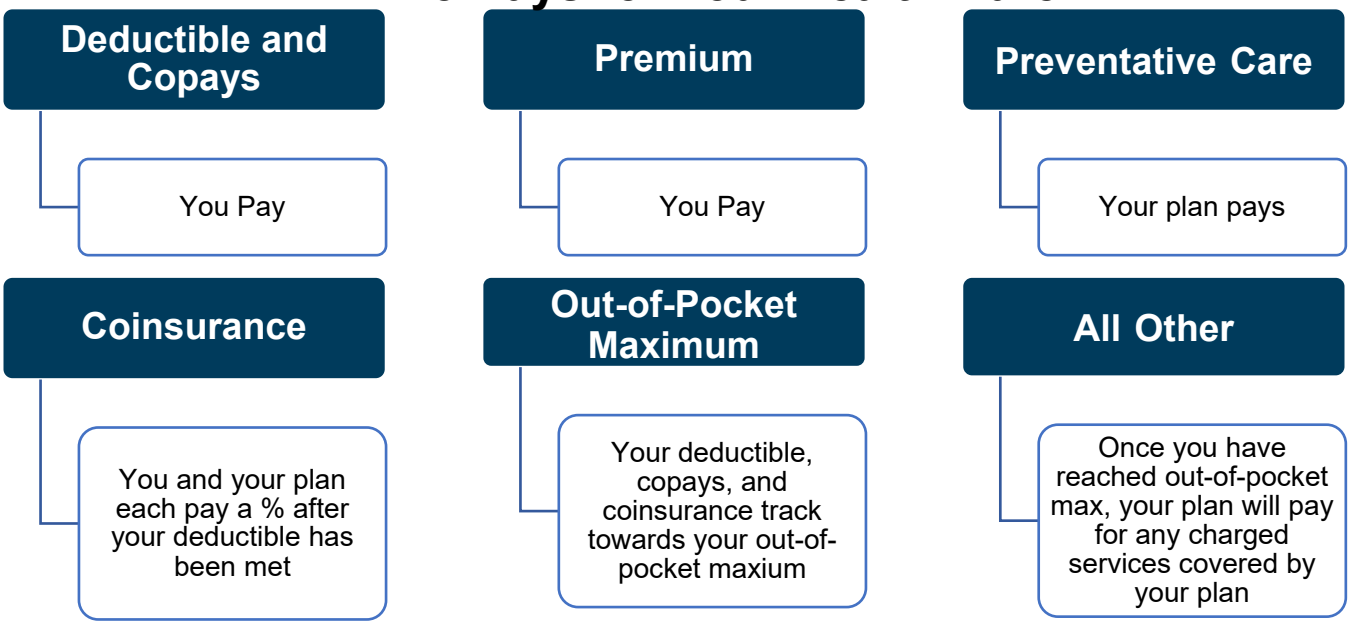
Copayment
- A fixed dollar amount you pay for healthcare services, such as doctor's visits, urgent care or emergency room services. Copayments track towards your out-of-pocket maximum, but do not apply towards the deductible.

Coinsurance
- The percentage of a covered healthcare service cost you pay after you have paid your deductible.

Preventative Care
- Routine healthcare services like check-ups, immunizations, and screenings for adults, women, and children.

Out-of-Pocket Maximum
- The most you will pay for healthcare services in one year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs covered with benefits (with some exceptions).

Who Pays for Your Health Care?



Benefits Contact Directory

Human Resources
If you have additional questions, you may also contact Charlie Carver / Kim Bugaski.
Charlie's Contact Info:
Email: carver@miprepschool.org
Phone: 734.358.9775
Kim's Contact Info:
Email: bugaski@miprepschool.org
Phone: 810.412.8840

Topic	Contact	Phone Number	Website/Email/Fax Number
General Benefit Information and/or Questions	General Agency Company 525 E Broadway Street Mt. Pleasant MI 48858		www.ga-ins.com Fax: 989-772-1855
Agent Account Executive Claims Department	Jason Clark Suzanne Tilmann	989-817-4312 989-817-4310 989-773-6981	jclark@ga-ins.com stilmann@ga-ins.com
Medical	Blue Cross Blue Shield / Blue Care Network	877-671-2583 800-662-6667	www.bcbsm.com
Dental	Delta Dental	800-524-0149	deltadentalmi.com
Vision	Kansas City Life/VSP network	800-821-6164	www.kclgroupbenefits.com
Group Life/AD&D	Kansas City Life	800-821-6164	www.kclgroupbenefits.com
Group Short Term Disability	Kansas City Life	800-821-6164	www.kclgroupbenefits.com
Group Long Term Disability	Kansas City Life	800-821-6164	www.kclgroupbenefits.com
Voluntary Life/AD&D (Workplace)	Jason Clark, Benefits Agent	989-817-4312	jclark@ga-ins.com
Pet Care	Pet Care Solutions	800-891-2565	customercare@petbenefits.com

Benefits Package Outline

Medical Insurance:

BCBS PPO $500 with Elective Abortion**

- Annual Deductible of $500 for one member/$1,000 per family
- 80/20% coinsurance after deductible
- Annual Co-Insurance Maximum: $2,500 for one member/$5,000 per family
- Office Visit Copays: $20 / Specialist Copay: $40 / UC Copay: $60 / ER Copay: $250; waived if admitted
- Annual out-of-pocket maximum: $8,150 for one member/$16,300 per family
- Preventive services covered at 100%
- Dependent children covered to end of the year in which they turn 26
- **Prescription Coverage:**
    - Generic: $20 Copay
    - Preferred Brand: $60 Copay
    - Nonpreferred Brand: $80 Copay or 50% of the approved amount; maximum $100
    - Preferred Specialty: 20% of approved amount; maximum $200
    - Nonpreferred Specialty: 25% of approved amount; maximum $300

Blue Elect Plus POS $2000 with Elective Abortion**

- Annual Deductible of $2,000 for one member/$4,000 per family
- 80/20% coinsurance after deductible
- Office Visit Copays: $30 / Specialist Copay: $50 / UC Copay: $50 / ER Copay: $250; waived if admitted
- Annual out-of-pocket maximum: $8,150 for one member/$16,300 per family
- Preventive services covered at 100%
- Dependent children covered to end of the year in which they turn 26
- **Prescription Coverage:**
    - Preferred Generic / Nonpreferred Generic: $10 Copay / $30 Copay
    - Preferred Brand: $60 Copay
    - Nonpreferred Brand: $80 Copay
    - Preferred Specialty: 20% of approved amount; maximum $200
    - Nonpreferred Specialty: 20% of approved amount; maximum $300

Blue Elect Plus HSA POS $3200 with Elective Abortion**

- Annual Deductible of $3,200 for one member/$6,400 per family
- 100% coinsurance after deductible
- Office Visits (Primary/Specialist/Urgent/ER): 100% coinsurance after deductible
- Annual out-of-pocket maximum: $6,900 for one member/$13,800 per family
- Preventive services covered at 100%
- Dependent children covered to end of the year in which they turn 26
- **Prescription Coverage**:
    - Preferred Generic / Nonpreferred Generic: $10 / $30 after deductible
    - Preferred Brand: $60 after deductible
    - Nonpreferred Brand: $80 after deductible
    - Preferred Specialty: 20% of approved amount; maximum $200 after deductible
    - Nonpreferred Specialty: 20% of approved amount; maximum $300 after deductible

Benefits Package Outline (Continued)

Medical Insurance (Continued):

Blue Care Network – HMO $500 with Elective Abortion** ***(Available for Michigan Employees)***

- Annual Deductible of $500 for one member/$1,000 per family
- 80/20% coinsurance after deductible
- Annual Co-Insurance Maximum: $2,500 for one member/$5,000 per family
- Office Visit Copays: $20 / Specialist Copay: $40 / UC Copay: $50 /
  ER Copay: $250 after deductible; waived if admitted
- Annual out-of-pocket maximum: $8,150 for one member/$16,300 per family
- Preventive services covered at 100%
- Dependent children covered to end of the year in which they turn 26
- **Prescription Coverage:**
  - Preferred Generic / Nonpreferred Generic: $10 Copay / $30 Copay
  - Preferred Brand: $60 Copay
  - Nonpreferred Brand: $80 Copay
  - Preferred Specialty: 20% of approved amount; maximum $200
  - Nonpreferred Specialty: 20% of approved amount; maximum $300

Dental Insurance:

Delta Dental**

- $1,000 Annual Benefit Maximum per Member
- $25 Deductible per Member/$75 per family per benefit year
- Services covered as follows:
  - **Diagnostic/Preventive Services:** 100% in-network
  - **Basic:** 80% in-network
  - **Major:** 50% in-network
  - **Orthodontic:** 50% in-network; lifetime max. $1,000; children under age 19

Vision Insurance:

Kansas City Life (KCL) – VSP network**

- $10 co-pay for eye examination every 12 months.
- $10 co-pay for eyewear.
- $130 allowance toward any frame every 12 months.
- $130 allowance for elective contact lenses every 12 months.

Group Life/AD&D Insurance:

Kansas City Life (KCL)**

- Life & AD&D Benefit Amount: $50,000

Group Short Term Disability Insurance:

Kansas City Life (KCL)**

- Benefit amount equal to 66.67% of earnings up to $1,000 maximum per week.
- Benefit may start 1st day from the date you are unable to work due to an injury and 8th day due to an illness.
- Maximum Benefit Period is 26 weeks.

Benefits Package Outline (Continued)

Group Long Term Disability Insurance:

Kansas City Life (KCL)**

- Benefits amount equal to 66.67% of earnings up to $6,000 per month.
- 180-day elimination period before benefits begin.
- Pre-existing condition limitations apply.
- Benefit Duration: Social Security Normal Retirement Age (SSNRA)

Voluntary Life/AD&D (Workplace) Insurance:

EMC

- Additional life insurance is available through payroll deduction.
- Portability available.
- If interested, contact Jason Clark, Benefits Agent at jclark@ga-ins.com.

Pet Care Insurance:

Pet Benefit Solutions

- Two plan options available (you can enroll in BOTH)
  - Total Pet Plan (Single or Family) – payroll deducted
  - Wishbone (Customized quote) – direct bill
    - Must complete the following quote process: https://www.wishboneinsurance.com/reimagineedu

This is an easy to read guide that provides basic plan information. For specific information, please contact the carrier or review the carrier certificates for each plan. Certificates are available through Employee Navigator or human resources department. Benefits are subject to change without notification. If there is a discrepancy between this guide and the carrier certificate, the carrier certificate overrides information found in this booklet.

Employee Navigator

Online Benefit Enrollment Instructions

Step 1: Log in
Go to www.employeenavigator.com and click **Login** (top right of screen)
- First-time users: Register as a new user.

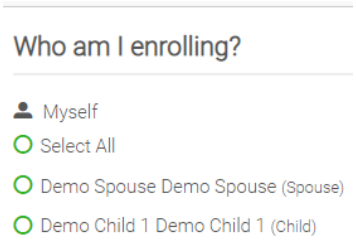
Tip: The following information will be needed.
- First name
- Last name
- Company Identifier (ID): Reimagine-EduLLC
- Last 4 of SSN
- Date of Birth

Step 2: Welcome!
After you login, click **Let's Begin** to complete your required tasks.

Step 3: Start Enrollments
After clicking **Start Enrollment**, you'll need to complete some personal and dependent information before moving to your benefit elections.

Tip: Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and social security number.

Step 4: Benefit Elections
To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?** (Sample below)



Below your dependents, you can view your available plans and cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.

Click **Save & Continue** at the bottom of each screen to save your elections. If you don't want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

Step 5: Forms (If Applicable)
If you have elected benefits that require a form, you will be prompted to complete a form.
Step 6: Review and Confirm Elections
Review the benefits you selected on the enrollment summary page to make sure they are correct then click Sign and Agree to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.
TIP: If you miss a step, you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.

Chauffeured Claims Service

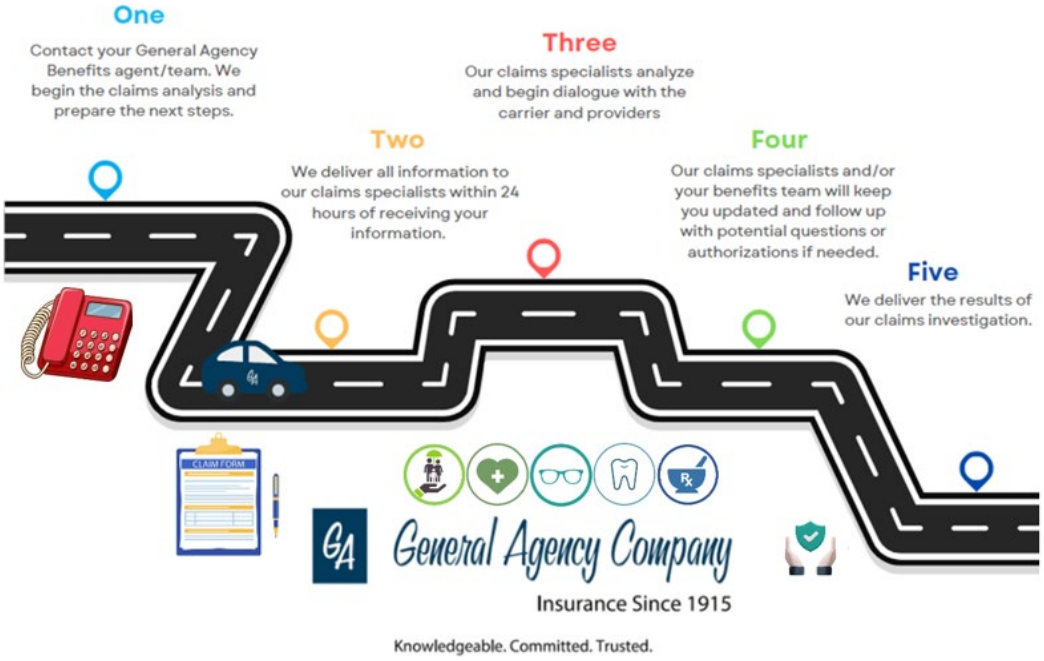
As a valued client of the General Agency Company, you will receive the benefit of our special “Chauffeured Claims Service” with every claim.

With most employee benefits agencies, once you have a claim, you are turned over to the carrier and other potential third parties to deal with your medical claims on your own. This is someone you do not know and someone who does not know you or your specific health situation. When it comes down to it, they have nothing to do with helping you with your claim. If a carrier denies your claim, you may be stuck navigating the entire appeal process on your own.

The General Agency Company has a full-time claims department to review your claim and work through the entire process with you. It is our goal to make sure that your medical insurance and other benefits coverages work as designed when you need them. Our experienced claims advocates have many years of experience scrutinizing claims to make sure that they are paid in an accurate manner.

Often there are errors in coding, simple background information errors, etc. that are quickly turned around on your behalf so that the carrier can reprocess and pay claims accordingly. Sometimes there are more complex claims details that require substantial time and effort that you do not have. That is when our advocates really go to work for you.

Once you have our team on your side, you will not want to be without us. We have been told by industry experts that this service is an unnecessary additional expense. We do not feel that way. The way we see it, you have entrusted us to handle your insurance program, and we need to work for you and be your advocate, EVERY step of the way.



Health Savings Account (HSA)

A health savings account (HSA) is like a 401(k) for healthcare. HSAs are tax-advantaged accounts that can accumulate interest and earn investment returns. The funds can be used to pay for qualified medical expenses today or can be saved for future expenses. The account is owned by you, is 100% vested from day one, and lets you build up savings for future needs.

Triple Tax Advantage

HSAs come with a triple tax benefit:

1. Reduces federal income taxes: When you contribute to an HSA directly from your paycheck, you reduce your federal income tax by amount you deposit in your HSA. You are also able to contribute post-tax and claim that contribution when filing your taxes.
2. Tax-free interest: Your money earns interest while it is in the account, and you do not pay taxes on the interest earned. Any gains on dollars invested in mutual funds are also tax-free for qualified medical expenses.

Tax-free withdrawals: You never pay taxes on HSA withdrawals when used to pay for qualified medical expenses, including medical, dental, vision, and pharmacy expenses.

HSA Eligibility

To qualify for an HSA, you must be enrolled in an HSA-powered health plan and meet the following requirements:

- Have no other health coverage, such as a flexible spending account, military, or VA benefits (see IRS Publication 969).
- Not be enrolled in Medicare.
- Not to be claimed as a dependent on someone else's tax return.

How to enroll in an HSA

First, enroll in an HSA qualified plan. You can fund your HSA through pre-tax payroll deductions or transfer money into your account. To take full advantage of tax savings and to build a reserve for the future, consider maximizing your contributions as set by the IRS.

Contribution Limits

2024

- Single: $4,150
- Family: $8,300

At age 55, and additional $1,000 is allowed annually.

Qualified Medical Expenses

Qualified medical expenses are designated by the IRS. They include medical, dental, vision, and prescription expenses. See IRS publication 502 for a list of specific examples. Some examples include:

- Acupuncture
- Birth Control
- Chiropractor
- Contact Lenses

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

_____

_____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Reimagine Education, LLC	82-1509979
5. Employer address	**6. Employer phone number**
7034 E Court Street	248-289-5521

7. City	8. State	9. ZIP code
Davison	MI	48423

10. Who can we contact about employee health coverage at this job?	
Charlie Carver	
11. Phone number (if different from above)	**12. Email address** carver@miprepschool.com
734-358-9775	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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	ALASKA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS Medicaid	**CALIFORNIA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA Medicaid	INDIANA Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA Medicaid and CHIP (Hawki)	**KANSAS 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 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY Medicaid	**LOUISIANA 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: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	**MASSACHUSETTS Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA Medicaid	**MISSOURI Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA Medicaid	**NEBRASKA Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA Medicaid	NEW HAMPSHIRE Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY Medicaid and CHIP	**NEW YORK Medicaid**
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	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	**NORTH DAKOTA Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	**OREGON Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	**RHODE ISLAND Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA Medicaid	**SOUTH DAKOTA Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid	**UTAH Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT Medicaid	**VIRGINIA Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	**WYOMING Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

READY TO HELP

MICHIGAN

How to register for your online member account

Enjoy the convenience — and freedom — you get with your account:

- Check your out-of-pocket balance and plan's benefits.
- Track your claims and explanation of benefits statements.
- Find care and look up costs.
- Show your virtual member ID card, and order more plastic cards for adult members on your plan.

Plus, get your member discounts, health and well-being resources and more.

REGISTER FOR YOUR ACCOUNT IN ONE OF THREE WAYS:

Go online.

1. Go to **bcbsm.com/register**.
2. Select *Register Now*.

   Your adult family members can register for their accounts, too.

Use our app.

1. Download the app from the App Store® or Google Play™ (search **BCBSM**).
2. Tap the app and then *Register*.

Text us.

Text **REGISTER** to **222764** to start setting up your account.*

If you need help registering for your account, call the Web Support Help Line at **1-888-417-3479**.

*Message and data rates may apply. Visit **bcbsm.com** for our *Terms and Conditions of Use* and *Privacy Practices*.

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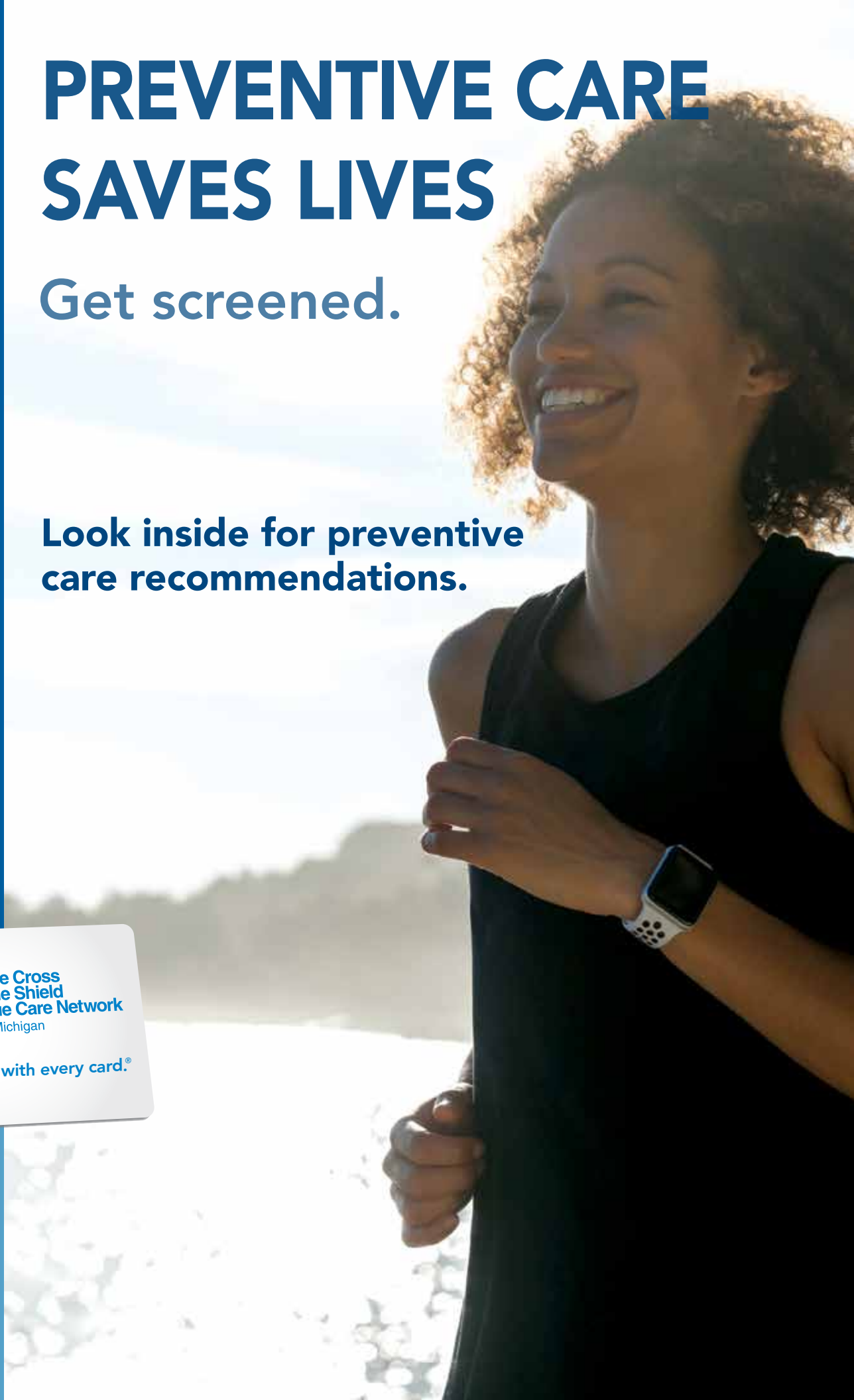
PREVENTIVE CARE SAVES LIVES

Get screened.

Look inside for preventive care recommendations.



Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

SAVE A LIFE ... YOURS

Blue Cross Blue Shield of Michigan and Blue Care Network members may receive some exams and services at no cost.

Regular checkups, the right screenings and a healthy lifestyle can help you prevent or detect life-threatening chronic conditions, such as heart disease, diabetes and cancer.

Blue Cross and BCN pay for some preventive care with little or no out-of-pocket costs to you when you choose in-network care.

Before you receive preventive care, make sure you know what your specific health care plan pays and what you must pay.

I'd been having some blurry vision and was certain I'd get a new eyeglass prescription at my annual eye exam. Instead, I got a big surprise when my optometrist said, "I'd like you to go to the emergency room." He told me I needed testing for a potentially life-threatening condition of the brain that was causing my optic nerves to swell.*

While I didn't end up having a deadly aneurism or brain infection, I was diagnosed with idiopathic intracranial hypertension, which causes excess cerebrospinal fluid pressure on the brain and eyes. If I hadn't gotten treatment in a timely manner, permanent blindness and debilitation were possible outcomes.

With firsthand experience, I can say, preventive care really can save your life.

Sue A.
Member and employee
Blue Cross Blue Shield of Michigan

*An annual preventive care eye exam is included with most vision plans.

RECOMMENDED PREVENTIVE CARE GUIDELINES*

INFANTS and TODDLERS BIRTH TO 24 MONTHS

	AGE	GUIDELINE
Well-child exam: including parental education; growth and development; nutrition; physical activity; vaccines; safety (safe sleep, injury, poison, burn prevention, car seats, secondhand smoke, parental coping); social determinants of health; health risks; and other important issues	0 to 24 months	11 visits
Autism screening	18 to 24 months	Once
Dental screening and fluoride	Beginning at 6 months	Choose a dentist
Lead screening blood test	12 to 18 months	Once (if at an increased risk or on Medicaid plan — ask your doctor)
Newborn hearing and metabolic screening	Birth (after 24 hours)	Once (before 1 month old)
Vision screening	0 to 24 months	Once (between 6 months to 12 months)
IMMUNIZATIONS		
Chickenpox (varicella)	12 to 15 months	First dose
COVID-19	6 months and up	Annually
DTaP (diphtheria, tetanus and pertussis)	2, 4 and 6 months 15 to 18 months	First, second and third dose Fourth dose
Flu	6 months and up	Two doses one month apart, then every year
Hepatitis B	Birth 1 to 2 months 6 to 18 months	First dose Second dose Third dose
HiB (Type B flu)	2 to 15 months	Three to four doses depending on vaccine
MMR (measles, mumps and rubella)	12 to 15 months	First dose
Pneumonia	2 months 4 months 6 months 12 to 15 months	First dose Second dose Third dose Fourth dose
Polio	2 months 4 months 6 to 18 months	First dose Second dose Third dose
Respiratory syncytial virus monoclonal antibody (nirsevimab)	8 months or younger 8 to 19 months	One dose One dose if at risk for lung disease
Rotavirus (stomach virus)	2 to 6 months	Two or three dose series

*Source for these guidelines is the U.S. Preventive Services Task Force as of 2023. Guidelines are subject to change.

RECOMMENDED PREVENTIVE CARE GUIDELINES*

CHILDREN and ADOLESCENTS AGES 2 TO 21

	AGE	GUIDELINE
Well-child exam: discuss growth and development; mental health; dental health; age-appropriate safety issues (injury, motor vehicle safety — car seats, seat belt use, parental coping, secondhand smoke, skin cancer prevention, bicycle safety and helmet use); nutrition (height, weight, body mass index); physical activity; age-appropriate health risks and social determinants of health; substance use disorder; pregnancy prevention	2 to 21 years	Every year
Chlamydia, gonorrhea and other sexually transmitted infections	Under 25 years	Every year if sexually active
Cholesterol screening	10 to 12 years and 13 to 21 years	If at an increased risk, screen ages 2 to 8 years and 12 to 16 years.
Dental screening and teeth cleaning	2 to 17 years	Every 6 months; if diagnosed with periodontal disease or other health conditions, every 3 to 4 months
HIV screening	13 and older	At least once in lifetime; if at increased risk, screen annually
Oral cancer screening	18 to 21 years	Annually; screen annually at any age if tobacco usage
Vision screening	3 to 6 years 8, 10, 12, 15 years 16 to 21 years	Annually Once at each age listed Annually *If risk factors are present, more frequent exams may be needed.*
IMMUNIZATIONS		
Chickenpox (varicella)	4 to 6 years	Second dose
COVID-19	2 to 21 years	Annually
DTaP (diphtheria, tetanus, and pertussis)	4 to 6 years	Fifth dose
Flu	2 years and older	Every year
HPV, boys and girls	9 to 14 years 15 to 21 years	Two doses Three doses
MMR (measles, mumps and rubella)	4 to 6 years	Second dose
Meningitis vaccine	11 to 12 years and 16 years	First dose Booster
Polio	4 to 6 years	Fourth dose
Tdap (tetanus, diphtheria, pertussis)	11 to 12 years	One dose

*Source for these guidelines is the U.S. Preventive Services Task Force as of 2023. Guidelines are subject to change.

ADULTS AGES 18 TO 49

	AGE	GUIDELINE
Annual physical: physical and mental health assessment; nutrition (record height, weight, body mass index); physical activity; health risks (including social determinants of health); intimate partner violence; tobacco use; substance use disorder; safety; skin cancer prevention; and other issues	18 to 21 years 21 to 49	Every year Every 1 to 5 years
Blood pressure screening	18 and older	Every year (or more often if at a high risk — ask your doctor)
Breast cancer screening	18 to 39 40 to 49	Discuss with your doctor if at risk and need earlier screening Every other year
Cervical cancer screening	 18 to 29 30 to 49	Women only Pap test every 3 years Pap test every 3 years and HPV test every 5 years, or HPV/Pap cotest every 5 years — ask your doctor
Colorectal cancer screening	45 to 49	Ask your doctor — if at risk, more frequent screenings may be needed; strategies include: gFOBT or FIT stool test every year; stool DNA-FIT test every 1 to 3 years; CT colonography plus sigmoidoscopy every 5 years; sigmoidoscopy every 10 years plus annual FIT; screening colonoscopy every 10 years
Dental screening and teeth cleaning	18 to 49	Every 6 months
Depression screening	18 to 49	Everyone, including pregnant and postpartum women — ask your doctor
Diabetes (blood sugar)	35 to 49	If overweight
HIV screening	18 to 49	At least once in lifetime; if at increased risk, screen annually
Oral cancer screening	18 to 49	Annually; if diagnosed with periodontal disease or other health conditions, every 3 to 4 months
Sexually transmitted infections	18 to 49	Sexually active women and older women at increased risk for infection: screen for chlamydia, gonorrhea; also screen if at risk for syphilis, hepatitis B and C — ask your doctor
Vision screening	18 to 49	At least every 2 years; annually preferred; if risk factors are present, more frequent exams may be needed
IMMUNIZATIONS		
COVID-19	18 to 49	Annually
Flu	18 to 49	Every year
HPV (human papillomavirus)	26 and younger 27 to 45 years	Complete one series Discuss with your doctor whether likely to benefit, if not previously vaccinated
Pneumonia, meningitis, hepatitis A, hepatitis B, Hib	18 to 49	Ask your doctor
Respiratory syncytial virus	18 to 49	All pregnant women who are 32 to 36 weeks pregnant between September and January
Tetanus	18 to 49	Once every 10 years
Varicella (chickenpox)	18 to 49	Two doses if no previous immunization or history of infection — ask your doctor

*Source for these guidelines is the U.S. Preventive Services Task Force as of 2023. Guidelines are subject to change.

RECOMMENDED PREVENTIVE CARE GUIDELINES*

ADULTS and SENIORS AGES 50 AND OLDER

	AGE	GUIDELINE
Annual physical: physical and mental health assessment; nutrition (record height, weight, body mass index); health risks; (personalized based on individual risk and including social determinants of health); tobacco use; substance use disorder; and other issues	50 and older	Every year
Blood pressure check	50 and older	Every year; more often if reading is higher than 140/90
Breast cancer screening	50 and older	Women only; every 2 years
Cervical cancer screening — not recommended for women who've had a total hysterectomy for benign disease	50 to 64 65 and older	Pap test every 3 years and HPV test every 5 years, or HPV/Pap cotest every 5 years — ask your doctor No screening if prior tests were normal and you're not at high risk
Colorectal cancer screening	50 to 75 76 to 85	Ask your doctor — if at risk, more frequent screenings may be needed; strategies include: gFOBT or FIT stool test every year; stool DNA-FIT test every 1 to 3 years; CT colonography plus sigmoidoscopy every 5 years; sigmoidoscopy every 10 years plus annual FIT; screening colonoscopy every 10 years Discuss with your doctor
Dental screening and teeth cleaning	50 and older	Every 6 months; if diagnosed with periodontal disease or other health conditions, every 3 to 4 months
Diabetes screening (blood sugar)	50 to 70	If overweight
Hepatitis C screening	18 to 79	One-time screening — if you're high risk, ask your doctor
HIV screening	50 to 65	At least once in lifetime; if at increased risk, screen annually
Lung cancer screening	50 and older	Based on individual risk; ask your doctor
Oral cancer screening	50 and older	Annually
Osteoporosis screening (brittle bones)	 50 to 64 65 and older	Women only Ask your doctor At least 1 bone scan
Prostate cancer	50 and older	Men only; screening recommendations are based on individual risk; ask your doctor
Sexually transmitted infections	50 and older	Get screened if you're at risk for syphilis, hepatitis B and C
Vision screening	50 to 64	At least every 2 years; annually preferred; if risk factors are present more frequent exams may be needed
IMMUNIZATIONS		
Chickenpox (varicella)	50 and older	Two doses if no previous immunization or history of infection — ask your doctor
COVID-19	50 and older	Annually
Flu	All ages	Every year
Meningitis, hepatitis A, hepatitis B	50 and older	Ask your doctor
Pneumonia	Before age 65 65 and older	If risk factors present — ask your doctor Two doses at least 1 year apart
Respiratory syncytial virus	60 and older	One dose
Shingles (zoster)	50 and older	Two-dose series
Tetanus	All ages	Once every 10 years

*Source for these guidelines is the U.S. Preventive Services Task Force as of 2023. Guidelines are subject to change.

Keep this brochure to help you identify the preventive care you need. The charts, based on age and gender, provide a road map for achieving a healthier life.

This isn't a comprehensive list of care that could be paid by your specific plan. Log in to your online member account at **bcbsm.com** for more information about your benefits. If you don't have a member account, go to **bcbsm.com/register**.

You might also like these apps:

Search for *USPSTF Recommendations app**

Search for *CDC Vaccine Schedules app**

Schedule your preventive screenings today.

CALL YOUR DOCTOR
TO SCHEDULE AN APPOINTMENT.

IF YOU DON'T HAVE A DOCTOR
FIND ONE AT bcbsm.com/find-a-doctor.

Looking for more information about health and well-being?
Visit bcbsm.com.

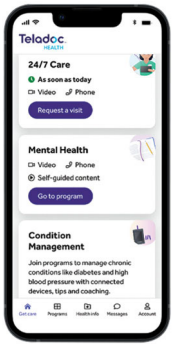
Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Virtual Care 2024

Previously Blue Cross Online Visits℠

Virtual care that's always there



GET CARE WHEN YOU NEED IT, WHEREVER YOU ARE.

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

Virtual Care is included with your Blue Cross Blue Shield of Michigan and Blue Care Network health care plan.

24/7 CARE

Have a virtual visit with a U.S. board-certified doctor for minor illnesses such as colds, sore throats, urinary tract infections and pink eye. Visits are available for adults and children.

Medical visits are available 24/7, anywhere in the U.S., when your primary care provider isn't available. You don't need an appointment and the average wait time is 10 minutes. Prescriptions, if needed, can be sent to your preferred pharmacy.

MENTAL HEALTH

Through the Mental Health option, you can connect with a licensed therapist or U.S. board-certified psychiatrist when you're dealing with stressful situations or issues such as grief, anxiety and depression.

Mental health visits require an appointment, but many therapists and psychiatrists have evening and weekend availability.

SIGN UP TODAY

Visit bcbsm.com/virtualcare for a link to download the Teladoc Health app.

Family members ages 18 and older will need to create their own Virtual Care accounts. When updating or creating an account, choose your plan name and enter your member ID so your coverage is applied correctly. Call **1-800-835-2362** with any questions about your account or to arrange a telephone visit.

READY TO HELP

MICHIGAN

All Virtual Care services from Teladoc Health are separate from virtual care other providers may offer. Remember to follow up with your primary care provider. Your plan may have copayments, deductibles and out-of-pocket costs.

Virtual Care 2024

Previously Blue Cross Online Visits℠

Frequently asked questions

Virtual care that's always there

WHAT IS VIRTUAL CARE?

Taking care of yourself and your family's health can be as easy as using your smartphone, tablet or computer for a virtual visit with a U.S. board-certified doctor or licensed therapist.

With **Virtual Care** by Teladoc Health®, you don't need an appointment for medical care, although an appointment for mental health visits is required.

HOW DO I SIGN UP?

Visit **bcbsm.com/virtualcare** for a link to download the Teladoc Health app. You can also open the Blue Cross Blue Shield of Michigan mobile app, click *Find a Doctor* and then *Virtual Care*.

You'll need your Blue Cross member ID card. Remember to choose your health plan and enter your member ID number when updating or creating your account so your coverage is applied correctly.

READY TO HELP

MICHIGAN

WHEN WOULD I USE *24/7 CARE*?

When your primary care provider isn't available, you can talk to a U.S. board-certified doctor about minor illnesses such as:

- Sinus and respiratory infections
- Cold and flu
- Painful urination
- Eye irritation or redness
- Sore throat

Your primary care provider may offer virtual visits. Talk to your provider about the services he or she offers.

If your life is at risk, call 911 or go to the nearest emergency room.

WHEN WOULD I USE *MENTAL HEALTH*?

You can have a virtual visit with a therapist or psychiatrist when you're struggling with challenges such as anxiety, depression and grief.

This private and confidential mental health care gives you more options and access. It's meant to provide ongoing, long-term support.

For immediate behavioral health care, call the Behavioral/Mental Health and Substance Abuse number on the back of your Blue Cross member ID card.

Virtual Care provides routine psychological and psychiatric treatment. Virtual Care does not provide treatment for complex mental health and substance use disorder conditions.

HOW DO I HAVE A VIRTUAL VISIT?

1. Open the Teladoc Health app. Or open the Blue Cross app, click *Find a Doctor* and then *Virtual Care*.
2. Choose a service: *24/7 Care* or *Mental Health*.
3. Pick a doctor or begin a scheduled visit.
4. Meet with the doctor or therapist online.
5. Get a prescription, if appropriate, sent to your preferred pharmacy.
6. After your visit, you can share an optional visit summary with your primary care provider.

HOW LONG DOES A VISIT TAKE?

For medical visits, the average wait time is 10 minutes. Length of visits vary. Doctors will take as much time as necessary to address the issue, answer questions and determine next steps.

Therapy visits are scheduled for 45 minutes. Psychiatry visits are 30 to 40 minutes for the initial visit; follow-up visits are 15 minutes.

DO I NEED TO MAKE AN APPOINTMENT?

Medical care is available 24/7 without an appointment.

Mental health visits are available by appointment only. Licensed therapists and U.S. board-certified psychiatrists are available from 7 a.m. to 9 p.m. seven days a week.

Therapy is available for members ages 13 and up. Psychiatry is available for members ages 18 and up.

A parent or guardian will need to be present at the start and end of therapy visits for children ages 13 to 17.

HOW MUCH DOES IT COST?

Medical visits are $65 or less. If you have a plan with a copay, it's generally equal to or less than what you pay for a primary care office visit.

Costs for mental health visits vary depending on the type of provider and the services you receive. Your out-of-pocket costs are based on your existing outpatient behavioral health benefits.

You'll see your cost before you start your visit. Be sure you've added your Blue Cross health plan information to your Virtual Care account.

WILL I GET A PRESCRIPTION DURING A VISIT?

If a prescription is needed, the doctor will send an electronic prescription to a pharmacy you choose. Make the most of your benefits by choosing an in-network pharmacy. You'll pay for the prescription at the pharmacy according to your pharmacy benefit.

Doctors don't prescribe controlled substances.

WHAT KIND OF PROVIDERS ARE AVAILABLE?

The doctors and therapists are specially trained in online visits. You can read their profiles to learn about them, including the languages they speak, education and gender.

Doctors have an average of 20 years practicing medicine and are U.S. board-certified. They have experience in areas such as pediatrics, family medicine and emergency care. Psychiatrists are board-certified in psychiatry.

Providers are licensed in the state where you're having a visit.

CAN MY FAMILY USE VIRTUAL CARE?

Yes. Everyone on your health care plan can use it. Parents and guardians can add children ages 17 and younger to their account and have medical visits on their behalf.

Spouses and adult children ages 18 and older must set up their own accounts.

WHAT IF I NEED HELP WITH VIRTUAL CARE?

If you have questions or need help with your Virtual Care account or an online visit, please call **1-800-835-2362**, 24/7.

All Virtual Care services from Teladoc Health are separate from virtual care other providers may offer. Remember to follow up with your primary care provider. Your plan may have copayments, deductibles and out-of-pocket costs.

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta, o 877-469-2583, TTY: 711 si usted todavía no es un miembro.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك، أو برقم 877-469-2583 TTY:711، إذا لم تكن مشتركا بالفعل.

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話；如果您還不是會員，請撥電話877-469-2583, TTY: 711。

[illegible] 877-469-2583 TTY:711 [illegible]

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị, hoặc 877-469-2583, TTY: 711 nếu quý vị chưa phải là một thành viên.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj, ose 877-469-2583, TTY: 711 nëse nuk jeni ende një anëtar.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하거나, 이미 회원이 아닌 경우 877-469-2583, TTY: 711로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন বা 877-469-2583, TTY: 711 যদি ইতোমধ্যে আপনি সদস্য না হয়ে থাকেন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty lub pod numer 877-469-2583, TTY: 711, jeżeli jeszcze nie masz członkostwa.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an oder 877-469-2583, TTY: 711, wenn Sie noch kein Mitglied sind.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda o chiama il 877-469-2583, TTY: 711 se non sei ancora membro.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号(メンバーでない方は877-469-2583, TTY: 711)までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по номеру телефона отдела обслуживания клиентов, указанному на обратной стороне вашей карты, или по номеру 877-469-2583, TTY: 711, если у вас нет членства.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na svom jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice ili 877-469-2583, TTY: 711 ako već niste član.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta, o 877-469-2583, TTY: 711 kung ikaw ay hindi pa isang miyembro.

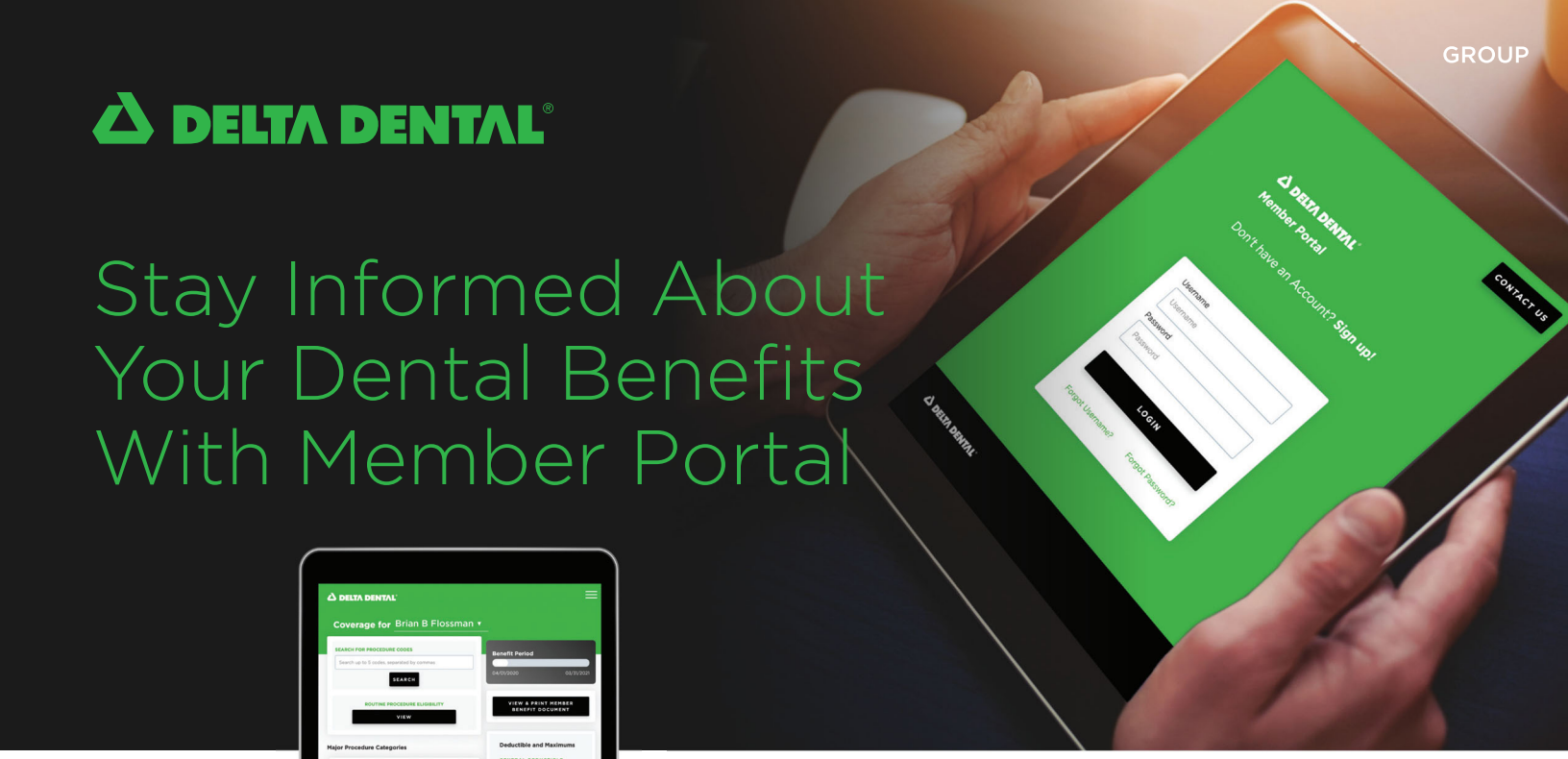
Important disclosure

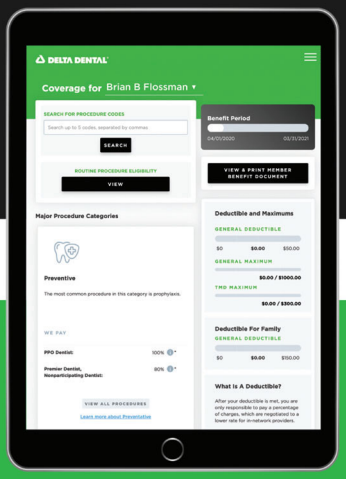
Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card, or 877-469-2583, TTY: 711 if you are not already a member. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

DELTA DENTAL®

Stay Informed About Your Dental Benefits With Member Portal





Member Portal gives you 24/7 access to important information about your dental benefits.

With Member Portal, you can:

- See which members are covered on your plan, now and in the future
- Find an in-network dentist
- See common procedures
- Access an online ID card
- View the status of all claims and toggle between different family member claims
- View and print Explanation of Benefits (EOBs)

NOTE: Member Portal has replaced Consumer Toolkit.

Get started today

Visit www.memberportal.com

Log in using your existing Consumer Toolkit® credentials

OR

If you do not have existing credentials, click "Sign up"

Complete the required fields and follow the on-screen instructions to register as a new user

NOTE: You will need the subscriber's ID (the person whose name is on the benefit package). The member ID is an assigned number unique to the subscriber. In many cases, the member ID is the same as the subscriber's Social Security number.

Questions? Call Toolkit Support at 866-356-0301

Privacy of your online benefit information is assured through highly secure encryption technology.

VSP Vision

KANSAS CITY LIFE INSURANCE COMPANY

Thank you for enrolling in the Kansas City Life Insurance Company VSP Vision Plan.

As a member, you'll get access to great eye doctors who deliver quality vision care, personalized attention, and the best choices in eyewear.

VSP Choice Network

You have the freedom to choose the provider who's right for you with more than 36,000 in-network doctors to choose from. With the largest national network of independent doctors and over 5,000 retail chain locations, like Costco and Visionworks, it's easy to find a conveniently located VSP network doctor.

VSP® Vision care for life

It's easy to use your VSP benefit.

- Create an account at *vsp.com*. Review your vision benefit and access your eligibility and coverage information.
- Find superior eye care near you. The decision is yours – choose to see a VSP network doctor or an out-of-network provider. If you choose to see an out-of-network provider, your coverage will be less than with a VSP network doctor, and you'll need to submit a claim. Visit *vsp.com* or call 800-877-7195 to find a VSP network doctor.
- At your appointment, tell them you have VSP. There's no ID card needed. If you'd like a card to refer to, you can print one on *vsp.com*.

That's it! There are no claim forms to complete when you see a VSP network doctor.

Premier Program

Get even more from your benefit when you visit a practice that participates in the Premier Program. You'll get a wide selection of designer frames, extra savings on contact lenses, advanced eye exams using the latest high-tech equipment, and access to exclusive bonus offers.

Check out more ways to save at *vsp.com/specialoffers*.

Walmart or Sam's Club

When choosing Walmart or Sam's Club as an out-of-network service provider, VSP makes it simple. All you have to do is say "I have VSP" and they'll handle the claim for you. Hundreds of frames are fully covered.

Thank you for choosing Kansas City Life Insurance Company and VSP as your vision care provider.

KANSAS CITY LIFE

GROUP BENEFITS

Underwritten by: Kansas City Life Insurance Company
3520 Broadway • Kansas City, MO 64111-2565
P.O. Box 219425 • Kansas City, MO 64121-9425
Toll-free: 877-266-6767, ext. 8302 • Fax: 816-753-2964
groupbenefits@kclife.com • *www.kclgroupbenefits.com*

Group Life Conversion vs. Portability Q&A

KANSAS CITY LIFE INSURANCE COMPANY

	Conversion	Portability *
Am I eligible to convert or port my life coverage if my group life coverage ends?	Yes, if you are an eligible member of a covered class of employees, you are eligible to convert your coverage to a whole life policy.	Yes, provided you were covered under the policy for a minimum of 12 consecutive months before applying for portability, you may port your term insurance policy.
Do I need to answer medical questions?	No	No
Will I receive a new policy?	Yes, a new whole life policy will be mailed to you.	Yes, coverage will continue under the provisions of the group life insurance policy until December 31 of the current year. Then, a new certificate of coverage will be mailed to you.
How much life insurance may I convert or port?	If your Group Life insurance or any portion of it ends due to termination of employment with the policyholder organization or membership in any of this policy's classes, you may convert all or any portion of your life insurance which was in force on the date of termination. However, the amount of insurance may not be greater than the amount which terminated. If your Group Life insurance ends due to termination of the Group Life insurance policy or amendment of the Group Life insurance policy which makes your class ineligible for life insurance, you may be eligible to convert a limited amount of insurance.	The amount of insurance available for portability for an employee is a minimum of $20,000 and a maximum of the benefit amount in force on the date your employment in an eligible class terminates, or $250,000, whichever is less.
Can my dependents convert or port their coverage?	Yes, your dependents may convert their coverage to a new individual policy of life insurance, other than term insurance, if the child's insurance terminates because your insurance ceases or the child is no longer a dependent as defined.	Yes, but only if the employee elects to port his/her coverage as well. The amount of insurance for children is limited to no more than $5,000 and cannot exceed the coverage amount in effect at the time portability is elected.
If I was not actively at work due to an illness or injury when my coverage ended, may I convert or port my coverage?	Yes	Yes
Is there a minimum amount that I must convert or port?	Yes. $5,000 or the amount which terminated – whichever is less.	Yes. Employee – $20,000; Spouse – $10,000; Child(ren) – $2,500
After I convert/port my coverage, will my coverage reduce?	No	No
When will coverage end?	As long as premiums are paid, your coverage will remain in force.	Coverage will terminate should coverage become effective under a Group Life policy. Coverage under the Group Portability policy will be for the lesser of two years or until Dec. 31, following your 70th birthday. Effective Dec. 31, following your 70th birthday, you are not eligible for Group Portability coverage.

**Portability is not available in all states.*

	Conversion	Portability*
Are extension of benefits or other riders available for conversion or portability?	No. The new individual policy will be issued without Waiver of Premium, Accidental Death and Dismemberment, Accelerated Death Benefit, or any other riders or additional benefits.	No. Any extension of benefits, Waiver of Premium, Accidental Death and Dismemberment, or any other riders will not apply to coverage under the Portability option.
May I elect to both convert and port my coverage?	No. You may do one or the other, but not both.	
Does the Accelerated Death Benefit apply?	No	Yes. Upon diagnosis of a terminal illness or injury, you may make a one-time election to accelerate a partial payment of death benefits.
Can I increase my coverage amount?	You may not increase your amount.	
Suicide exclusion?	No	No
How soon after losing coverage must I decide to convert or port?	You have 31 days after your coverage terminates to complete an application and pay the required premium to the Company to convert or port your coverage.	
How much premium will I be charged?	Please contact Kansas City Life Insurance Company for conversion rates.	The premium rate for continued coverage to the end of the calendar year will be the same as the Policy premium rate in force on the date your employment or eligibility ends. On January 1, the next year, the premium rate will be based on the then current premium rates for the group portability policy.
May I pay my premium via ACH?	Yes	Yes
How frequently will premium be due?	You may choose to pay your premium annually, semi-annually, quarterly or monthly.	Your premium must be paid quarterly.

**Portability is not available in all states.*

This is a brief description only and is not a contract. Ages, periods of time, dollar amounts, and certain benefits may vary by group and will be outlined in the certificate of coverage. The Group Master Policy will determine all rights and benefits. For costs and further details of the coverage including exclusions and any reductions or limitations, see your agent or write to the Company. Policy and certificate referenced herein: PJ136/CJ136.

Dedicated to excellence.
Your partner in employee benefits.

KANSAS CITY LIFE

GROUP BENEFITS

Underwritten by: Kansas City Life Insurance Company
3520 Broadway • Kansas City, MO 64111-2565
P.O. Box 219425 • Kansas City, MO 64121-9425
Toll-free: 877-266-6767, ext. 8200 • Fax: 816-531-4648
groupbenefits@kclife.com • *www.kclgroupbenefits.com*

GET TO KNOW YOUR

Employee Assistance Program

Administered by Acentra HEALTH

Your Employee Assistance Program (EAP) is a complimentary service available to you through your employer. The EAP provides counseling sessions at no cost to you, as well as offering a wide variety of services to enhance overall wellbeing and support healthy work/life balance. Services and commonly addresses issues are described below. The program is completely confidential and available to you, your household family members, and dependents.

EAP SERVICES & RESOURCES

KANSAS CITY LIFE GROUP BENEFITS

IMMEDIATE 24/7 SUPPORT AND GUIDANCE

Master's level counselors and work/life specialists are standing by twenty-four hours a day, seven days a week, 365 days a year to answer any questions about the program, provide in-the-moment guidance, and connect you to any of the resources described below.

COUNSELING & SUPPORT

Whether you are dealing with stress, anxiety, depression, relationship issues, substance abuse issues, work issues, or other challenges, we can help. Let us connect you with a highly qualified counselor for in-person, phone, or video counseling sessions. You, your household family members, and dependents are eligible for free confidential counseling sessions.

ONLINE TOOLS & RESOURCES

The EAP website listed below is your one-stop resource for tools and information designed to address life's pressing concerns. You will find webinars, self-assessments, soft skills trainings, podcasts, articles, and more. Additionally, you can access calculators, childcare and eldercare resources, download legal and financial forms, and more.

MANAGEMENT & ORGANIZATIONAL SERVICES

Unlimited telephonic consultations are available to leadership to provide solutions to complex individual and team issues, including ways to reduce conflict and address performance and behavioral issues. The EAP also provides immediate guidance and support following a traumatic or critical incident that impacts the workplace, including coordination of critical incident debriefings.

LEGAL CONSULTATION

Legal concerns can be stressful, costly and often result in lost work time. Reach out to the EAP for a referral for a free 30-minute consultation with a lawyer for any issue (excluding work related issues). After the 30-minutes, you will receive a 25% discount for additional time and services. General legal information and forms, including a simple will form, can be found on the website.

FINANCIAL CONSULTATON

Sometimes we don't know where to start when we are having financial issues or need help budgeting, saving, or have other financial questions. Contact the EAP for a free 30-minute phone consultation with a financial expert. Additional information on budgeting, debt management, and getting ready for retirement can be found on the website.

WORK/LIFE SUPPORT & REFERRAL SERVICES

Let us do the leg work when it comes to researching fitness centers, colleges, adoption services, relocation services, volunteer opportunities, pet care, entertainment, doctors, home repair services, and so much more. Your time is too valuable; our research team is standing by to do the work for you.

CAREGIVER SUPPORT SERVICES

Are you looking for childcare, summer camps, afterschool activities, or back-up care? Need help finding referrals for assisted living facilities or in-home care for an older parent? We can help. Reach out to speak to one of our Child or Elder Specialists, available 24/7. In addition to referrals, they can offer expert advice and guidance tailored to your area of need.

CALL TOLL-FREE, 24/7:
1.877.239.8783

WEBSITE:
www.EAPHelplink.com
Code: KCLEAP5

SCAN ME

Scan this QR code using your phone camera to go directly to the EAP website

VALUE ADDED SERVICES FROM A COMPANY YOU CAN TRUST

Beneficiary

Travel

Identity

KANSAS CITY LIFE

GROUP BENEFITS

Value Added Services from Generali Global Assistance

The benefits of doing business with Kansas City Life Insurance Company go beyond our exceptional Group coverage. By selecting Kansas City Life to provide your coverage, employees will have access to outstanding services from our partner, Generali Global Assistance (GGA). Value Added Services – just one of many benefits of choosing Kansas City Life.

Beneficiary Companion

Travel Assistance

Identity Theft

GENERALI
GLOBAL ASSISTANCE

You can count on Generali Global Assistance 24/7/365. Take a look at the benefits.

Available 24 hours a day
866-409-4690
+1-240-330-1462 (Collect outside the U.S.)
ops@us.generaliglobalassistance.com

Beneficiary Companion

A service with survivors in mind

At a time of loss, the last thing survivors want to do is make phone calls and handle paperwork. With Kansas City Life's Group Benefit's Beneficiary Companion, they don't have to. Generali Global Assistance will take care of the administrative details involved in closing a loved one's affairs, relieving the stress of paperwork and allowing beneficiaries to focus on the healing process.

Guidance

Kansas City Life Group Benefit's Beneficiary Companion service offers the following types of support:

- Guidance on how to obtain death certificate copies (necessary for performing final notifications)
- 24/7 live support and counsel from a dedicated Beneficiary Assistance Coordinator
- The Beneficiary Companion Guidebook that serves as a handy reference tool for beneficiaries navigating the aftermath of a loved one's death

Assistance

Dedicated Beneficiary Assistance Coordinators manage the assistance process which includes notification to the following:

- Social Security Administration
- Credit reporting agencies
- Credit card companies
- Banks and other financial institutions
- Third-party vendors
- Government agencies

Social media shut down

In an increasingly digital world, it's more common than ever for loved ones to have an active social media presence. However, it can be an emotionally painful and time-consuming process to bring closure to those accounts. Our coordinators can work with the beneficiary to:

- Discontinue access to loved one's social media accounts
- Assist with memorialization of eligible accounts to preserve a loved one's digital profile

Identity protection and fraud resolution

Every year the identities of nearly 2.5 million deceased Americans are stolen to fraudulently open accounts, obtain loans, tax refunds, and other services, according to the IRS[1]. Studies have shown that a deceased person's identity is an attractive target for criminals, especially given the relative ease of obtaining their personally identifiable information. GGA's Identity Protection services give beneficiaries additional peace of mind by providing guidance on how to protect their loved one's identity and resolution assistance in the event of identity theft. Services include:

- Review of credit report with the beneficiary
- Suppression of the deceased person's credit report or a freeze/closure of the account with credit bureaus
- Full-service resolution assistance should there be an incident of identity theft, including affidavit assistance, credit bureaus and fraud department notification, help filing police report, creditor follow-up, and other services

[1]https://hrhcpa.com/ghosting-exploits-the-stolen-identities-of-the-dead

Travel Assistance

Safe travels with travel assistance services

With Generali Global Assistance (GGA), one quick phone call can take the hassle out of a traveling emergency. When you travel 100 miles or more away from home on trips of 90 days or less, you have access to travel medical and personal assistance services.

With a local presence in 200 countries and territories worldwide and 24/7/365 assistance centers staffed with multilingual assistance coordinators and case managers as well as medical staff, GGA is here to help you obtain the care and attention you need in case of an emergency while traveling.

In the event of a life-threatening emergency, call the local emergency authorities first to receive immediate assistance, and then contact GGA.

Available travel assistance services

Emergency medical payment

GGA will advance on-site emergency inpatient medical payments to you, up to $10,000 USD upon receipt of satisfactory guarantee of reimbursement from you. The cost of medical services is your responsibility.

Medical search and referral

GGA will assist you in finding physicians, dentists and medical facilities.

Replacement of medication and eyeglasses

GGA will arrange to fill a prescription that has been lost, forgotten or requires a refill, subject to local law, whenever possible. GGA will also arrange for shipment of replacement eyeglasses. Costs for shipping of medication or eyeglasses, or a prescription refill, etc. are your responsibility.

Medical monitoring

During the course of a medical emergency resulting from an accident or sickness, professional case managers, including physicians and nurses, GGA will monitor your case to determine whether the care is appropriate.

Visit by family member/friend

If you are traveling alone and must be or are likely to be hospitalized for seven or more days or are in life-threatening condition, GGA will arrange and coordinate payment for the round-trip transportation for one family member or friend, designated by you from his or her home to the place where you are hospitalized. Transportation costs are the responsibility of you, your family member or friend.

Dependent children assistance

If any dependent children under the age of 19 traveling with you are left unattended because you are hospitalized, GGA will coordinate and arrange payment for their economy class transportation home. Should transportation with an attendant be necessary, GGA will arrange for a qualified escort to accompany the child(ren). Transportation cost is your responsibility.

Traveling companion assistance

If a travel companion loses previously made travel arrangements due to your medical emergency, GGA will arrange for your traveling companion's return home. Transportation costs are the responsibility of you or your traveling companion.

Emergency evacuation/medically necessary repatriation

In the event of a medical emergency, when a physician designated by GGA determines that it is medically necessary for you to be transported under medical supervision to the nearest hospital or treatment facility or be returned to your place of residence for treatment, GGA will coordinate and arrange payment for the transport under proper medical supervision.

Repatriation of mortal remains

In the event of your death while traveling, GGA will coordinate and arrange payment for all necessary government authorizations, including a container appropriate for transportation and for the return of the remains to place of residence for burial.

Trip interruption

If you or an immediate family member is critically injured, sick or dies while traveling, GGA shall arrange for you or your immediate family member's return to the preferred place of hospitalization or burial via the most direct route on economy class airfare. Transportation cost is your responsibility.

Additional travel assistance services

Pre-trip information – Know what you need from currency exchange to consulate referrals before heading out.

Language translation – Get assistance from an interpreter on the phone or on site.

Lost/stolen items – Retrieve lost or stolen luggage, ticket documentation or personal items.

Emergency cash – Emergency advances of up to $500 USD are available in a time of need. (Transfer/deliver fees are your responsibility.)

Emergency travel – Airline, hotel and/or car rental reservations are made during an emergency.

Legal assistance – Legal assistance and bail are available if you're arrested. (Service costs are your responsibilities.)

Emergency messaging – Urgent messages will be sent to your family, friends or associates during an emergency.

Vehicle return – If you're unable, GGA will arrange payment and return of your rental during an emergency. (Service costs are your responsibility.)

Pet return – Hospitalized? GGA will arrange to return your pets home. (Service costs are your responsibility.)

Identity Theft

Protect yourself against identity theft

While the means to detect and prevent identity theft continue to evolve, the crime continues to impact millions of Americans every single year. As criminals continue to search for new ways to commit identity theft, with social networks and healthcare records becoming growing areas to exploit, identity theft is an ever-increasing problem.

Comprehensive protection

Generali Global Assistance (GGA) basic identity theft protection program provides consumers with the information to protect themselves and guidance to help them resolve identity theft. This cost-effective solution offers:

Prevention

- Identity theft prevention kit
- Expertise available 24/7 (support available immediately upon enrollment)

Detection

- Three bureau fraud alert placement assistance

Resolution

- Credit information review
- ID theft affidavit assistance
- Wallet protection
- Translation service
- Emergency cash advance

Generali Global Assistance (GGA) Conditions and Exclusions

Generali Global Assistance (GGA) is not responsible for the validity of the documents presented by the Beneficiary Representative or by the Executor of the Estate, the accuracy of the contents of the Covered Member's credit report nor is GGA responsible for accounts that have been closed by a Covered Member's relative without the Beneficiary Representative's knowledge.

GGA is not responsible for the provision of probate or governmental agency services or proceedings relating to the Estate of the deceased Covered Member. GGA does not guarantee that its intervention on behalf of the Covered Member duly enrolled in the Beneficiary Companion Program will result in a particular outcome or that its efforts on behalf of the Covered Member will lead to a result satisfactory to the Covered Member. GGA services do not include, and GGA cannot assist the Covered Member, for thefts involving non-U.S. bank accounts. GGA is neither an insurer nor provider of insurance and nothing in this program is intended to provide a policy of insurance or insurance benefits to any Covered Member. GGA reserves the right, in its sole and exclusive discretion, to refuse to provide any Services to a Covered Member for a cause of action that occurred prior to his or her enrollment in the Identity Theft program and/or in the Beneficiary Companion program.

GGA shall provide services to all members. On any expenditure for which the member is responsible, GGA shall not be obligated to provide services without first securing funds from the member in payment of such expenditure. If the member pays for covered expenses without receiving an approval or authorization in writing from GGA, then GGA shall not be obligated to reimburse the member for any such expenditure. In the event a member requests a service not included in a program, GGA may, in its sole and absolute discretion, provide such benefits or services at the sole expense of the member, including a reasonable fee to GGA for its efforts on behalf of the member.

GGA provides the services under this program in all countries of the world. However, conditions such as war, natural disaster or political instability may exist in some countries that render assistance services difficult or impossible to provide. In such instances services cannot always be assured. GGA shall attempt to assist a member consistent with the limitations presented by the prevailing situation in the area. GGA reserves the right to suspend, curtail or limit its services in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strikes, nuclear accidents, acts of God or refusal of authorities to permit GGA to fully provide services. In the event a member travels in any area in which such conditions exist, GGA nonetheless shall endeavor to provide services consistent, however, with the risks and conditions then prevailing. GGA shall not be responsible for failure to provide, or for delay in providing services when such failure or delay is caused by conditions beyond GGA's control, including but not limited to flight conditions, labor disturbance and strike, rebellion, riot, civil commotion, war or uprising, nuclear accidents, natural disasters, acts of God or where rendering a service is prohibited by local law or regulations.

Decisions by physicians or other health care professionals employed by, or under contract to, or designated by GGA as to the medical necessity for providing any of the medical services covered by this program are medical decisions based on medical factors and shall be conclusive in determining the need for such services. GGA shall not evacuate or repatriate a member if an GGA designated physician determines that such transport is not medically advisable or necessary or if the injury or illness can be treated locally. In all cases, the medical professionals, medical facilities or legal counsel suggested by GGA to provide direct services to the eligible person pursuant to this program are not employees or agents of GGA, and the final selection of any such medical professional, medical facility, or legal counsel is your choice alone. GGA assumes no responsibility for the quality or content of any such medical or legal advice or services. GGA shall not be liable for the negligence or other wrongful acts or omissions of any of the healthcare or legal professionals providing direct services arising out of or pursuant to this program. The member shall not have any recourse against GGA by reason of its suggestion of, or contract with, any medical professional or attorney.

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TOTAL PET PLAN

Frequently Asked Questions

What is Total Pet Plan?

Total Pet Plan brings the best brands in pet care together to create a bundle that covers everything your pets need. Receive benefits from **PetPlus**, **Pet Assure**, **AskVet**, and **ThePetTag** at one low payroll deduct rate.

What does Total Pet cover?

As a Total Pet Plan member, you'll receive:

- PetPlus: Up to 40% off and free shipping on all orders from **PetCareRx.com**
- Pet Assure: 25% savings on in-house veterinary care at participating vets
- AskVet: Chat with a US-based Veterinarian for questions on your pet's health, wellness, behavior and more
- ThePetTag: Durable ID tag that can be scanned if your pet goes missing, bringing them home faster than a microchip

Which pets can I enroll?

You can enroll any dog and cat in Total Pet Plan. There are no restrictions due to age, breed or health of your pet. Pet Assure Veterinary Discounts also cover exotic pets.

How do I access my Total Pet benefits?

Log in to your account at **www.petbenefits.com** to access all of your plan benefits.

Is this insurance?

No, with the Total Pet Plan you receive instant savings and pet care services without any paperwork.

Are there any additional fees?

No, your membership cost gives you access to all of your benefits without any additional fees.

Are there usage limitations?

No, all benefits have unlimited usage for the pets enrolled.

What happens to my membership if I'm no longer eligible for benefits?

Members who are no longer payroll deduct eligible or are leaving the company can port coverage at the same group rate within 28 days of termination.

The following pages include FAQs on each individual component of Total Pet Plan.

PETplus Pet Assure AskVet The PetTag

PetPlus

What is PetPlus?

Receive members-only pricing (up to 40% off) on products you're already buying for your pets. Products include prescriptions, preventatives, food, treats, toys and more! Shipping is always free and same-day pickup is available for most human-grade prescriptions.

How do I access my PetPlus account after enrolling?

After you enroll, you will receive instructions via mail and email on how to activate your online account. You can start shopping online as soon as you activate your account.

How do I place an order for delivery?

Shop online using your PetPlus membership at **PetCareRx.com**. Savings are automatically applied at checkout and shipping is always free.

How do I pick up my pet's prescription at a pharmacy?

If your pet is prescribed a human-grade medication, ask the vet for a written prescription for your pet's medication. Take your pet's prescription and PetPlus Rx card to any participating pharmacy.

The pharmacist will fill your pet's prescription and PetPlus will charge your credit card on file at the listed member rate. You should NOT be charged at the pharmacy for your purchase.

When do I receive my PetPlus card?

Your PetPlus card is available on your PetPlus dashboard as soon as you activate your account. You can either print out your card at home or show it to the pharmacy right from your mobile device.

Pet Assure

What is Pet Assure?

Pet Assure is a veterinary discount plan that saves you 25% at participating veterinarians on all in-house medical services, no exclusions. Even pre-existing conditions are covered!

How do I use Pet Assure?

When you visit a participating vet, present your Pet Assure member ID card from the Pet Assure app at checkout, and the veterinary staff will apply a 25% discount to all in-house medical services. There is no paperwork or forms to fill out. You can use your savings immediately on your benefit start date.

What procedures are discounted?

Participating veterinarians discount all in-house medical services. This includes the office visit, vaccinations, surgery, dental cleaning, spay and neuter surgery, x-rays and any other procedures the vet performs. Even procedures related to pre-existing conditions are discounted.

Are there any exclusions?

No, there are absolutely no exclusions. All in-house medical services are covered, including wellness, sick and emergency care. You can enroll any type of pet, regardless of type, breed, age or health.

Can I use this together with pet insurance?

Yes. Pet insurance typically only covers major medical claims and often excludes wellness exams or pre-existing conditions. Pet Assure does not have any exclusions and will save you money on the procedures not covered by pet insurance. The Pet Assure savings are instant and can help you save on veterinary care prior to meeting your insurance deductible and while you wait for insurance reimbursement.

Where can I find a list of participating vets in my area?

You can search for participating practices by visiting **www.petbenefits.com/search**. Mention that you're a Pet Assure member when you call to make an appointment.

If a veterinarian you would like to visit does not participate, you can invite them to join by clicking the "Invite to Pet Assure" button. With a few details, you'll have a custom-generated email to send to your vet inviting them to join and providing instructions for them to contact Pet Assure for further details.

AskVet

AskVet

What is AskVet?

AskVet is 24/7 pet telehealth service that gives you direct access to a veterinarian via live chat.

How do I access AskVet?

Log in to your PetPlus account. Click Connect Now on your PetPlus dashboard to chat with an AskVet Veterinarian.

Can AskVet replace my primary veterinarian?

No, AskVet does not diagnose or prescribe, and is not intended to be used as a replacement for your primary veterinarian.

Who are the veterinarians at AskVet?

AskVet veterinary telehealth specialists are US-based licensed veterinarians trained to help you make the best decisions for your pet.

What can an AskVet veterinarian help me with?

AskVet offers 24/7 decision support on all of your pet care questions and concerns. While AskVet cannot provide a diagnosis or prescribe medication, they can help you decide the best course of action or learn more about managing your pet's existing condition.

ThePetTag

What is ThePetTag?

ThePetTag is a lost pet recovery service that provides your pets with a durable ID tag that's directly linked to your contact information.

How do I request a pet tag?

Once enrolled, log in to your Pet Benefits account and register your pet(s) with Pet Assure. Request a tag for your registered pet(s), and ThePetTag will mail your pet's ID tag in 1-2 weeks.

How does ThePetTag Work?

Scanning your pet's tag with a smartphone provides your public contact information to the individual that finds your pet, getting them home quicker than a microchip! Link main and emergency contacts to your pet's tag without the limits of engraving or fear of illegible ID tags.

ThePetTag's 24/7 pet locator helpline is also available for help contacting a lost pet's family.

How do I update my emergency contact information?

Your address, phone number, and additional emergency contacts can be updated from your Pet Benefit Solutions account or in the Pet Assure app at any time – even after your pet goes missing

wishbone

FREQUENTLY ASKED QUESTIONS

General

What is pet insurance?

Pet health insurance is an insurance policy that covers the cost of veterinary care if your pet experiences an accident or illness.

What is a wellness plan?

A wellness plan provides reimbursement on expected, routine veterinary visits such as wellness exams, vaccinations, and flea and tick prevention. Veterinary costs are reimbursed based on a schedule of benefits.

My pet is already sick or injured. Can pet insurance help?

Pet insurance, as with all insurance, is for unexpected accidents and illnesses. Unfortunately pet insurance does not cover pre-existing conditions. However, getting coverage for your pet will cover most future accidents and illnesses should something happen.

Enrollment

When can I enroll my pet in Wishbone?

You may enroll your dog or cat starting at just 7 weeks old. Like children, young dogs and cats have the highest risk of accidents. And because their immune systems aren't mature, they're more susceptible to infectious diseases. Wishbone plans have no upper age limits, so senior dogs and cats get the same great coverage as kittens and puppies.

How do I enroll in Wishbone?

Visit **www.wishboneinsurance.com** to get a quote and enroll.

Which plan should I enroll in?

Wishbone offers you the option to enroll in accident and illness coverage, wellness coverage, or both. Select the coverage that works best for your pet(s).

Accident and illness coverage helps with unexpected veterinary costs. Pet families who want to be prepared for large vet bills in the event of an accident or illness typically select this coverage. Pre-existing conditions are not covered in accident and illness plans.

Wishbone's wellness plans are designed to save you money on expected and preventative care for your pet. Pet families who want to be reimbursed for providing their pet with complete preventative care choose this coverage.

Can I use my own veterinarian?

Yes. When your pet is insured with Wishbone, you can use any licensed veterinarian in the US, Canada, or any region under US government control, such as territories or military bases in foreign countries. Wishbone has no network, no schedule of benefits and no pre-authorization procedures. Wishbone wants your pet to receive the best care possible, which is why they also cover visits to specialists and emergency after-hours clinics.

Coverage

Is my pet covered if we're traveling?

Yes, all Wishbone policies include coverage at licensed veterinarians when traveling in the US, Canada, or any region under US government control, such as territories or military bases in foreign countries.

How long are my waiting periods?

A waiting period refers to the amount of time after your start date before coverage begins. Waiting periods vary by type of coverage, payment method, and state insurance regulations. For specific information on your waiting periods, get a quote, give us a call at (800) 887-5708, or refer to the Declarations Page of your policy. For all policyholders, routine care coverage has no waiting periods.

Do you use a benefit schedule?

A benefit schedule is a list that puts a limit on what each type of treatment can cost.

Wishbone's accident and illness plan does not use a benefit schedule. Instead, Wishbone reimburses you on your actual vet bill after the deductible, up to your plan's maximum benefit.

Wishbone's wellness plan does use a benefit schedule. Routine care costs will be reimbursed up to the plan's limit.

Will Wishbone cover my pet's dental needs?

Good dental care is vitally important to the overall health of your pet. Wishbone's accident and illness plan includes coverage for periodontal disease and other dental issues if proper preventative care as outlined in the policy document has been performed.

You can elect to enroll in a wellness plan that includes dental coverage to save on routine dental cleaning.

Claims

How do I file a claim?

The easiest and fastest way to file a claim is through your Wishbone member account. Once you login you can submit and view your claims online. Be sure to submit a completed claim form and supporting paid invoices within 180 days of the treatment date.