Employee Benefits Enrollment Guide

Plan Year: 2026

St. Clair County Community Mental Health

Providing Opportunities for Health, Wellness, & Connection

2026 Benefits Guide

This handbook aims to familiarize you with general information about the benefit plans for which you may be eligible as an employee of the St. Clair County Community Mental Health Authority (SCCCMHA).

Please note that this handbook serves as a summary of our benefits. It is intended for informational purposes only. It does not interpret or change the terms of the official plan documents. If information in this document conflicts with the official plan documents, the provisions of the official plan documents will take precedence.

We encourage you to take the time to review your options and select the coverage that best suits you and your family.

Health Benefits Summary

- **Medical & Pharmacy** – Blue Cross Blue Shield of Michigan (through Western Michigan Health Insurance Pool (WMHIP))
- **Dental** – Delta Dental of Michigan, Ohio & Indiana – *No cost to Regular Full Time Employees & Dependents*
- **Vision** – EyeMed – *No cost to Regular Full Time Employees & Dependents*
- **Flexible Spending Account (FSA) - Medical & Dependent Care** – Wex Benefits
- **Health Savings Account (HSA)** Wex Benefits
- **Life Insurance** – Symetra Life Insurance
- **Long Term Disability** – Symetra Life Insurance

Thank you for taking the time to review your benefits!
Feel free to reach out if you have any questions:
HRDepartment@scccmh.org

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Eligibility

SCCCMHA is pleased to offer its employees a comprehensive benefit program. These benefits are designed to support and protect you and your family while you are an active employee. Benefit plans are available to all regular full-time employees.

Dependent Eligibility:

Dependents may also be covered under your Medical, Dental & Vision plans.

- Legal spouse (Marriage license is required)
- Dependent children – through the end of the calendar year turning 26 (birth certificate, adoption certificate, or legal guardian paperwork required)
- Newborns – as of date of birth (30 days to add to plan)
- Disabled dependents – must be enrolled in the plan before their 26th birthday

When enrolling dependents, you must provide the required legal documentation as well as the date of birth and social security number for each dependent.

Cobra Continuation Coverage

When you or any of your dependents no longer meet the eligibility requirements for health plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

How to Enroll

All new hires or staff changing status to regular full-time will meet with a member of the Human Resource team to review and make benefit elections. Once you have made your elections, you will not be able to change them until the next open enrollment period, which will be in November 2027, unless you have a Qualifying Life Event (QLE).

How to Make Changes

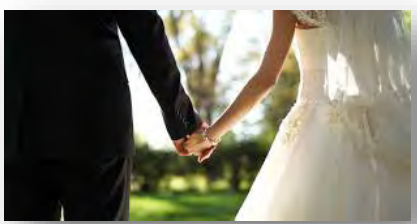
A Qualifying Life Event (QLE) is a significant change in a person's life circumstances that allows you to enroll in or make changes to your health insurance coverage outside the regular open enrollment period. These events trigger a Special Enrollment Period (SEP), providing a 30-day window of time, from the date of the event, to adjust insurance plans. Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Benefit changes due to a QLE will only be processed if supporting documentation is received by HR within 30 days of the event. Contact the HR Department to confirm that you qualify for a qualifying life event change by dialing extension 4700 or emailing HRDepartment@scccmh.org

The following events qualify for a change in coverage:

- Marriage
- Divorce or legal separation
- Birth or placement for adoption of a child
- Death of a dependent
- Ineligibility of dependent – turning 26 and aging off parents' plan
- Loss of other coverage
- Entitlement or Medicare or Medicaid

Changes made must be consistent with the QLE. As a result, you may choose to:

- Enroll in coverage (if you previously declined)
- Drop your benefits coverage
- Add or remove covered dependents
- Change your coverage level (Single, Employee +, or Family)
- Increase medical/dependent flexible spending account election(s)



Medical/Prescription/Hearing Care Coverage

All new regular full-time employees' benefit elections will become effective one full calendar month after the date of hire.

Medical/Prescription/Hearing Care Coverage

Our medical plans offer a variety of benefits for preventive health, illness, or accidents, as well as pharmacy products and hearing care coverage. Regular full-time employees pay a portion of the cost of the premium for medical plan coverage for themselves and eligible dependents through bi-weekly pre-tax deductions.

All plans offered by SCCCMHA are administered through Blue Cross Blue Shield of Michigan (BCBS) obtained through the agency's membership in the Western Michigan Health Insurance Pool (WMHIP), with AJ Gallagher as the representing agent for the Blue Cross plans. You will receive a Member ID Card from BCBS. Please review the Benefits-At-A-Glance Summaries on the following pages for more information on the Medical/Prescription/Hearing Care coverage.

Did You Know?

- Information on free health-related services and opportunities can be found by visiting www.BCBSM.com and by downloading the Pool App.

Interested in Opting Out of Medical/Prescription/Hearing Care Coverage?

Eligible employees who elect not to participate in the medical plan are entitled to annual compensation:

- $2,500/single ($96.15/pay) – those with single enrollment coverage
- $3,000 /Employee +1 ($115.38/pay) – those with Employee + 1 enrollment coverage
- $3,500/family ($134.62/pay) – those with Family enrollment coverage

Compensation for opting out of medical coverage is payable in equal bi-weekly installments. To be eligible for this payment, the employee must provide evidence of other health care coverage for themselves and their entire tax family, which meets minimum essential coverage (MEC) standards and is not obtained through the Healthcare Exchange and sign an attestation stating as such.

Acceptable documentation to verify coverage:

- Creditable coverage letter from your spouse/parent's employer
- A letter on company letterhead that includes name(s), carrier information, and effective date of insurance
- Notice from the medical carrier that includes the employee and dependent(s) name(s) and the effective date of insurance

Medical benefits are the services and treatments covered by a health insurance plan to help individuals maintain their health and treat illnesses or injuries.

Getting Started

The summaries starting on the next page provide a general overview of the BCBS plans offered by SCCCMHA. You will find Member Responsibility, Covered Medical Services, Hearing Care Coverage, and Prescription Drug Coverage for each of the three plans. Before you review, please read the information provided below to become familiar with how costs are shared with BCBS.

How you share costs with BCBS

As a BCBS member, you have help paying for your health care. However, some costs you share with BCBS – here's how.

Beginning of your plan year

- You pay **copayments**, if applicable, for certain covered services, like doctor's office visits and urgent care.
- Depending on your plan, throughout the year BCBS pays for **certain preventive and wellness care at no cost** to you.
- You pay for **all other medical costs** until you meet your deductible, if your plan includes a deductible.

Once you have met your deductible

- You now pay **coinsurance** instead of the total cost, and continue to pay **copayments**, until the total you have paid for copayments, coinsurance and deductibles equals your out-of-pocket maximum.
- If there's more than one person on your plan, you may have to meet a family out-of-pocket maximum as well as an individual maximum.

Once you have reached the out-of-pocket maximum

- The plan pays for all other covered services. You don't owe a thing.

End of the plan year

- Your **deductible** and **out-of-pocket maximum** reset to zero for the next plan year. *Note: For plans except for High Deductible Health Plans, any amount you pay toward the in-network deductible from October through December counts toward the current year's out-of-pocket maximum, and also carries over to your in-network deductible for the next year.*

Important Terms to Know

Copayment (or copay)
A fixed amount you pay for a covered health care service, usually when you get the service. ***When a copayment is charged, the service may also be subject to coinsurance.***

Deductible
The amount you owe for covered health care services before your health care plan begins to pay. ***The deductible may not apply to all services.***

Coinsurance
Your share of the costs of a covered health care service, usually a **percentage** (for example, 20 percent) of the allowed amount for the service. ***Your coinsurance also counts towards your out-of-pocket maximum.***

Out-of-Pocket Maximum
The most you'll pay in deductible, copayments and coinsurance during the year.

For details on your plan's coverage, refer to the "Benefits-at-a-Glance" on the following pages.

Blue Cross Blue Shield Plans

SCCCMHA offers three Blue Cross Blue Shield PPO plans. Each plan includes medical, prescription, and hearing coverage.

Plan	Deductibles (In-Network)	Annual Out-of-Pocket Maximums (In-Network) **
Value 1000 104 (80% Co-insurance)	$1000 – Individual $2000 - Family	$4,500 – Individual $9,000 - Family
Enhanced HSA 2000 040 041 (100% Co-insurance after deductible has been met) *	$2000 – Individual $4000 - Family	$3,000 – Individual $6,000 - Family
Value HSA 3000 066 067 (80% Co-insurance after deductible has been met) *	$3,000 – Individual $6,000 - Family	$6,000 – Individual $12,000 - Family

*Deductible must be met before co-insurance becomes effective

** Includes deductible, co-insurance, and co-pays

Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 104
Division Code(s): 1020, 1120
PPO – VALUE 1000 104, RX37, Hearing
Effective Date: 01/01/2025
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

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

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

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$1,000 per member $2,000 per family	$2,000 per member $4,000 per family
Copays • Fixed Dollar Copays	$30 copay for : • Primary Care Physician (PCP) office visits • Chiropractic spinal manipulations $50 copay for : • Specialist office visits $60 copay for : • Facility Urgent care services • Professional Urgent care services $150 copay for : • Facility medical emergency	$150 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	20% up to a maximum of: $2,500 per member $5,000 per family	40% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$4,500 per member $9,000 per family Includes Deductible, Coinsurance and Copays	$4,500 per member $9,000 per family Excludes Deductible and includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Not Covered

Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $30 pcp copay; $50 specialist copay	Covered - 60% after deductible
Telemedicine Visits	Covered - 100% after $30 pcp copay; $50 specialist copay	Covered - 60% after deductible
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 100% after $30 copay	Not Covered
Office Consultations	Covered - 100% after $30 pcp copay; $50 specialist copay	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $150 copay; copay waived if admitted	Covered - 100% after $150 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Facility Urgent Care Services	Covered - 100% after $60 copay	Covered - 60% after deductible
Physician Urgent Care Services	Covered - 100% after $60 copay	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care Limited to lifetime maximum of 360 days	Covered - 100%	Covered - 100%
Home Health Care	Covered - 80% after deductible	Covered - 60% after deductible
Skilled Nursing Limited to 120 days per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 50% after deductible	Covered - 50% after deductible
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible
Expanded Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	Not Covered	Not Covered

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Telemedicine Mental Health Care	Covered - 80% after deductible	Covered - 60% after deductible

Virtual Care - Online Mental Health Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 80% after deductible	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Pre-authorization required **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	Covered - 80% after deductible	Covered - 60% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 60% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Services Limited to a maximum of 12 visits per member per calendar year	Covered - 100% after $30 copay	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Not Covered	Not Covered
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 60% after deductible
Facility Clinic Visit	Covered - 80% after deductible	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 30 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 104
Division Code(s): 1020, 1120
Hearing Care Coverage
Effective Date: 01/01/2025
Benefits-at-a-glance

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Member's responsibility (coinsurance)

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

Covered services

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

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 104
Division Code(s): 1020, 1120
Prescription Drugs
Effective Date: 01/01/2025
Benefits-at-a-glance

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

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30-day supply	$20 copay - Generic drugs $40 copay - Preferred brand drugs $80 copay - Non-Preferred brand drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Retail and Mail Order - 90-day supply	$40 copay - Generic drugs $80 copay - Preferred brand drugs $160 copay - Non-Preferred brand drugs
Specialty Drugs **Exclusive Specialty Network**: We only cover specialty drugs when obtained from our exclusive specialty pharmacy network. Covered drugs will be subject to the member's cost-share requirements. If a member obtains specialty drugs from any other provider, they may be responsible for the total cost.	Retail 30-day: $20 copay - Generic drugs $40 copay - Preferred brand drugs $80 copay - Non-Preferred brand drugs Members are restricted to a 30-day supply and certain specialty drugs are limited to only a 15-day supply for each fill.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	
Smoking Cessation Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered

Diabetic Supplies	Select diabetic supplies and devices are covered when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include: Glucometers, Continuous Glucose Monitors and Sensors, Insulin Delivery Monitors, Test Strips and Lancets and Insulin Delivery Reservoirs. • Diabetic supplies will be subject to your preferred brand - name drug and/or nonpreferred brand-name drugs cost-share requirement. • “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your nonpreferred brand-name drugs cost-share requirement. • If you receive diabetic supplies and devices paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same diabetic supplies. Also see *Other Covered Services* for Test Strips, Lancets, Needles and Syringes.

Features of your prescription drug plan

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

Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 040, 041
Division Code(s): 3000, 3100
PPO – ENHANCED HSA 2000 040 041, RX7
Effective Date: 01/01/2025
Benefits-at-a-glance

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

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

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	$2,000 per member $4,000 per family	$4,000 per member $8,000 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	0%	20% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums The full family out of pocket maximum must be met before it is considered satisfied.	$3,000 per member $6,000 per family Includes Deductible, Coinsurance and Copays	$6,000 per member $12,000 per family Excludes Deductible and includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

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

Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 80% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 80% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

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

Emergency Medical Care

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

Diagnostic Services

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

Maternity Services Provided by a Physician

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

Hospital Care

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

Alternatives to Hospital Care

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

Surgical Services

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

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100% after deductible	Covered - 80% after deductible
Kidney, Cornea, Bone Marrow and Skin	Covered - 100% after deductible	Covered - 80% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100% after deductible	Covered - 80% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 100% after deductible	Covered - 80% after deductible
Telemedicine Mental Health Care	Covered - 100% after deductible	Covered - 80% after deductible
Virtual Care - Online Mental Health Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 100% after deductible	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network
Applied Behavior Analysis (ABA) Pre-authorization required **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	Covered - 100% after deductible	Covered - 80% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 100% after deductible	Covered - 80% after deductible
Nutritional Counseling	Covered - 100% after deductible	Covered - 80% after deductible

Other Covered Services

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

Therapy Services

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 040, 041
Division Code(s): 3000, 3100
Hearing Care Coverage
Effective Date: 01/01/2025
Benefits-at-a-glance

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Member's responsibility (coinsurance)

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

Covered services

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

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

Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 040, 041
Division Code(s): 3000, 3100
Prescription Drugs
Effective Date: 01/01/2025
Benefits-at-a-glance

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

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Deductible	$2,000 per member $4,000 per family
Retail - 30-day supply	$10 copay after deductible - Generic drugs $40 copay after deductible - Brand drugs $0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 80% of the approved amount, less the member's copay.
Retail and Mail Order - 90-day supply	$20 copay after deductible - Generic drugs $80 copay after deductible - Brand drugs
Specialty Drugs **Exclusive Specialty Network**: We only cover specialty drugs when obtained from our exclusive specialty pharmacy network. Covered drugs will be subject to the member's cost-share requirements. If a member obtains specialty drugs from any other provider, they may be responsible for the total cost.	Retail 30-day: $10 copay after deductible - Generic drugs $40 copay after deductible - Brand drugs Members are restricted to a 30-day supply and certain specialty drugs are limited to only a 15-day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum. Note - Adjustments may be required to accurately reflect your annual out-of-pocket maximum with your true out-of-pocket costs.

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

Features of your prescription drug plan

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

Blue Cross Blue Shield of Michigan

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 066, 067
Division Code(s): 3000, 3100
PPO - VALUE HSA 3000 066, 067_Rx24, Hearing
Effective Date: 01/01/2025
Benefits-at-a-glance

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

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

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year The full family deductible must be met under a two person or family contract before benefits are paid for any person on the contract.	$3,000 per member $6,000 per family	$6,000 per member $12,000 per family
Copays • Fixed Dollar Copays	No Copay	No Copay
Coinsurance • Percent Coinsurance	20%	40% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums All members on the contract can contribute to the family out of pocket maximum; however, a single member will not exceed the individual out of pocket maximum.	$6,350 per member $6,550 per member in family plan $12,700 per family Includes Deductible, Coinsurance and Copays	$12,700 per member $25,400 per family Excludes Deductible and includes Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

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

Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 80% after deductible	Covered - 60% after deductible
Telemedicine Visits	Covered - 80% after deductible	Covered - 60% after deductible
Virtual Care - Online Medical Visits Note: Online Medical visits by a non-BCBSM selected vendor are not covered.	Covered - 80% after deductible	Not Covered
Office Consultations	Covered - 80% after deductible	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 80% after deductible	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 80% after deductible	Covered - 80% after deductible
Non-Emergency use of the Emergency Room	Covered - 80% after deductible	Covered - 60% after deductible
Facility Urgent Care Services	Covered - 80% after deductible	Covered - 60% after deductible
Physician Urgent Care Services	Covered - 80% after deductible	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 80% after deductible	Covered - 80% after deductible
Home Health Care	Covered - 80% after deductible	Covered - 80% after deductible
Skilled Nursing Limited to 90 days per calendar year	Covered - 80% after deductible	Covered - 80% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - male reproductive organs excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - female reproductive organs excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible
Expanded Abortion Services **Note:** Abortions are not covered if rendered in a location where abortions are not legal.	Not Covered	Not Covered

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 80% after deductible	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-Network	Out-of-Network
Inpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Mental Health Care and Substance Use Disorder Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Telemedicine Mental Health Care	Covered - 80% after deductible	Covered - 60% after deductible
Virtual Care - Online Mental Health Visits Note: Online Mental Health visits by a non-BCBSM selected vendor are not covered.	Covered - 80% after deductible	Not Covered

Autism Spectrum Disorders, Diagnoses and Treatment

Benefits	In-Network	Out-of-Network

Applied Behavior Analysis (ABA) Pre-authorization required **Note:** Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).	Covered - 80% after deductible	Covered - 60% after deductible
Physical, Occupational and Speech Therapy Physical, Occupational and Speech therapy with an autism diagnosis is unlimited	Covered - 80% after deductible	Covered - 60% after deductible
Nutritional Counseling	Covered - 80% after deductible	Covered - 60% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Services Limited to a maximum of 12 visits per member per calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Diabetic Supplies Test Strips, Lancets, Needles and Syringes	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Covered - 80% after deductible	Covered - 60% after deductible
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 60% after deductible
Facility Clinic Visit	Covered - 80% after deductible	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 30 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 066, 067
Division Code(s): 3000, 3100
Hearing Care Coverage
Effective Date: 01/01/2025
Benefits-at-a-glance

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Member's responsibility (coinsurance)

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

Covered services

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

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

Western Michigan Health Insurance Pool
Group Number: 71565 Package Code(s): 066, 067
Division Code(s): 3000, 3100
Prescription Drugs
Effective Date: 01/01/2025
Benefits-at-a-glance

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

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Deductible	$3,000 per member $6,000 per family
Retail - 30-day supply	$10 copay after deductible - Generic drugs $40 copay after deductible - Preferred brand drugs $80 copay after deductible - Non-Preferred brand drugs $0 copay after deductible – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Retail and Mail Order - 90-day supply	$20 copay after deductible - Generic drugs $80 copay after deductible - Preferred brand drugs $160 copay after deductible - Non-Preferred brand drugs
Specialty Drugs **Exclusive Specialty Network**: We only cover specialty drugs when obtained from our exclusive specialty pharmacy network. Covered drugs will be subject to the member's cost-share requirements. If a member obtains specialty drugs from any other provider, they may be responsible for the total cost.	Retail 30-day: $10 copay after deductible - Generic drugs $40 copay after deductible - Preferred brand drugs $80 copay after deductible - Non-Preferred brand drugs Members are restricted to a 30-day supply and certain specialty drugs are limited to only a 15-day supply for each fill.
High-Cost Drug Discount Optimization Program	Prescription drug manufacturers provide coupon programs for certain pharmaceuticals. Your benefit plan requires you to enroll in BCBSM-approved coupon programs when available for select medications. This benefit may lower the cost sharing typically required for these drugs. Your out-of-pocket expense for these drugs will be no more than your cost sharing. When a coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum. Note - Adjustments may be required to accurately reflect your annual out-of-pocket maximum with your true out-of-pocket costs.

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

Features of your prescription drug plan

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

Regular Full-Time Employee Contributions
Benefit Plan Costs - 2026

	2026 Bi-Weekly Payroll Contribution
Value 1000 104 ($1000/$2000 deductible / 80% coinsurance)	
Employee Only	$105.04
Employee + 1	$219.66
Family	$286.44
Enhanced HSA 2000 040 041 ($2000/$4000 deductible / 100% coinsurance)	
Employee Only	$119.20
Employee + 1	$249.29
Family	$325.07
Value HSA 3000 066 067 ($3000/$6000 deductible / 80% coinsurance)	
Employee Only	$12.78
Employee + 1	$26.72
Family	$34.83

For regular full-time employees, your cost is represented above and is based on the plan you choose and your pay frequency.

The above plans utilize the Blue Cross Blue Shield of Michigan network with OptumRx managing the pharmacy benefit. Please note that all plans have out-of-network benefits; however, if you choose to see a provider that is not in-network, you will have higher out-of-pocket costs due to increased out-of-network deductibles and coinsurance. All plans are compliant with the Patient Protection and Affordable Care Act (PPACA).

Regular Part-Time Employee Contributions
Benefit Plan Costs - 2026

Plan	Full Cost Per Month	Full Cost Per Pay
Value 1000 104 ($1000/$2000 deductible / 80% coinsurance)		
Employee Only	$889.43	$410.51
Employee + 1	$1,860.05	$858.48
Family	$2,425.66	$1,119.54
Enhanced HSA 2000 040 041 ($2000/$4000 deductible / 100% coinsurance)		
Employee Only	$920.11	$424.67
Employee + 1	$1,924.24	$888.11
Family	$2,509.34	$1,158.16
Value HSA 3000 066 067 ($3000/$6000 deductible / 80% coinsurance)		
Employee Only	$689.53	$318.24
Employee + 1	$1,442.02	$665.55
Family	$1,880.50	$867.92
Dental - Delta Dental		
One Person/Family (same rate)	$74.04	$34.17
Vision - EyeMed		
Employee Only	$4.77	$2.20
Employee + 1	$9.06	$4.18
Family	$13.31	$6.14

For regular part-time employees, your cost is represented above and is based on the plan you choose and your pay frequency.

The above plans utilize the Blue Cross Blue Shield of Michigan network with OptumRx managing the pharmacy benefit. Please note that all plans have out-of-network benefits; however, if you choose to see a provider that is not in-network, you will have higher out-of-pocket costs due to increased out-of-network deductibles and coinsurance. All plans are compliant with the Patient Protection and Affordable Care Act (PPACA).

St. Clair County Community Mental Health Authority – 2026 Medical Plan Options						
PLAN(S)	**Value 1000 104**		**Enhanced HSA 2000 040 041**		**Value HSA 3000 066 067**	
Plan Basics	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**	**In-Network**	**Out-Network**
Individual Deductible	$1,000	$2,000	$2,000	$4,000	$3000	$6000
Family Deductible	$2,000	$4,000	$4,000	$8,000	$6000	$12,000
Coinsurance Level	80%	60%	100%	80%	N/A	N/A
Coinsurance Max Ind	$2,500	40%	N/A	N/A	N/A	N/A
Coinsurance Max Fam	$5,000	40%	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum Ind	$4,500	$4,500	$3,000	$6,000	$6,350	$12,700
Out-of-Pocket Maximum Fam	$9,000	$9,000	$6,000	$12,000	$12,700	$25,400
Other Plan Details						
Hospital Services	80% after Ded	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Inpatient Care	80% after Ded	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Urgent Care	$60 Copay	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Emergency Care *(waived if admitted)*	$150 Copay		100% after Ded		80% after Deductible	
Primary Care Office Visits	$30 Copay	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Online Office Visits *(approved providers)*	$30 Copay	60% after Ded	100% after Ded	80% after Ded	80% after Ded	Not Covered
Specialist Visit	$50 Copay	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
OP Beh. Health *(f/f and online)*	80% after Ded	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Diagnostic, X-ray, Lab	80% after Ded	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Durable Medical Equipment	80% after Ded	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
Chiropractic Spinal Manip.	$30 Copay	60% after Ded	100% after Ded	80% after Ded	80% after Ded	60% after Ded
	(Max 12 visits annually)		(Max 24 visits annually)		(Max 12 visits annually)	
Hearing Care Coverage	Yes		Yes		Yes	
Prescription Drugs						
Generic	$20 Copay		$10 Copay after Ded		$10 Copay after Ded	
Formulary Brand	$40 Copay		$40 Copay after Ded		$40 Copay after Ded	
Non-Formulary Brand	$80 Copay		$40 Copay after Ded		$80 Copay after Ded	
Preferred Specialty	$40 Copay		$40 Copay after Ded		$40 Copay after Ded	
Non-Preferred Specialty	$80 Copay		$40 Copay after Ded		$80 Copay after Ded	
Mail Order Rx *(90 Days)*	2x Copay		2x Copay after Ded		2x Copay after Ded	
Bi-Weekly Payroll Contribution						
Single	$105.04		$119.20		$12.78	
2 Person	$219.66		$249.20		$26.72	
Family	$286.44		$325.07		$34.83	

The above comparison is a high-level overview of the medical plans offered to you as an employee of SCCCMHA. If any statement conflicts with the applicable plan document, the applicable plan documents will govern.

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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Blue Cross Blue Shield Blue Care Network of Michigan

Web or mobile, get the most from your plan

We know that health insurance can be confusing. To help you understand and manage your costs and care, BCBS offers a wide range of tools on their web site, bcbsm.com. Once you register your account with a computer, nearly everything you can do on the website you can do on your smartphone or tablet.

Register for your online account

Don't have an account with BCBS yet? It only takes a few minutes to register. To get started, go to **bcbsm.com** and select the login tab in the upper right-hand corner. You'll need your **enrollee ID card** handy to complete the process.

You can also access your online account using the app. To get the BCBS app, search BCBSM in the App Store or Google Play.

What can you find online?

You can find provider directories, explanation of benefits statements, and medical claim information. You can also:

- Request additional **identification cards** or get access to mobile device tools including **virtual ID cards**
- Get help **choosing a doctor**, including:
  - Participating providers for your plan
  - Doctor reviews
  - Physician quality measurements
- Find information about your **plan benefits**, including:
  - Eligibility and coverage on the contract
  - Coverage for specific health care services
  - Coverage Advisor tool to help you choose a plan, as well as understand your out-of-pocket costs
- Use tools to help you **manage your costs**:
  - Access explanation of benefits statements online
  - Keep track of deductibles, maximums and copays
  - Obtain treatment cost estimates
- Manage health spending accounts (if applicable):
  - Get information on wellness and healthy living
  - Read health tips, articles and prevention information
  - Research a condition
  - Take a health assessment or use our digital health coaching tools

BCBS Member Handbook

The BCBS Member Handbook provides an overview of your health plan that can help you get the most out of your coverage. It explains things like how your health plan works, how to get care, and how to contact BCBS if you have questions. To view the BCBS Member Handbook, log into your online account and navigate to My Coverage, Plan Documents.

WebMD Health Services

My Health, powered by WebMD, gives you the online tools needed to improve and maintain your health. Find information to help you live healthier and better, with articles, tools, videos, and podcasts related to the health topics that matter most to you. Just select the health topics that interest you and get fast access to related resources.

Blue365

Maintaining a healthy lifestyle doesn't have to strain your budget. BCBS has partnered with a wide range of health and wellness companies for discounts on the products you want and need, from gym memberships to weight loss programs and cookbooks. Save on the things you need to help you stay healthy and active. Grocery discounts make eating better easier and more affordable than ever. And travel discounts let you reward yourself for living well.

Virtual Care by Teladoc Health®

Do you need care, but your primary care doctor is unavailable? Are you traveling, and not feeling your best? Teladoc Health may be a good option for you. Through the Teladoc Health app, you can talk to a board-certified doctor by phone or video within minutes, 24/7 — no appointment needed.

- ✓ See a doctor from the comfort of your home
- ✓ Get medical care in as little as 15 minutes
- ✓ Pay the same or less as a regular office visit
- ✓ Get prescriptions sent to your preferred pharmacy

When you need convenient medical care

The medical professionals through Teladoc Health have experience with internal and family medicine, as well as pediatrics. They are also trained to offer care online. And prescriptions, if needed, can be sent to your local pharmacy.

When you need convenient mental health care

Your mental health is important, too. You can use Teladoc Health to see a therapist or psychiatrist virtually to work through life's challenges. Please note: Mental Health services are not 24/7 and are available by appointment only. If you need 24/7 support, your BCBS plan gives you other mental health options. Visit https://www.bcbsm.com/behavioral-mental-health/support/ for more information.

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.

Teladoc Health® is an independent company that provides Virtual Care Solutions for Blue Cross Blue Shield of Michigan and Blue Care Network.
Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

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READY TO HELP

MICHIGAN

Improved well-being tailored to **YOU**

NEW FOR 2025

Blue Cross Well-Being℠

Expect more from your well-being program.

A new and improved well-being program is coming soon. Starting Jan. 1, 2025, the online well-being resources included with your health plan are transitioning to Personify Health™ from WebMD® to provide an innovative, best-in-class well-being experience. The program is available to you and your covered family members 18 and older at no added cost.

We're ready to help you build healthy habits to improve your overall health with:

- An enhanced virtual experience that delivers personalized daily content based on your interests, health risks and demographics
- Seamless integration with more than 100 tracking devices and apps, including Apple Health and Google Fit
- A checklist to help you stay on top of recommended preventive health care based on your specific needs
- A detailed health assessment with more guidance for modifiable health risks
- Self-guided well-being courses called Journeys® to help you build healthy habits that stick
- A Mayo Clinic-modeled tobacco cessation program to help you stop smoking, vaping and using nicotine

On Jan. 1, 2025, simply log in to your member account at bcbsm.com or our mobile app to start your new well-being journey.

WebMD Health Services is an independent company supporting Blue Cross Blue Shield of Michigan by providing health and well-being services.

Personify Health is an independent company that provides health and well-being services on behalf of Blue Cross Blue Shield of Michigan and Blue Care Network.

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

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Pregnancy Assistant: Help for a healthy pregnancy

Blue Cross HEALTH & WELL-BEING℠

If you're pregnant, planning to become pregnant or supporting someone who's pregnant, the Pregnancy Assistant program from Blue Cross Health & Well-Being℠, powered by WebMD®, is for you.

Pregnancy Assistant is a fun and easy-to-use program that features a dashboard of quizzes, checklists, articles, videos, images of the stages of fetal development that you can click on for more information, and activities to help expectant mothers learn and follow guidelines to help them carry their child full term.

Pregnancy Assistant features a variety of helpful tools:

- A **symptom tracker** that allows you to track common pregnancy-related symptoms and provides information on self-care and when to contact a doctor
- **My Activities**, which lets you choose and track a variety of activities that can play a positive role in a healthy pregnancy
- **My Pregnancy**, which tracks the weeks of pregnancy
- **Track my Progress**, which features a *Contraction Timer* and a *Kick Counter*
- **Checklists** that can help you decide what to pack for the hospital, diaper bag contents, feeding supplies and more
- **Pregnancy 101**, a page filled with articles on a variety of healthy pregnancy topics

Check out Pregnancy Assistant today:

- Log in or register for your member account at **bcbsm.com** or through the Blue Cross mobile app.
- Click or tap *Programs & Services*, click on *Wellness*, then click on *Go to WebMD*, to enter the Blue Cross Health & Well-Being site. You'll need to register if it's your first time on the site.
- Click *Resources* in the menu.
- Click on the *My Pregnancy Assistant* card on the *Resources* page.

WebMD Health Services is an independent company supporting Blue Cross Blue Shield of Michigan by providing health and well-being services.

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

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Western Michigan Health Insurance (WMHIP) Membership & Programs

As a member of the Pool, you have access to life-changing programs that put your health first.

Whether you're looking to improve your overall well-being or ready to reverse diabetes, The Pool has options available for you.

The best part? They're all **FREE**!

Additionally, the following program is available to you as a member of the pool, at no cost to you:

- **Maven** - Free access 24/7 for you and your partner, during your pregnancy and postpartum care.

Coming in early 2026

- **Bexa** – Onsite radiation-free breast exams. Bexa brings innovative breast health screening directly to your workplace, making early detection simple and convenient.
- **Mayo Clinic Complex Care** – A 2nd opinion program.

For more information regarding any WMHIP programs, your BCBS benefits, and much more, download the free WMHIP app.

You can also view Pool information within ADP, under Resources and then Tools/References.

THE POOL
Western Michigan Health Insurance

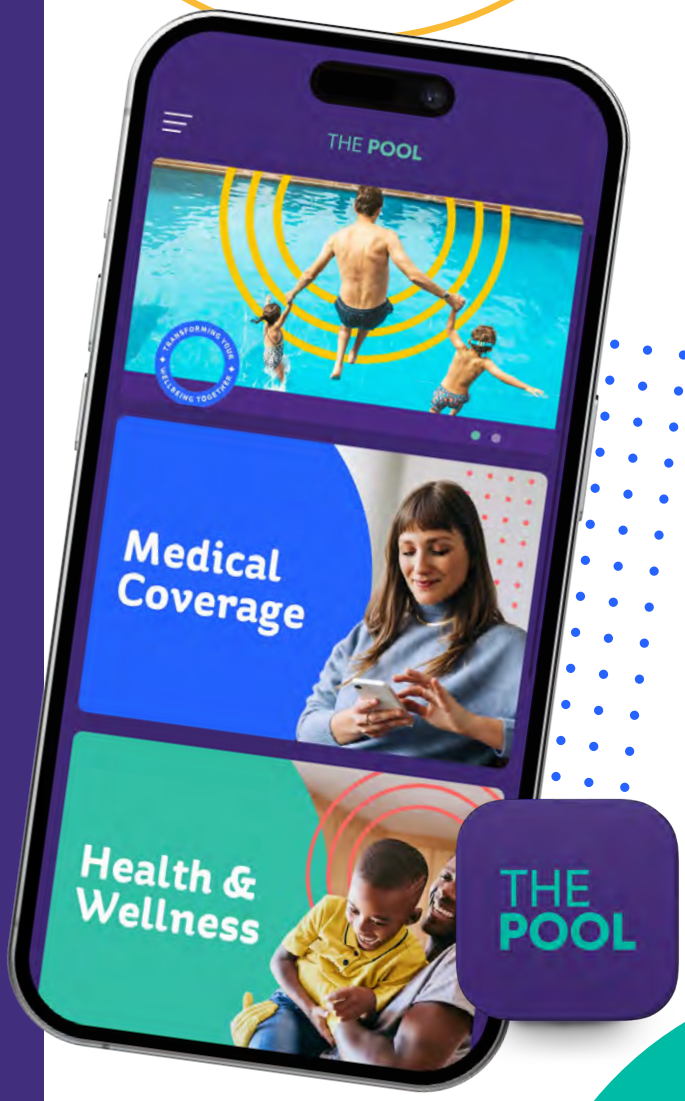
Download The Pool app today!

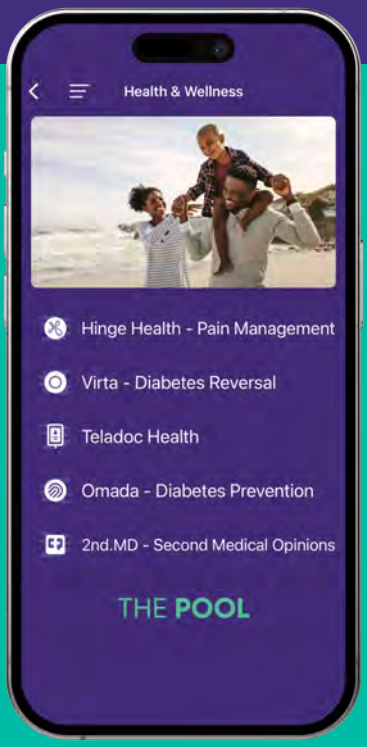
Available to all Pool members

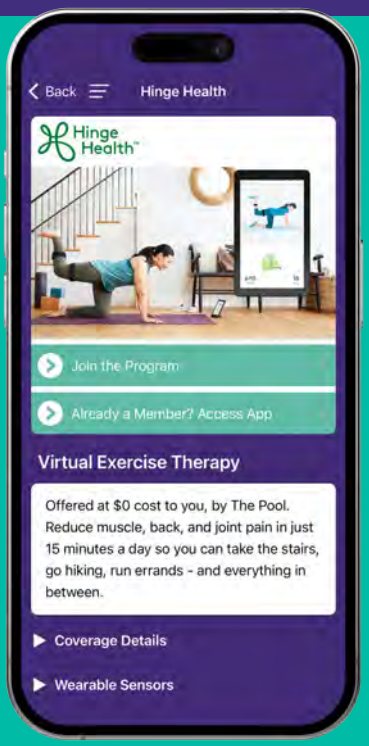
Scan the QR code to download our app to your smartphone.

Download on the App Store

GET IT ON Google Play







Your connection to better health.

Now available on your smartphone

- Health Benefits
- Wellness Resources
- Free Pool Member Benefits
- and more!

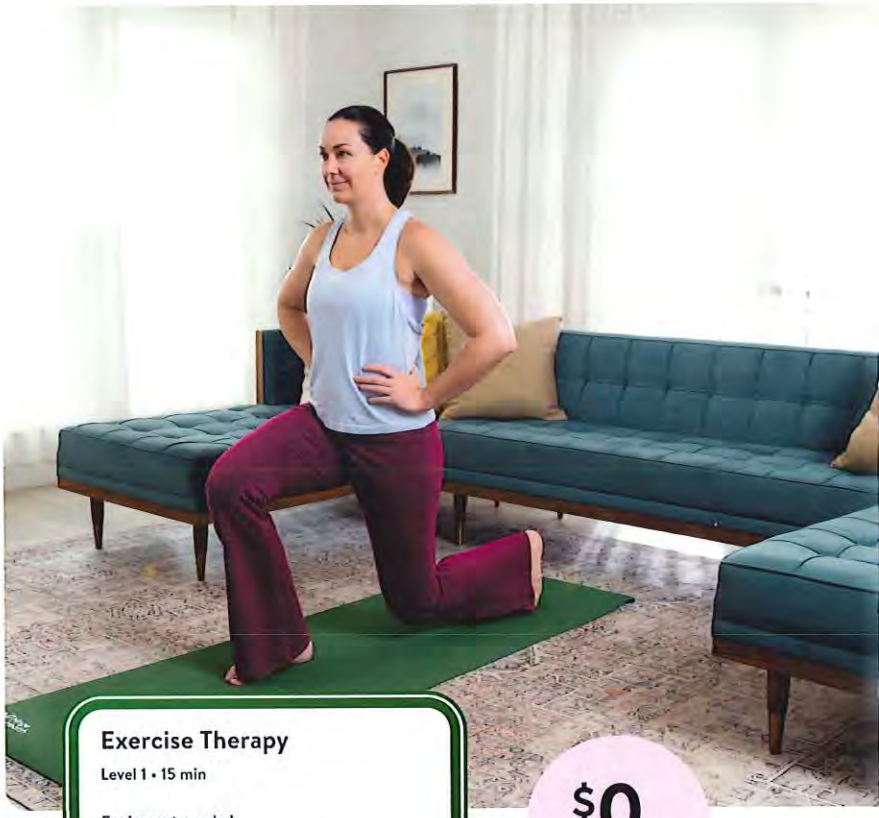
THE **POOL**
Western Michigan Health Insurance | Hinge Health

You earned Hinge Health benefits

With Hinge Health, you can get virtual care to reduce everyday joint and muscle aches, recover from injury, relieve pelvic pain and discomfort, and more.

Specialized care, personalized for you

- **1-on-1 support**
  From a physical therapist or health coach.
- **A care plan**
  Designed for your everyday activities and busy life.
- **All costs covered**
  Hinge Health is offered through The Pool. **There's no out-of-pocket cost to you.**



$0
cost to you

4.9★
App rating based on 30K+ reviews and counting

68%
average reduction in pain per participant[1]

Get virtual physical therapy and more. Scan the QR code or visit:

hinge.health/thepool-join25

Please use the default camera on your device to scan the QR code, not a third-party application. If you are directed to a site other than the URL listed above, do not proceed.

[1]Participants with chronic knee and back pain after 12 weeks. Bailey, et al. Digital Care for Chronic Musculoskeletal Pain: 10,000 Participant Longitudinal Cohort Study. JMIR. (2020).

Tap into pain relief anytime, anywhere

Access your exercise program anytime via the Hinge Health app.

Get 5–10 guided exercises each session. Do them on your schedule in 15 minutes or less.

Make your exercises more or less challenging whenever you want.

I felt tremendously better. There was little to no pain in my beck, back or arm....and for the first time I felt confident I would not drop my coffee cup in the middle of the kitchen.

Matt C., Hinge Health member

Hinge Health has been featured in

Inc. SHAPE Forbes Prevention

Sign up in 3 easy steps

1 **Fill out a short questionnaire to tell us about the pain you're experiencing.**

2 **Sign into the Hinge Health app to complete a quick movement assessment.**

3 **Start your exercise program. And start feeling better.**

Scan the QR code or visit:

hinge.health/thepool-join25

Please use the default camera on your device to scan the QR code, not a third-party application. If you are directed to a site other than the URL listed above, do not proceed.

NEW MEMBERS ONLY

Start your program, and get a massage gun on us!*

*Eligibility is based on the program you are placed in and subject to availability upon completion of your first exercise therapy session. Item appearance may vary.

Employees and dependents 18+ enrolled in a Pool medical plan are eligible.

Los empleados y dependientes mayores de 18 años inscritos en un plan médico de Pool son elegibles.

Frequently Asked Questions

What is the Virta treatment?

Virta is a treatment that safely reverses type 2 diabetes without the risks, costs, or side effects of medications or surgery.

How does Virta reverse type 2 diabetes?

Virta is very different from other diabetes treatments. Virta teaches you how to change your diet so that your body burns fat for energy.

This lowers your blood sugar and need for diabetes medication. Imagine eating eggs, bacon, and avocado for breakfast!

We change *what* you eat, not how much you eat.

By changing what you eat, you can reduce your blood sugar and the need for expensive medication!

We fully support those who want to exercise, but it is not required to achieve diabetes reversal.

How does Virta work with my specific lifestyle?

We personalize everything: food preferences, food access, religious beliefs, and more—we customize and design the Virta treatment to make sure that it works for *you*.

What does the Virta treatment include?

- Unlimited 1:1 health coaching
- Free diabetes testing supplies like meters and strips, delivered right to your door!
- Doctor-driven support
- Smartphone app for tracking ketones, glucose, and weight
- On-demand resources like recipes, grocery lists, meal plans and more!

What does this cost?

The Pool fully covers the cost of Virta (valued at over $3,000) for you and your eligible family members with type 2 diabetes. Apply today to begin your journey toward better health!

This seems great! How do I start?

This process is very simple! After you apply, you'll be connected with an enrollment advisor who can answer any questions and help you start your journey towards better health!

Apply today at
www.virtahealth.com/join/thepoolmi

Virta is available to The Pool members and eligible dependents between the ages of 18 and 79 who are enrolled in a health plan through Priority Health or Blue Cross Blue Shield of Michigan. This benefit is currently being offered to those with type 2 diabetes. There are some medical conditions that would exclude patients from the Virta treatment. Start the application process now to find out if you qualify.

omada

THE POOL
Western Michigan Health Insurance

Lower your risk for diabetes

1 in 3 adults has prediabetes—yet 81% don't know it.[1]

Prediabetes is a serious condition caused when your blood sugar levels are higher than normal. It increases the risk of type 2 diabetes, heart disease, and stroke.

That's why you have access to Omada, a program that provides proven, one-on-one support to help prevent type 2 diabetes and related health issues.

"I used to get frustrated trying to decide how to manage my diabetes with other health conditions and a busy lifestyle. I now feel I can manage and was easier than I thought it would be."

— KAREN, OMADA MEMBER

You may be at risk for prediabetes and type 2 diabetes if:[2]

- **You are 45 years old or older.**
  The older you are, the higher your risk.
- **Type 2 diabetes runs in your family.**
  If your parents or siblings have it, you may have it or develop it.
- **You are overweight or physically inactive.**
  Being overweight is one of the most common risk factors.

You have access to Omada at $0 cost to you, if eligible.

Omada members get:

- A dedicated care team with a health coach.
- Personalized care plan tailored to each member's lifestyle.
- Smart scale and app to easily track your progress 24/7.

Claim your benefit at
omadahealth.com/wmhip

1 National Diabetes Statistics Report. Centers for Disease Control and Prevention 2020.
2 American Diabetes Association Type 2 Diabetes Risk Test. diabetes.org/diabetes/risk-test.
Images used are not real members. Testimonials are based on members' real experiences and individual results. We do not claim that these are typical results that members will achieve. Results may vary.

$0 cost to you

omada

THE POOL
Western Michigan Health Insurance

Access health programs built just for you

The Pool is offering Omada® for one-on-one health coaching and smart devices to help members lower blood pressure or prevent chronic disease.*

The best part: Omada is no cost to you if you're eligible to join—up to a $1,400 value.

Programs available to you

- Take control of blood pressure
- Manage weight and lower health risks

Join Omada for access to

- Personal support from a health coach
- Easy monitoring with smart devices and tools
- Online peer groups and communities

High blood pressure program members also get specialist support to help keep an eye on blood pressure highs and lows.

All Omada members receive a welcome kit*

With easy-to-use devices, based on your needs, shipped to your door and yours to keep. All at no cost to you.

- Blood pressure monitor
- Smart scale

Claim my welcome kit:
omadahealth.com/wmhip

Omada is available at no cost to you and your covered family members with your health plan through The Pool.

*Certain features and smart devices are only available if you meet program and clinical eligibility requirements. Images, including apps, do not reflect real members or information about a specific person.

2nd.MD

Get a second opinion from an expert specialist

Feel confident about your medical decisions

As part of your company benefits, you can get an expert second opinion from a leading specialist at **no additional cost** to you. Directly connect with experts by video from the comfort of home.

How it works

Activate your account and request a consult

Call 1.866.841.2575
Visit 2nd.MD/activate

Speak with a nurse

Talk to one of our experienced, compassionate nurses to see if a second opinion is right for you. We'll handle the rest, including gathering your medical records, finding the right specialist and setting up the video consultation.

Consult with a leading specialist

Ask questions and get personalized advice about your diagnosis and treatment plan from a specialist in your condition. Video consultations are available when it's convenient for you, including nights and weekends!

Our specialists can help you:

- Confirm a new or existing diagnosis
- Explore treatment plans and medications
- Understand if a recommended surgery or procedure is right for you

We have a wide network of expert doctors across thousands of conditions, including:

- Muscle, joint and bone
- Cancer
- Heart disease and stroke
- Digestive/GI
- Autoimmune
- Pediatric medicine
- Men's health
- Women's health
- Mental health
- Brain and nervous system
- Ear, nose and throat
- And many more

Who is eligible?

2nd.MD is confidential, fast and no additional cost to you and your eligible dependents.

94% of 2nd.MD users would recommend 2nd.MD to a family member or friend.*

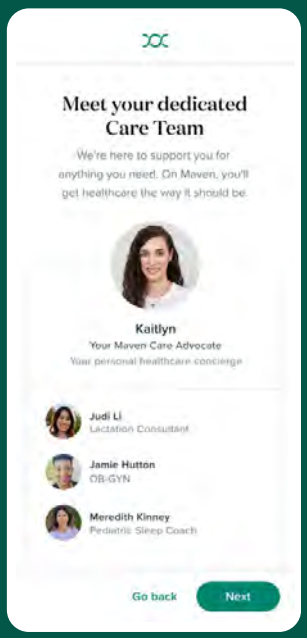
CALL 911 IMMEDIATELY IF YOU ARE HAVING A MEDICAL EMERGENCY. 2nd.MD is not an emergency service. 2nd.MD is an independent resource to support you in receiving information from Expert Medical Specialists. 2nd.MD does not practice medicine or provide patient care and is independent from the Specialists providing the expert medical consultations.

MAVEN | THE POOL
Western Michigan Health Insurance

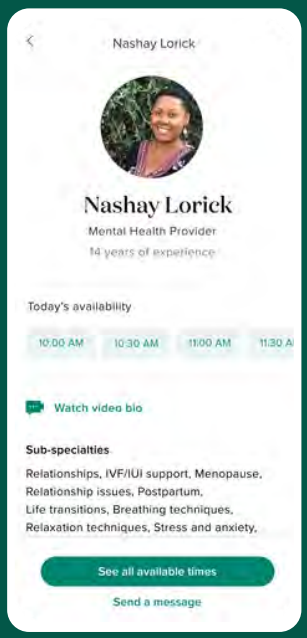
Meet Maven. Free virtual support for those sleepless nights, first smiles, and everything in between.

You and your partner have free access to Maven for 24/7 pregnancy and postpartum care and guidance–all in one app.

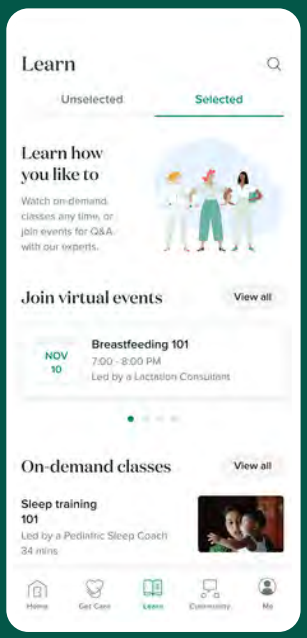
Your membership includes:



24/7 personalized support
from a dedicated Care Advocate



Virtual appointments and messaging
with providers–any time day or night



On-demand classes, groups and articles
for expert guidance you can trust

Get support with things like:

- Creating your birth plan
- Breastfeeding or bottle feeding support
- Navigating infant sleep
- Returning to work
- Managing your mental health

Scan the QR code to get started or go to mavenclinic.com/join/takecare or download the Maven Clinic app

Join today for free

The Pool employees and spouses on the BCBSM and Priority Health medical plans are eligible for Maven.

Dental Insurance

Dental Insurance is provided through Delta Dental of Michigan and is provided at no cost to regular full-time employees.

If you waive dental insurance as a regular full-time employee, you have three options:

1. A $200 credit (or $7.70/pay) to your Flexible Spending Account (FSA) for those eligible for an FSA;
2. A $200 credit (or $7.70/pay) to your Health Savings Account (HSA) for those participating in a qualified high-deductible health plan; or
3. A $150 cash rebate (or $5.77/pay).

Also eligible are your legal spouse, your dependent children to the end of the calendar year in which they turn 26, and your dependent unmarried children who are eligible to be claimed by you as a dependent under the U.S. Internal Revenue code during the current calendar year.

If you and your spouse are both eligible under this contract, you may be enrolled as both a Subscriber on your own application card and as a dependent on your spouse's application card. Your dependent children may be enrolled on both application cards as well. Delta Dental will coordinate benefits.

Benefits will cease on the last day of the month in which the employee is terminated.

Regular part-time employees may purchase dental benefits with 100% of the cost at the employee's expense.

Manage your dental plan online with Member Portal - Member Portal | Delta Dental of Michigan

Member Portal gives you easy, secure online access to your benefits information 24/7. Use this free service if you have Delta Dental benefits for:

- **Eligibility.** Review your specific benefits, including eligibility for dependents.
- **Up-to-date benefit information.** Find current information about your benefits, such as how much of your annual maximum has been used to date, how much is still available to use, and levels of coverage for specific dental services.
- **Claims information.** Review specific claims transactions, reimbursements, payments and pre-treatment estimates. You can also print a copy of your Explanation of Benefits (EOB) statements.
- **ID Cards.** Print a copy of your ID card to give to your dentist. Please note that ID cards are not required and do not verify eligibility, although many dental offices like to keep a copy on file.
- **Paperless EOBs.** Sign up for paperless delivery of your EOB statements.
- **Dentist search.** Search for participating dentists near you.

DELTA DENTAL

Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 1481-0009
St. Clair County Community Mental Health Authority

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the Dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO™ Dentist	Delta Dental Premier® Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Basic Services			
Radiographs – X-rays	50%	50%	50%
Minor Restorative Services – fillings and crown repair	50%	50%	50%
Endodontic Services – root canals	50%	50%	50%
Periodontic Services – to treat gum disease	50%	50%	50%
Oral Surgery Services – extractions and dental surgery	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Other Basic Services – misc. services	50%	50%	50%
Relines and Repairs – to prosthetic appliances	50%	50%	50%
Major Services			
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	No Age Limit	No Age Limit	No Age Limit

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges and you are responsible for that difference.

- Ø Oral exams (including evaluations by a specialist) are payable twice in any period of 12 consecutive months.
- Ø Prophylaxes (cleanings) are payable twice in any period of 12 consecutive months.
- Ø People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her Dentist about treatment.
- Ø Fluoride treatments are payable twice in any period of 12 consecutive months for people age 18 and under.
- Ø Bitewing X-rays are payable once in any period of 12 consecutive months and full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any five-year period.
- Ø Sealants are not a Covered Service.
- Ø Composite resin (white) restorations are payable on posterior teeth.
- Ø Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Ø Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.
- Ø People with special health care needs may be eligible for additional services including exams, hygiene visits, dental case management, and sedation/anesthesia. Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management,

healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of Dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,000 per Member total per Benefit Year on all services except orthodontic services. $1,500 per Member total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per month fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist.

Deductible – None.

Waiting Period – Enrollees who are eligible for Benefits are covered on the first day of the month following 30 days of employment.

Eligible People – All full-time employees of St. Clair County Community Mental Health Authority and COBRA (Consolidated Omnibus Budget Recognition Act of 1985) enrollees, if applicable.

Also eligible are your Spouse and your Children to the end of the calendar year in which they turn 26, including your Children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse's application. Your Dependent Children may be enrolled on both your and your Spouse's applications as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Benefits will cease on the last day of the month in which your employment is terminated.

Vision Insurance

Vision Insurance is provided through EyeMed and is provided at no cost to regular full-time employees.

Also eligible to regular full-time employees are your legal spouse, your dependent children to the end of the calendar year in which they turn 26, and your dependent unmarried children who are eligible to be claimed by you as a dependent under the U.S. Internal Revenue code during the current calendar year.

Regular part-time employees may purchase vision coverage with 100% of the cost at the employee's expense.

You may use any in-network licensed Optician, Optometrist, or Ophthalmologist.

The EyeMed network is quite extensive. To locate an in-network provider, use this link: https://www.eyemedvisioncare.com/locator/locator.emvc?execution=e1s1

Log on to your EyeMed member portal to manage your benefits as well as a host of helpful information EyeMed Vision Benefits – Members

St. Clair County Community Mental Health

40% OFF

additional complete pair of prescription eyeglasses

20% OFF

non-covered items, including non-prescription sunglasses

Find an eye doctor

(Insight Network)

- 866.804.0982
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads Up

You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	$5 copay	Up to $40
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $130 allowance	Up to $91
STANDARD PLASTIC LENSES		
Single Vision	$10 copay	Up to $30
Bifocal	$10 copay	Up to $50
Trifocal	$10 copay	Up to $70
Lenticular	$10 copay	Up to $70
Progressive - Standard	$65 copay	Up to $50
Progressive - Premium Tier 1 - 4	$95 - 185 copay	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45	Up to $5
Anti Reflective Coating - Premium Tier 1 - 3	$57 - 85	Up to $5
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid and Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $130 allowance	Up to $91
Contacts - Disposable	$0 copay; 100% of balance over $130 allowance	Up to $91
Contacts - Medically Necessary	$0 copay; paid in full	Up to $210
OTHER		
Hearing Care from Amplifon Network	Up to 64% off hearing aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam	Once every plan year	Once every plan year
Frame	Once every other plan year	Once every other plan year
Lenses	Once every other plan year	Once every other plan year
Contact Lenses	Once every other plan year	Once every other plan year

(Plan allows member to receive either contacts and frame, or frames and lens services)

EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866.939.3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, Policy number VC-19, form number M-9083, or Policy number VC-146, form number M-9184, in New York underwritten by Fidelity Security Life Insurance Company of New York, Policy Number VCN-1, form number MN-1, or Policy Number VCN-19, form number MN-28. This is a snapshot of your benefits. The Certificate of Insurance is on file with your employer.

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from—independent eye doctors, your favorite retail stores, even online options.

Keep your eyes open for extra discounts

Members already save an average 71% off retail using their EyeMed benefits,[1] but our long list of special offers takes benefits even further.

Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

[1] Based on weighted average of sample transactions; EyeMed Insight network/$10 exam copay/$10 materials copay/$120 frame or contact lens allowance.

Create a member account at eyemed.com

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor—search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION EST. 1961 TARGET OPTICAL

PDF-2004-M-377

Flexible Spending Accounts

SCCCMHA partners with Wex Benefits for medical Flexible Spending Account (FSA) and Dependent Care Flexible Spending Accounts (DCFSA). All regular full-time employees are eligible to participate in an FSA or DCFSA. Both plans require active enrollment or re-enrollment each plan year.

FSA Account Highlights

A medical FSA is a pre-tax benefit account that allows employees to set aside money to pay for out-of-pocket health care expenses not covered by their insurance, such as deductibles, copayments, and prescriptions. By contributing pre-tax dollars, you reduce your taxable income, leading to tax savings on your contributions. Funds are typically used within the plan year, though the agency does allow a limited rollover for unused funds.

How it Works

Enrollment: You can only enroll in an FSA as a newly hired employee or during the open enrollment period.

Contributions: During enrollment, you decide how much to contribute for the year. This amount is then deducted from your paycheck before taxes are calculated, reducing your taxable income.

Usage: You can use the funds for eligible health expenses, using a Wex Benefit debit card or through reimbursement. You will receive a debit card from Wex Benefits to use at the pharmacy or other health care providers.

Keep in mind that any expense you use your Wex debit card for that is not equal to a flat dollar copay amount associated with your health plan may require a receipt to be submitted to Wex Benefits for substantiation. Alternatively, you can pay for expenses out of pocket and submit your receipts to Wex Benefits for reimbursement.

Eligible Expenses:

- Common eligible expenses include:
- Medical, dental, and vision care (copayments, deductibles, eyeglasses, contact lenses, braces, etc.)
- Prescription medications and prescribed over-the-counter (OTC) drugs
- Professional services like chiropractic, acupuncture, and physical therapy
- Certain OTC items like bandages and first-aid supplies
- For a complete listing of eligible expenses, visit https://fsastore.com/fsa-eligibility-list

Tax Savings:
The tax savings are equivalent to the amount of taxes you would have paid on the money you set aside.

Use-it-or-Lose-it Rule:
Generally, you must use the funds within the plan year. However, SCCCMHA follows the IRS guideline and allows participants to rollover $680 into the next plan year. If you do not spend all of the money you have contributed to your FSA, any amount unused over that is forfeited.

No Changing Contributions:
Once you've selected your contribution amount, you cannot change it during the plan year unless you experience a qualifying life event.

Plan Year 2026 FSA Maximum Contribution Limits:

- $3,400 – Annual Election
- $680 – Rollover to 2027 Plan Year

Please note that you, or if you are married, **you and your spouse**, are not allowed to participate in both an FSA and a Health Savings Account.

Dependent Care FSA (DCFSA) Account Highlights

DCFSA is a pre-tax Flexible Spending Account that allows you to set aside money from your paycheck to pay for work-related care expenses for an eligible dependent, such as a child under age 13 or a disabled adult who cannot care for themselves. The primary benefit is tax savings, as these contributions are excluded from your gross income, which reduces your overall tax burden.

Eligible expenses include daycare, preschool, before/after-school care, summer day camps, and elder care, but typically exclude tuition, overnight camps, and educational services.

For 2026, the maximum annual contributions:

- **$7,500**: for married couples filing jointly or single individuals.
- **$3,750**: for married individuals filing separately.

How it Works

Elect an amount: You decide how much you want to contribute to your DCFSA annually. The elected amount is deducted from your paycheck before taxes are withheld, saving you money.

Pay for care: You use the funds in your account to pay for eligible dependent care expenses that allow you (and your spouse, if married) to work or look for work.

Reimbursement: You can submit claims for out-of-pocket expenses and receive reimbursement from DCFSA.

Eligible Dependents:

- A qualifying child under age 13.
- A spouse or other dependent who is mentally or physically incapable of self-care.

Examples of Eligible Expenses:

- Daycare centers and nursery schools, Before- and after-school programs, Summer day camps, Elder care or adult day care, and In-home or out-of-home babysitting services.

What's Not Covered:

- Private school tuition (for kindergarten and up).
- Overnight camps or sleep-away camps.
- Educational expenses not directly related to care, such as lessons or tutoring.
- Care provided by a dependent, a child under 19, or the employee's spouse.

Key Considerations:

Use-it-or-lose-it: Unlike some health FSAs, funds in a DCFSA typically cannot be rolled over to the next plan year; you must use them or forfeit them.

Annual election:
You must re-enroll each year and cannot change your contribution amount mid-year unless you have a qualifying life event.

Spousal requirement:
If you are married, your spouse must also be working or attending school full-time for you to be eligible.

Staff who participate in either a medical FSA or a DCFSA can view account balances, submit for reimbursement by logging on to their member portal at Wex Benefits - [Benefits Account Login | Benefits Administration Acct Login | WEX Inc. Login]

Health Savings Account

What is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is a tax-advantaged savings account that can be used to pay for qualified medical expenses. It is only available to individuals enrolled in a high-deductible health plan (HDHP) and offers a "triple tax advantage".

- **Tax-deductible contributions:** Money put into an HSA is not taxed. If the contributions are made through your employer's payroll, they are not subject to federal income tax or FICA taxes (Social Security and Medicare).
- **Tax-free growth:** Interest and investment earnings within an HSA grow tax-free.
- **Tax-free withdrawals:** Withdrawals for qualified medical expenses are not subject to federal taxes.

How an HSA works

1. **Enroll in a Qualified High-Deductible Health Plan (HDHP).** To be eligible for an HSA, you must be covered by a high-deductible health plan (HDHP). These plans typically have lower monthly premiums but higher deductibles. You can enroll as a newly hired employee and during annual open enrollment. Participants are required to complete an active enrollment or re-enrollment each plan year.

   Enrollment Requirements:
   - Choose a banking institution and set up an HSA. Most banks and credit unions allow members to have an HSA at no additional cost or fee.
   - Complete the HSA Deduction form and submit it to the Finance Department for processing
2. **Contribute funds:** You can contribute money to the HSA up to the annual limit set by the IRS. For 2026, the maximum contributions are $4,400 for self-only coverage and $8,750 for family coverage.
3. **Pay for expenses:** You can use the funds to pay for qualified medical expenses, including doctor visits, prescriptions, copayments, and deductibles.
4. **Funds roll over:** Unlike a Flexible Spending Account (FSA), HSA funds do not have a "use-it-or-lose-it" rule. Your balance carries over from year to year.
5. **Invest your balance:** You have the option to invest your HSA funds, similar to a 401(k), to potentially grow your savings over time.
6. **Withdrawals in retirement:** After age 65, you can withdraw funds for any purpose without penalty. If used for non-medical expenses, the withdrawal is taxed as ordinary income, similar to a traditional IRA.

Eligibility requirements

To contribute to an HSA, you must meet all of the following criteria:

- Be covered by an HSA-eligible HDHP – Enhanced HSA 200 040 041 or Value HSA 3000 066 067
- Not be enrolled in Medicare.
- Not be claimed as a dependent on someone else's tax return.

Key advantages

- **Long-term savings:** The ability to invest your balance and roll over unused funds makes an HSA a powerful tool for saving for future medical costs, especially in retirement.
- **Portability:** You own your HSA, so you can keep it even if you change jobs or health plans.
- **Flexibility:** After age 65, you can use the funds for any expense without the 20% penalty.

Employee Life Insurance

Local 3385 Employees - Life

SCCCMHA provides Local 3385 Employees with a $40,000 Basic Life/Accidental Death and Dismemberment policy through Symetra Life Insurance Company at no cost to the employee.

Local 3385 Employees can choose to purchase supplemental Life Insurance in the amounts of:

- $40,000
- $80,000

If you choose to enroll for an amount of insurance that surpasses the guaranteed issue amount (Core) offered by SCCCMHA, you will be required to submit an Evidence of Insurability (EOI) form to Symetra Life Insurance for approval. You will receive notice directly from Symetra if you have been approved or denied supplemental life insurance. If approved, your deductions will start at the beginning of the next month.

Additional Life Insurance is paid for with a payroll deduction from your bi-weekly pay. Please see the Symetra Certificate to estimate the cost of supplemental life insurance.

Local 1518, Chapter 20 Employees - Life

SCCCMHA provides Local 1518, Chapter 20 Employees with a $50,000 Basic Life/Accidental Death and Dismemberment policy through Symetra Life Insurance Company at no cost to the employee.

Local 1518, Chapter 20 Employees can choose to purchase supplemental Life Insurance in the amounts of:

- $50,000
- $100,000

If you choose to enroll for an amount of insurance that surpasses the guaranteed issue amount (Core) offered by SCCCMHA, you will be required to submit an Evidence of Insurability (EOI) form to Symetra Life Insurance for approval. You will receive notice directly from Symetra if you have been approved or denied supplemental life insurance. If approved, your deductions will start at the beginning of the next month.

Supplemental life insurance is paid for with a payroll deduction from your bi-weekly pay. Please see the Symetra Certificate to estimate the cost of supplemental life insurance.

Changes to your life insurance elections can only be made during open enrollment.

Group Life Insurance | **Basic Life and Accidental Death & Dismemberment**

SUMMARY OF BENEFITS — Class 1

Sponsored By: St. Clair County Community Mental Health Authority
Effective Date: January 1, 2024
Policy Number: 01-020776-00

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Eligibility

All Full-Time Local 3385 Employees excluding Executives working a minimum of 37.5 hours per week.

Employee	Life and AD&D Benefit
Amount	$40,000
Guaranteed Issue (Life benefit only)	$40,000

Benefit Reduction	Employee
No Reductions.	

Additional Benefit Details

Accelerated Death Benefit	If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the employee. Please refer to your employee certificate for additional information.
Conversion	A conversion benefit is available that allows you to convert your group coverage to an individual policy if certain conditions apply. Please refer to your employee certificate for additional information.
Waiver of Premium	With proof of disability, Symetra Life Insurance Company will waive Life Insurance premiums for a period of time for an employee that becomes disabled prior to a certain qualifying age. Certain restrictions, such as an elimination period, apply. Please refer to your employee certificate for additional information.
AD&D Riders	Includes Seat Belt, Airbag, Repatriation, Child Education, Day Care, Rehabilitation, Spouse Education, Adaptive Home and Vehicle, Critical Burn, Therapeutic Counseling, Felonious Assault and Coma benefits. Please refer to your employee certificate for additional information.

Value Added Services

Beneficiary Companion	Support services for beneficiaries who have experienced a loss.
Travel Assist	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.
Identity Theft Protection	Help is just a phone call away wherever employees travel, including lost wallet protection, translation service and emergency cash.

This summary provides only a brief description of the Life Insurance coverage insured by Symetra Life Insurance Company under the LGC-13000 8/06 series Group Life Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-020776-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

Group Life Insurance — Supplemental Life

SUMMARY OF BENEFITS — Class 1

Sponsored By: **St. Clair County Community Mental Health Authority**
Effective Date: **January 1, 2024**
Policy Number: **01-020776-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Eligibility

All Full-Time Local 3385 Employees excluding Executives working a minimum of 37.5 hours per week.

Employee	Life Benefit
Amount	Option 1: $40,000, subject to a maximum of 5 x Basic Annual Earnings (rounded to the next higher $1,000). Option 2: $80,000 or $50,000 if you initially become insured after age 70, subject to a maximum of 5 x Basic Annual Earnings (rounded to the next higher $1,000).

Benefit Reduction	Employee
No Reductions.	

Evidence of Insurability

Evidence of Insurability is required for all amounts of insurance selected after the initial 31-day eligibility period and for any amount in excess of the Guarantee Issue amount.

Additional Benefit Details

Accelerated Death Benefit	If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the employee. Please refer to your employee certificate for additional information.
Conversion	A conversion benefit is available that allows you to convert your group coverage to an individual policy if certain conditions apply. Please refer to your employee certificate for additional information.
Portability	This coverage may be continued at group rates upon termination of employment. Certain restrictions apply. Please refer to your employee certificate for additional information.

Waiver of Premium	With proof of disability, Symetra Life Insurance Company will waive Life Insurance premiums for a period of time for an employee that becomes disabled prior to a certain qualifying age. Certain restrictions, such as an elimination period, apply. Please refer to your employee certificate for additional information.

Value Added Services

Beneficiary Companion	Support services for beneficiaries who have experienced a loss.
Travel Assist	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.
Identity Theft Protection	Help is just a phone call away wherever employees travel, including lost wallet protection, translation service and emergency cash.

Rates for Supplemental Life coverage

Monthly Supplemental Employee Life Rates per $1,000 of coverage

AGE	RATE	AGE	RATE
Under 25	$0.090	50 - 54	$0.370
25 - 29	$0.090	55 - 59	$0.590
30 - 34	$0.090	60 - 64	$0.590
35 - 39	$0.110	65 - 69	$0.590
40 - 44	$0.160	70 - 74	$0.590
45 - 49	$0.230	75 +	$0.590

Calculating Your Cost

Supplemental Employee Life: _____ (volume) x _____ (rate) ÷ 1,000 = $_____ Monthly Cost

This summary provides only a brief description of the Life Insurance coverage insured by Symetra Life Insurance Company under the LGC-13000 8/06 series Group Life Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-020776-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

Group Life Insurance | **Basic Life and Accidental Death & Dismemberment**

SUMMARY OF BENEFITS — Class 2

Sponsored By: St. Clair County Community Mental Health Authority
Effective Date: January 1, 2024
Policy Number: 01-020776-00

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Eligibility

All Full-Time Chapter 20 Employees excluding Executives working a minimum of 37.5 hours per week.

Employee	Life and AD&D Benefit
Amount	$50,000
Guaranteed Issue (Life benefit only)	$50,000

Benefit Reduction — Employee

No Reductions.

Additional Benefit Details

Accelerated Death Benefit	If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the employee. Please refer to your employee certificate for additional information.
Conversion	A conversion benefit is available that allows you to convert your group coverage to an individual policy if certain conditions apply. Please refer to your employee certificate for additional information.
Waiver of Premium	With proof of disability, Symetra Life Insurance Company will waive Life Insurance premiums for a period of time for an employee that becomes disabled prior to a certain qualifying age. Certain restrictions, such as an elimination period, apply. Please refer to your employee certificate for additional information.
AD&D Riders	Includes Seat Belt, Airbag, Repatriation, Child Education, Day Care, Rehabilitation, Spouse Education, Adaptive Home and Vehicle, Critical Burn, Therapeutic Counseling, Felonious Assault and Coma benefits. Please refer to your employee certificate for additional information.

Value Added Services

Beneficiary Companion	Support services for beneficiaries who have experienced a loss.
Travel Assist	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.
Identity Theft Protection	Help is just a phone call away wherever employees travel, including lost wallet protection, translation service and emergency cash.

This summary provides only a brief description of the Life Insurance coverage insured by Symetra Life Insurance Company under the LGC-13000 8/06 series Group Life Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-020776-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

Group Life Insurance — Supplemental Life

SUMMARY OF BENEFITS — Class 2

Sponsored By: **St. Clair County Community Mental Health Authority**
Effective Date: **January 1, 2024**
Policy Number: **01-020776-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Eligibility

All Full-Time Chapter 20 Employees excluding Executives working a minimum of 37.5 hours per week.

Employee	Life Benefit
Amount	Option 1: $50,000, subject to a maximum of 5 x Basic Annual Earnings (rounded to the next higher $1,000). Option 2: $100,000 or $50,000 if you initially become insured after age 70, subject to a maximum of 5 x Basic Annual Earnings (rounded to the next higher $1,000).

Benefit Reduction — Employee

No Reductions.

Evidence of Insurability

Evidence of Insurability is required for all amounts of insurance selected after the initial 31-day eligibility period and for any amount in excess of the Guarantee Issue amount.

Additional Benefit Details

Accelerated Death Benefit	If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the employee. Please refer to your employee certificate for additional information.
Conversion	A conversion benefit is available that allows you to convert your group coverage to an individual policy if certain conditions apply. Please refer to your employee certificate for additional information.
Portability	This coverage may be continued at group rates upon termination of employment. Certain restrictions apply. Please refer to your employee certificate for additional information.

Waiver of Premium	With proof of disability, Symetra Life Insurance Company will waive Life Insurance premiums for a period of time for an employee that becomes disabled prior to a certain qualifying age. Certain restrictions, such as an elimination period, apply. Please refer to your employee certificate for additional information.

Value Added Services

Beneficiary Companion	Support services for beneficiaries who have experienced a loss.
Travel Assist	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.
Identity Theft Protection	Help is just a phone call away wherever employees travel, including lost wallet protection, translation service and emergency cash.

Rates for Supplemental Life coverage

Monthly Supplemental Employee Life Rates per $1,000 of coverage

AGE	RATE	AGE	RATE
Under 25	$0.090	50 - 54	$0.370
25 - 29	$0.090	55 - 59	$0.590
30 - 34	$0.090	60 - 64	$0.590
35 - 39	$0.110	65 - 69	$0.590
40 - 44	$0.160	70 - 74	$0.590
45 - 49	$0.230	75 +	$0.590

Calculating Your Cost

Supplemental Employee Life: _____ (volume) x _____ (rate) ÷ 1,000 = $_____ Monthly Cost

This summary provides only a brief description of the Life Insurance coverage insured by Symetra Life Insurance Company under the LGC-13000 8/06 series Group Life Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-020776-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

Employee Short-Term & Long-Term Disability Insurance

Short-Term Disability

Regular full-time employees shall be eligible for continuation of pay when an illness or injury extends beyond twenty (20) consecutive workdays. Compensation shall commence on the twenty-first (21st) workday and shall provide two-thirds (2/3) of the disabled employee's normal gross pay. Verification of a continuing medical disability may be required by SCCCMHA in order to provide continuation of pay. Please review the agency's FMLA/Other Medical Leave policy or reach out to the Human Resources Department for more information.

Long-Term Disability

SCCCMHA provides employees with a Long-Term Disability Insurance (LTD) policy, through Symetra Life at no cost to the employee. LTD benefits begin after you have been out of work due to a sickness or injury for 180 days.

How it Works

Your monthly benefit, if approved for LTD, is:

- 66.67% of your monthly salary to a maximum of $4,000 per month for up to 5 years

You may choose to buy the supplemental LTD Insurance option:

Your monthly benefit, if approved for LTD, and you choose the buy-up option, will be:

70% of your monthly salary to a maximum of $6,000 per month up to age 65

If you choose to enroll for an amount of LTD insurance that surpasses the guaranteed issue amount (Core) offered by SCCCMHA, you will be required to submit an Evidence of Insurability (EOI) form to Symetra Life Insurance for approval. You will receive notice directly from Symetra if you have been approved or denied supplemental LTD insurance. If approved, your deductions will start at the beginning of the next month.

Additional LTD insurance is paid for with a payroll deduction from your bi-weekly pay. Please see the Symetra Certificate to estimate the cost of supplemental LTD insurance.

Changes to your long-term insurance elections can only be made during open enrollment.

Group Disability Insurance **Long Term Disability**

SUMMARY OF BENEFITS **Class 1**

Sponsored By: **St. Clair County Community Mental Health Authority**
Effective Date: **January 1, 2024**
Policy Number: **01-020776-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Eligibility

All Full-Time Employees excluding Executives working a minimum of 37.5 hours per week.

Benefit Highlights

Benefit Amount

66.67% of Salary up to $4,000 per month

Elimination Period

180 days (number of days you must be disabled to collect disability benefits)

Maximum Payment Duration

65/5/70:

Age at Disability	Maximum Payment Duration
Less than age 60	To age 65
60-64	5 years
65-69	To age 70, but not less than 1 year
70 and over	1 year

Definition of Disability

24 Months Regular Occupation

Accumulation of Elimination Days

You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability.

Pre-Existing Condition

This plan will cover a disability if it is caused by, contributed to by, or results from a pre-existing condition and the disability begins after being insured for 12 consecutive months from his/her effective date of coverage. If the time period requirements are not met, the disability is excluded from coverage under the plan.

Pre-Existing Condition means a sickness or injury for which the insured received treatment within 3 months prior to his/her effective date of coverage. Treatment includes consultation, care, or services from a doctor, or other medical professional recommended by a doctor. It also includes being prescribed medicines, taking prescribed medicines (or the fact that the insured should have been taking prescribed medicines, but chooses not to), and receiving diagnostic measures.

Survivor Income Benefit

A survivor benefit may be paid to your beneficiary if you should die while receiving qualifying disability payments.

Benefit Limitations

Mental Illness: 24 Months Per Lifetime
Substance Abuse: 24 Months Per Lifetime

Standard Provisions

- Maternity is covered the same as any other condition.
- 6 months recurrent disability/temporary recovery
  - If the insured recovers and returns to work, and the same sickness or injury causes the disability to occur again within 6 months of the date the prior disability ended, Symetra will resume monthly payments if the insured is covered under the policy for the period of temporary recovery.
- Waiver of premium
  - Premium payments for coverage are suspended for an insured while he/she is receiving disability income payments under this policy.
- Cost of living freeze
  - Except for increases in income earned (or received from any form of employment) once other income amounts have been subtracted from the gross monthly disability payment, the insured's payment will not be further reduced due to a cost of living increase in any other income amounts.
- Vocational rehabilitation
  - Provides assistance through services such as testing and training as well as job modification and placement.
- Social Security assistance
  - Helps an insured obtain Social Security disability benefits.
- Continuity of coverage

This summary provides only a brief description of the Disability Income Insurance coverage insured by Symetra Life Insurance Company under the GDC 4000 series Group Disability Income Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-020776-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

Group Disability Insurance **Buy Up Long-Term Disability**

SUMMARY OF BENEFITS **Class 1**

Sponsored By: **St. Clair County Community Mental Health Authority**
Effective Date: **January 1, 2024**
Policy Number: **01-020776-00**

The information in this summary may be replaced by any subsequently issued summary or policy amendment.

Eligibility

All Active Full-Time Employees excluding Executives working a minimum of 37.5 hours per week.

Benefit Highlights

Benefit Amount

70% of Earnings up to $6,000 per month

Elimination Period

180 days (number of days you must be disabled to collect disability benefits)

Maximum Payment Duration

65/5/70:

Age at Disability	Maximum Payment Duration
Less than age 60	To age 65
60-64	5 years
65-69	To age 70, but not less than 1 year
70 and over	1 year

Definition of Disability

24 Months Regular Occupation with Residual

Accumulation of Elimination Days

You can satisfy the days of your elimination period with either total (off work entirely) or partial (working some hours at your current job) disability.

Pre-Existing Condition

This plan will cover a disability if it is caused by, contributed to by, or results from a pre-existing condition and the disability begins after being insured for 12 consecutive months from his/her effective date of coverage. If the time period requirements are not met, the disability is excluded from coverage under the plan.

Pre-Existing Condition means a sickness or injury for which the insured received treatment within 3 months prior to his/her effective date of coverage. Treatment includes consultation, care, or services from a doctor, or other medical professional recommended by a doctor. It also includes being prescribed medicines, taking prescribed medicines (or the fact that the insured should have been taking prescribed medicines, but chooses not to), and receiving diagnostic measures.

Survivor Income Benefit

A survivor benefit may be paid to your beneficiary if you should die while receiving qualifying disability payments.

Benefit Limitations

Mental Illness: 24 Months Per Lifetime
Substance Abuse: 24 Months Per Lifetime

Standard Provisions

- Maternity is covered the same as any other condition.
- 6 months recurrent disability/temporary recovery
  - If the insured recovers and returns to work, and the same sickness or injury causes the disability to occur again within 6 months of the date the prior disability ended, Symetra will resume monthly payments if the insured is covered under the policy for the period of temporary recovery.
- Waiver of premium
  - Premium payments for coverage are suspended for an insured while he/she is receiving disability income payments under this policy.
- Cost of living freeze
  - Except for increases in income earned (or received from any form of employment) once other income amounts have been subtracted from the gross monthly disability payment, the insured's payment will not be further reduced due to a cost of living increase in any other income amounts.
- Vocational rehabilitation
  - Provides assistance through services such as testing and training as well as job modification and placement.
- Social Security assistance
  - Helps an insured obtain Social Security disability benefits.
- Continuity of coverage

This summary provides only a brief description of the Disability Income Insurance coverage insured by Symetra Life Insurance Company under the GDC 4000 series Group Disability Income Insurance policy. For a complete description, including all definitions, exclusions, limitations, and reductions in coverage, as well as information on termination of benefits, please contact your benefit administrator or refer to the Group Insurance Certificate you will receive when you become insured. Coverage will be offered under Group Policy number 01-020776-00. All benefits are subject to the terms and conditions of the Group Policy. If there is a difference between the information in this summary and the information contained in the Group Insurance Certificate, the terms of the Group Insurance Certificate will prevail. The terms of coverage may change over time; always refer to your current Group Insurance Certificate for information regarding your insurance benefits.

Insured by Symetra Life Insurance Company

Benefit Contact Information

Refer to this list when you need to contact one of your benefit vendors. For questions regarding specific benefits, limitations, or claims, contact the numbers listed in this guide or on your identification card. *When contacting any of the companies below, it is important to have the Insurance card or ID number(s) of the subscriber for the coverage you are calling about, as well as any appropriate paperwork, i.e., Explanation of Benefits, denial letter, receipts, etc.*

Carrier	Coverage	Plan Name & Number	Contact Information
Blue Cross Blue Shield Blue Care Network of Michigan	Group Health Plan & Prescription Coverage	Group #: 71565 Rx Group #: BCBSMAN Rx Bin #: 610014	Blue Cross Blue Shield of Michigan 600 E. Lafayette Blvd. Detroit, MI 48226 877-752-1233 www.bcbsm.com
DELTA DENTAL	Dental	Client #: 1481 Sub Client #: 0009	Delta Dental of Michigan, Ohio & Indiana 27755 Stansbury Blvd., Ste. 150 Farmington Hills, MI 48334 800-524-0149 www.deltadentalmi.com
eyeMed	Vision	Group #: 1026503	EyeMed 4000 Luxottica Place Mason, OH 45040 866-299-1358 www.eyemedvisioncare.com
wex™	Medical & Dependent Care Flexible Spending Accounts, Health Savings Account & COBRA Administration	Group ID: 36782	Wex Benefits 1 Hancock Street Portland, ME 04101 866-451-3399 https://customer.wexinc.com/login/benefits-login/
SYMETRA RETIREMENT | BENEFITS | LIFE	Life and Long-Term Disability	Policy Number: 01020776000	Symetra Life Insurance Company 777 108th Avenue NE, Ste. 1200 Bellevue, WA 98004-5135 1-800-796-3872 www.symetra.com
Additional Contact Information			
corebridge financial	Social Security Alternative & Retirement Planning		Employee Contact: Trecia Scribner trecia.scribner@corebridgefinancial.com Direct: 248-878-6232 / Office: 800-448-2542
SAINT CLAIR COUNTY 1820 MICHIGAN	St. Clair County Retirement Pension Plan *(For those hired before 1/1/2016)*		Tami M. Rumsey, HR Coordinator Offices of St. Clair County 200 Grand River Avenue, Ste. 206 Port Huron, MI 48060 www.stclaircounty.org trumsey@stclaircounty.org Direct: 810-989-6390 Main Line: 810-989-6910 ext. 6390 Fax: 810-985-3493

Employee Assistance Program (EAP)

At SCCCMH, we understand that personal challenges and job-related stress can affect your well-being. That is why we are proud to offer free and confidential Employee Assistance Program (EAP) services for you and your covered immediate family members. The EAP provides short-term counseling (up to five sessions per event, per calendar year) and other professional resources to help with:

- Stress or anxiety
- Depression or mood changes
- Work-life balance
- Relationship or family issues
- Grief or loss
- Legal, financial, parenting, and eldercare concerns
- Wellness tools and work-life balance support

For more information, please refer to Personnel – Employee Assistance Program (EAP), Policy #06-001-0135.

SCCCMH Contracted EAP Providers

- McLaren Port Huron Industrial Health – (810) 982-4980
- Professional Counseling Center – (810) 984-4202
- Sanilac County Community Mental Health – (810) 648-0330
- Lapeer County Community Mental Health – (810) 677-0500
- Renewal Christian Counseling Center – (586) 783-2950
- NorServ – (810) 329-4798

These services are provided at no cost and are completely confidential.

Accessing EAP Through LifeCare

In addition to the providers listed above, you and your covered immediate family members have access to EAP services through LifeCare, available directly on the ADP homepage. LifeCare offers a wide range of free and confidential support services, including: - Emotional support and short-term counseling - Legal and financial consultations - Parenting and eldercare resources - Wellness tools and work-life balance support.

You may access LifeCare by:

- Logging in to ADP and selecting the LifeCare icon, or
- Call 800-697-7315 (available 24/7 for personal assistance)

Requesting an Outside EAP Provider

If you would like to work with a provider who is not currently part of our EAP network, please contact Human Resources. We will make every effort to accommodate your request and explore alternative options. While services through contracted providers are free, outside services may involve:

- Coverage through your health insurance plan, or
- A sliding fee scale based on your ability to pay. HR can also assist you in finding low-cost or no-cost community resources whenever possible.

Retirement Plan Options

Social Security Alternative

All regular full-time employees contribute to a Social Security Alternative Account – 401(a) Deferred Compensation, instead of contributing to traditional Social Security. This account is set up with Corebridge Financial. The amount, 6.2%, is equal to the amount that would have been deducted from your pay for Social Security. The agency also matches those funds for participants, at 6.2%.

Benefits:

- Pre-tax contributions, which reduce current income taxes
- You are fully vested, meaning you will receive 100% of employee and employer contributions upon separation from employment
- You choose how you would like to invest the funds and can change your investment choices at any time
- You are the sole owner of the account, and only you can touch those funds
- You will still receive Social Security Benefits at retirement age. The amount will depend on how long you paid into Social Security. You can view your Social Security benefit by visiting: The United States Social Security Administration | SSA

457 (b) Retirement Option

All employees of SCCCMHA are eligible to contribute to a 457(b) Deferred Compensation retirement plan. However, only regular full-time employees will receive the employer match. When you meet with our Corebridge Financial representative, you will choose the percentage or flat amount that you would like to contribute.

Regular full-time employees will receive an employer match of up to 8% of their annual income.

Benefits:

- Pre-tax contributions, which reduce current income taxes
- You are fully vested, meaning you will receive 100% of your contributions, and if you are a regular full-time employee, you will also receive all employer contributions upon separation from employment
- You choose how you would like to invest the funds and can change your investment choices at any time
- You are the sole owner of the account, and only you can touch those funds

You are encouraged to meet with our Corbridge Financial representative as soon as possible to set up your Social Security Alternative Account – 401(a) Deferred Compensation Plan and/or 457(b) Deferred Compensation Retirement Plan.

corebridge financial

Meet your Corebridge team

No matter where you are in your career your Corebridge Financial team of local financial professionals is dedicated to helping you understand your retirement plan. They can help educate you on a range of important issues, including retirement planning, investment planning, financial planning, asset allocation, college planning, long-term care and more. Scan the code to schedule time to meet with your Corebridge financial professional today.

Trecia Scribner, CRPC®
Financial Advisor
Direct: 248.878.6232
Office: 800.448.2542
2601 Cambridge Court, Suite 150,
Auburn Hills, MI 48362
trecia.scribner
@corebridgefinancial.com

Scan here to schedule a convenient time.

1.800.448.2542 corebridgefinancial.com or corebridgefinancial.com/retire

We're here to help you take action

VC 39598 (12/2024) J1571804 EE

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

St. Clair County
Community Mental Health
Promoting Discovery & Recovery Opportunities for Healthy Minds & Bodies

BUILDING A BETTER US

A PARTNERSHIP BETWEEN CMH AND THE YMCA

YOUR MEMBERSHIP IS A BENEFIT AT CMH

- Easily upgrade to a household membership, so membership is affordable for the entire household. Household memberships enjoy reduced rates on child care, camp, swim lessons, and youth sports. In addition, a variety of family-friendly activities are included in your membership
- Access to more than 100 group exercise classes for all ages, levels and abilities
- Get started with "Wellness Works," a 3-week program provides a fitness assessment, support from a YMCA Wellness Coach and a personalized workout plan, access to Duffy Center 24/7
- Lower rates on fee-based classes and services
- Annual capital improvement fee is included in your benefit

For more than a workout. Building a better us.

Membership Rates - Your Membership is an CMH Benefit

Type	Description	2025
Adult	An individual, ages 18 - 61 years old	Your Benefit!
Household	All individuals living at a common address, proof may be required	$22.50
Household - Senior	All individuals living at a common address and the primary member is	$21.00
Household - Single Adult	All individuals living at a common address with one adult on member-	$19.00

Services - These services are available for a small fee

Child Watch/Kid Zone - Safe, clean, nurturing childcare for kids 6 weeks - 11 years old while you work out for this low monthly fee. The Y REQUIRES you stay on-site while your child is in our care.

$19.50 per household

YMCA OF THE BLUE WATER AREA

bluewaterymca.com

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

St. Clair County Community Mental Health
Promoting Discovery & Recovery Opportunities for Healthy Minds & Bodies

BUILDING A BETTER US

A PARTNERSHIP BETWEEN **COMMUNITY MENTAL HEALTH** AND THE YMCA

How do I get started?

Scan the QR code below to start your membership online, use the discount code: CMH2025

OR come down to the Y and our membership team will be able to assist you with starting your account. Just be sure to bring your **Community Mental Health** work badge with you!

YMCA OF THE BLUE WATER AREA

bluewaterymca.com

WHY THE Y?

Because at the Y you're part of something more. When you join the Y, you join a community organization that offers more health, more hope and more opportunity:

- Parents find a safe, nurturing environment for their children to stay active, be engaged and learn positive values.
- Families come together to have fun and spend quality time with each other.
- Children and teens play, develop self-confidence and know they are accepted.
- Adults connect with friends, pursue interests and learn how to live healthier.
- People from all backgrounds and walks of life come together to volunteer and help our community become stronger.
- We all build relationships that further our sense of belonging and purpose.

Nationwide Membership

With the AWAY logo on the back, you may use your YMCA of the Blue Water Area membership card at over 2000 YMCA's across the country. Visit www.ymca.net to find a YMCA in the city you'll be visiting or ask any staff member to call. Guest fees may apply.

Financial Assistance - Everyone is Welcome at the Y

The Y believes that everyone deserves the chance to succeed. Regardless of your financial situation, we'll work with you to receive all the benefits of our membership. Through the generosity of donors, we are able to provide programs and services to those who may not otherwise be able to participate. To apply for financial assistance, obtain a form from the Welcome Center. All Y members receive the

Health & Well Being
Boot Camp
Boot Camp for Seniors
Cardio-N-Core
Circuit Training
Enhance®Fitness
Hip-Hop Cardio
HITT
Intensity
Intervalocity
Kettlebell
Kickboxing
Pilates
Pound Fit
Power Abs
Power Sculpt
Spinning®
Step-N-Strength Circuit
Strength & Conditioning - Fee
Tap Cardio
Total Body Cardio
TRX®
Yoga
Zumba®

Pool
Aqua Pulse
Arthritis Aquatics
Current Walk
Deep Water Fitness
Family Pool Parties
H20 Flow
Power Splash
Silver Splash
Swim Evaluation
Swim Lessons for all ages

Youth
ChildWatch/KidZone - Fee
Kids Night Out
Family Wellness
Fitness for Kids (age 6-14)
Holiday, Snow, Summer Camp
Little Ninjas
Little Tumblers
Youth Sports
Youth Strength & Conditioning (age 10-13)

Sports & Recreation
Basketball
Futsal
Pickleball
Volleyball
Wellness Seminars
Runs/Walks

Amenities
Body Composition Testing
Competition Pool
Recreation Pool with slide, lazy river, buckets & sprays
Duffy Wellness Center
Gym
Locker Rooms (family, boys, girls, women, men with heated floors)
Steam Rooms

ST. CLAIR COUNTY WELLNESS
HAVE FUN. GET FIT.

You Can@ WORK HAVE FUN. GET FIT.

Free for SCC County Employees & Retirees including CMH & DHHS Employees
[Not available for family members]

Enjoy many different features of the YWC:

- Low Cost Fitness Classes
- 4-Station Magnum Fitness Systems Machine
- Treadmills | Bikes | Elliptical | Steppers
- Medicine Balls | Steps | Bands | Fitness Balls
- Free Weights | Kettlebells
- Dumbbell Sets (weights from 5- 100 lbs.)
- Wellness Committee Sponsored Challenges & Events
- Drinking fountain | restrooms | changing rooms & showers are also available!

YWC LOCATION

SCC Administration Building
200 Grand River Avenue
Port Huron, MI
Lower Level

YWC ACCESS

Access by swipe card & signed waiver only!
(enter through the east entrance by the Dodge Auditorium)
For swipe cards, contact Erica DeJohn in HR at (810) 989-6910
edejohn@stclaircounty.org

YWC HOURS

5:30am– 8:30pm

If you have any questions, please contact us at:
WellnessCommittee@stclaircounty.org

Join Our Facebook Group
www.facebook.com
SCC Your Wellness Center

MI Tri-Share
CHILD CARE

MI Tri-Share is a child care cost-sharing benefit available through your employer.
Please review the information below and apply at **MITriShare.org**.

Affordable Care

Three entities share the cost of your child care: You, Your Employer, and the State of Michigan. When your employer participates in MI Tri-Share, and you qualify, your child care cost is reduced by 66%!

Choice of Provider

Any licensed child care provider in Michigan can be used to provide care for children aged 0-12 with MI Tri-Share.

Employers can choose to extend this age up to 17 years old. This includes, but is not limited to, preschool, traditional child care (full or part-time), before and after-school care, summer care, and summer camps.

Convenience

Payment for child care is made directly to your provider through United Way of Northwest Michigan.

Your employer will collect your 1/3 portion of the costs from your earnings through payroll deduction or other collection method. They will then forward both the employer 1/3 and your 1/3 to United Way of Northwest Michigan.

Eligibility

Employee household income must fall between 200% - 400% of the Federal Poverty Level (FPL) relative to the number of individuals in the household (see chart). Families below this threshold could be eligible for the Child Development and Care Scholarship Program.

Employers may also have specific parameters around employee eligibility, age range covered, or other benefit choices.

MI Tri-Share Program Eligibility 2025

Household Size	Minimum - Maximum Income	Household Size	Minimum - Maximum Income
2 People	$42,300 - $ 84,600	6 People	$86,300 - $172,600
3 People	$53,300 - $106,600	7 People	$97,300 - $194,600
4 People	$64,300 - $128,600	8 People	$108,300 - $216,600
5 People	$75,300 - $150,600	9 People	$119,300 - $238,600

200% - 400% Federal Poverty Level - Effective May 1, 2025

More Connections

Are you starting your search for licensed care options?

Visit GreatStarttoQuality.org.
If you need additional assistance finding care that meets your needs, contact UWNWMI to help!

Required Notices

IMPORTANT NOTICE from St. Clair County Community Mental Health Authority about your prescription drug coverage and Medicare under the employer medical and pharmacy plan(s)

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Employer has determined that the prescription drug coverage offered by the EHIM plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday (including the month you turn 65), and continues for the ensuing three months. You may also enroll each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current employer coverage will not be affected. For most persons covered under the plan, the plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the plan's summary plan description or contact Medicare at the telephone number or web address listed herein. If you do decide to join a Medicare drug plan and drop your current employer coverage, be aware that you and your dependents will not be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

You should also know that if you drop or lose your current coverage with the employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage

Contact the person listed at the end of these notices for further information. Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.
- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1.800.772.1213 (TTY 1.800.325.0778).

Remember: Keep this Medicare Part D notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and are required to pay a higher premium (a penalty).

- Date: October 15, 2025
- St. Clair County Community Mental Health Authority
- Contact: Stephanie Shank, Human Resource Director

Women's Health and Cancer Rights Act Enrollment Notice

The Women's Health and Cancer Rights Act of 1998 was signed into law on Oct. 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which a mastectomy has been preformed
- Surgery and reconstruction of the other breast to produce asymmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient and will be subject to the same annual deductibles and coinsurance provisions which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description or contact Human Resources.

Women's preventive services

Under the Affordable Care Act, many insurers are required to cover certain preventive services at no cost to individuals. This list will expand to include additional services for women including annual well-woman visits, screening for gestational diabetes, human papillomavirus testing, also known as HPV testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, or HIV, contraceptive methods and counseling, breastfeeding support, supplies and counseling, and screening and counseling for interpersonal and domestic violence.

Notice regarding newborns' and mothers' health protection act

Group health plans and health insurance issuers offering group health insurance may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer to prescribe a length of stay not in excess of the above periods.

Michelle's law

If a full-time student engaged in a post-secondary education loses their full-time student status due to a severe illness or injury, they will maintain dependent status until the earlier of (1) one year after the first day of a medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the plan. A medically necessary leave of absence or change in enrollment at that institution must be certified by the dependent's attending physician.

HIPAA privacy and security

The health insurance portability and accountability act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected

health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. The notice of privacy practices has been recently updated.

For a full copy of the notice of privacy practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at HRDepartment@scccmh.com .

HIPAA special enrollment rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements.

New health insurance marketplace coverage options and your health coverage

Today, there is a new way to buy health insurance: the health insurance marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new marketplace.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

The 2026 open enrollment period for health insurance coverage through the marketplace runs from Nov. 1, 2025, through to Jan. 15, 2026.

Individuals must enroll or change plans prior to January 15, 2026, for coverage starting as early as Jan. 1, 2026. After Jan. 15, 2026, you can get coverage through the marketplace for 2026 only if you qualify for a special enrollment period or are applying for Medicaid or the children's health insurance program (CHIP).

Can I save money on my health insurance premiums in the marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does employer health coverage affect eligibility for premium savings through the marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your

employer's health plan. However, you may be eligible for a tax 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 meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.02 percent of your household income for the year (8.39% for 2024), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (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.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the human resources department.

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

Continuation coverage rights under COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, you should review the plan's Summary Plan Description or contact the plan administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific to a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan,

qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the plan due to either one of the following qualifying events: 1) your hours of employment are reduced, or 2) Your employment ends for any reason other than your gross misconduct. If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the plan due to any of the following qualifying events:

- Your spouse dies
- Your spouse's hours of employment are reduced
- Your spouse's employment ends for any reason other than his or her gross misconduct
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose coverage under the plan due to any of the following qualifying events:

- The parent-employee dies
- The parent-employee's hours of employment are reduced
- The parent-employee's employment ends for any reason other than his or her gross misconduct
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both)
- The parents become divorced or legally separated
- The child stops being eligible for coverage under the plan as a "dependent child"

When is COBRA Coverage Available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the plan administrator of the qualifying event.

You Must Give Notice of a Qualifying Event

For the other qualifying events (divorce, legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the plan administrator within 60 days after the qualifying event occurs. You must provide written notice to the Human Resources Department. You will be required to provide a copy of the court document showing the date the divorce or legal separation occurred.

How is COBRA Coverage Provided?

Once the plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is

a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which employment terminates, COBRA continuation coverage for his/her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

If You Have Questions

Questions concerning your plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPPA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA), in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Genetic Information Discrimination

Title II of the Genetic Information Nondiscrimination Act of 2008 (GINA), which prohibits genetic information discrimination in employment, took effect on November 21, 2009.

Under Title II of GINA, it is illegal to discriminate against employees or applicants because of genetic information. Title II of GINA prohibits the use of genetic information in making employment decisions, restricts employers and other entities covered by Title II (employment agencies, labor organizations and joint labor-management training and apprenticeship programs - referred to as "covered entities") from requesting, requiring or purchasing genetic information, and strictly limits the disclosure of genetic information.

The EEOC enforces Title II of GINA (dealing with genetic discrimination in employment). The Departments of Labor, Health and Human Services and the Treasury have responsibility for issuing regulations for Title I of GINA, which addresses the use of genetic information in health insurance.

Definition of "Genetic Information"

Genetic information includes information about an individual's genetic tests and the genetic tests of an individual's family members, as well as information about the manifestation of a disease or disorder in an individual's family members (i.e. family medical history). Family medical history is included in the definition of genetic information because it is often used to determine whether someone has an increased risk of getting a disease, disorder, or condition in the future. Genetic information also includes an individual's request for, or receipt of, genetic services, or the participation in clinical research that includes genetic services by the individual or a family member of the individual, and the genetic information of a fetus carried by an individual or by a

pregnant woman who is a family member of the individual and the genetic information of any embryo legally held by the individual or family member using an assisted reproductive technology.

Discrimination Because of Genetic Information

The law forbids discrimination on the basis of genetic information when it comes to any aspect of employment, including hiring, firing, pay, job assignments, promotions, layoffs, training, fringe benefits, or any other term or condition of employment. *An employer may never use genetic information to make an employment decision because genetic information is not relevant to an individual's current ability to work.*

Harassment Because of Genetic Information

Under GINA, it is also illegal to harass a person because of his or her genetic information. Harassment can include, for example, making offensive or derogatory remarks about an applicant or employee's genetic information, or about the genetic information of a relative of the applicant or employee. Although the law doesn't prohibit simple teasing, offhand comments, or isolated incidents that are not very serious, harassment is illegal when it is so severe or pervasive that it creates a hostile or offensive work environment or when it results in an adverse employment decision (such as the victim being fired or demoted). The harasser can be the victim's supervisor, a supervisor in another area of the workplace, a co-worker, or someone who is not an employee, such as a client or customer.

Retaliation

Under GINA, it is illegal to fire, demote, harass, or otherwise "retaliate" against an applicant or employee for filing a charge of discrimination, participating in a discrimination proceeding (such as a discrimination investigation or lawsuit), or otherwise opposing discrimination.

Rules Against Acquiring Genetic Information

It will usually be unlawful for a covered entity to get genetic information. There are six narrow exceptions to this prohibition:

- Inadvertent acquisitions of genetic information do not violate GINA, such as in situations where a manager or supervisor overhears someone talking about a family member's illness.
- Genetic information (such as family medical history) may be obtained as part of health or genetic services, including wellness programs, offered by the employer on a voluntary basis, if certain specific requirements are met.
- Family medical history may be acquired as part of the certification process for FMLA leave (or leave under similar state or local laws or pursuant to an employer policy), where an employee is asking for leave to care for a family member with a serious health condition.
- Genetic information may be acquired through commercially and publicly available documents like newspapers, as long as the employer is not searching those sources with the intent of finding genetic information or accessing sources from which they are likely to acquire genetic information (such as websites and on-line discussion groups that focus on issues such as genetic testing of individuals and genetic discrimination).
- Genetic information may be acquired through a genetic monitoring program that monitors the biological effects of toxic substances in the workplace where the monitoring is required by law or, under carefully defined conditions, where the program is voluntary.
- Acquisition of genetic information of employees by employers who engage in DNA testing for law enforcement purposes as a forensic lab or for purposes of human remains identification is permitted, but the genetic information may only be used for analysis of DNA markers for quality control to detect sample contamination.

Confidentiality of Genetic Information

It is also unlawful for a covered entity to disclose genetic information about applicants, employees or members. Covered entities must keep genetic information confidential and in a

separate medical file. (Genetic information may be kept in the same file as other medical information in compliance with the Americans with Disabilities Act.) There are limited exceptions to this non-disclosure rule, such as exceptions that provide for the disclosure of relevant genetic information to government officials investigating compliance with Title II of GINA and for disclosures made pursuant to a court order.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. 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)	Health Insurance Premium Payment (HIPP) Program Website: 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	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: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
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://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs 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 July 31, 2025, 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)

For More Information or Assistance

To request special enrollment or obtain more information, please contact:

Name	Stephanie Shank – Human Resource Director
	St. Clair County Community Mental Health Authority
	3111 Electric Avenue
City, State	Port Huron, MI 48060
Telephone	810-985-8900
E-mail	sshank@scccmh.org

Note: If you or your dependents enroll during a **special enrollment period**, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a pre-existing condition exclusion period.