2026 Enrollment Guide

Medical Carrier Contact

Blue Care Network – HMO

Member Services

(888) 417-3479

www.bcbsm.com

Vision Carrier Contact

Beam/VSP

Member Services

(800) 877-7195

Policy # MI02183

www.vsp.com

Dental Carrier Contact

Beam Benefits

Member Services

(800) 648-1179

Policy # MI02183

www.beambenefits.com

Karl J. Ruth Jr • kruth@ajmassoc.com • (248) 778-6070 • www.ajmassoc.com

Dear Employee:

At Comfort Keepers 799 we value your service and contributions, and we care about the health of you and your family members. Our goal for the upcoming benefit plan year is to provide you with options, based on your healthcare needs, as well as access to participating network medical doctors and hospitals and to provide coverage for the most frequently used services such as office visits and prescription drugs. Therefore, we have worked diligently with our Benefits Administrator, AJM Associates, Inc., to develop medical, prescription drug plans and ancillary coverage that incorporate National and Local network access while providing popular options at an affordable price.

You will have the opportunity, each year, during open enrollment to review your benefit plan options and to make any necessary changes for the upcoming benefit plan year. At this time, you can change your benefit elections or add / delete eligible dependents under the plan. Your elections will be effective **January 1, 2026 through December 31, 2026.** This Enrollment Guide is your regular full-time employee benefits manual. The purpose of this guide is to give you information and answer questions regarding your **2026** benefit package. Your benefits are an important part of your total compensation, so we invite you to familiarize yourself with the details of these plans and encourage you to seek clarification when necessary.

HOW TO ENROLL

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

HOW TO MAKE CHANGES

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. See **Open Enrollment** in this Enrollment Guide for details regarding IRS approved Qualifying Life Events.

We are excited and proud of this year's employee benefit offering and feel it is among the most competitive in our industry. As we continue to review employee satisfaction surveys, we intend to respond with further benefit package offering and refinements. Please feel free to contact Karl Ruth from our benefits administration company, Karl J. Ruth Jr., at AJM Associates, Inc. (248) 778-6070 with any questions or concerns you may have.

Open enrollment is the time of year when you can make any necessary changes to your current health election. The elections that you choose may be changed only at the next Open Enrollment Period, unless you have a Qualified Change of Status which would allow a Special Open Enrollment.

In accordance with federal regulations, the benefits you choose in your benefits package will remain in effect through the next plan year. However, you may be allowed to make changes in certain benefits if you have a **Qualified Change of Status Event**. Examples of qualified change of status events are listed below:

- Change in Status
- Change in employee's legal marital status
- Change in number of dependents
- Change in employment status (including change in work site location)
- Dependent satisfies (or ceases to satisfy) eligibility requirements
- Change in residence
- Commencement or termination of adoption proceedings
- Significant Cost Increase
- Significant Curtailment of Coverage
- Change in Coverage of Spouse or Dependent Under Other Employer's Plan
- FMLA Leave*
- COBRA Event
- Judgment, Decree, or Court Order
- Medicare or Medicaid Entitlement
- Employee/dependent loss of Medicaid or Children's Health Insurance Program (CHIP) or employee/dependent entitlement for a premium assistance program through Medicaid or CHIP. Please note that these qualifying events have a special 60 day enrollment period rather than the typical 30 day enrollment period.

Note that there are certain limitations and/or exclusions within <u>each</u> qualifying event. For more information please contact AJM Associates, Inc at (248) 778-6070.

The Internal Revenue Service requires that the change in benefits must be consistent with the change of status. If you have a change, you must complete a new Enrollment Form within 30 days of the event. These forms are available from Human Resources. **Changes made after 30 days will not be accepted.**

Notice of HIPAA Special Open Enrollment Rights – If you are declining enrollment for yourself or your dependents (including your spouse) because other health insurance coverage, you may in the future be able to enroll yourself or your dependents in these plans if you request enrollment within 30 days after your other coverage ends. In addition, if you acquire a new dependent, because of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself, your spouse and your newly acquired dependents if you request enrollment within 30 days after the marriage, birth, adoption and placement for adoption.

PLEASE LET US KNOW ABOUT:

Weddings	Within 30 days of marriage
New Babies	Within 30 days of birth
Adoptions	Within 30 days of the date of petition or adoption
Change of Name or Address	Immediately
Death	Within 30 days
Divorce	Within30 days
Military Service	Within 30 days of induction or when dependent is discharged
Dependent Children	Any change in status of dependent children
65th Birthday	When you or your dependent become eligible for Medicare.

Women's Health and Cancer Rights Act of 1998

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). These benefits are subject to applicable terms and conditions under your health plan, including copayments, deductible, and coinsurance provisions. They are also subject to medical insurance limitations and exclusions. This notification is a requirement of the act.

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

Newborn's and Mothers' Health Protection Act

The Newborns' Act is a federal law that prohibits group health plans and insurance companies (including HMOs) that cover hospitalization in connection with childbirth from restricting a mother's or newborn's benefits from such hospital stays to less than 48 hours following a natural delivery or 96 hours following delivery by cesarean section, unless the attending doctor, nurse midwife or other licensed health care provider, in consultation with the mother, discharges the mother or newborn child earlier.

Genetic Information Nondiscrimination Act of 2008

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of disease or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members. Genetic information cannot be requested, required or purchased for underwriting purposes or before enrollment, participants and covered dependents cannot be required to undergo a genetic test, and genetic information cannot be used to adjust premiums or contributions for the group. However, a plan is permitted to use the minimum necessary amount of genetic testing results to decide about claim payment.

Notice of HIPAA Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your health information and to provide you with a notice of the Plan's legal duties and privacy practices with respect to your health information. A copy of the HIPPA Privacy Notice is included within this enrollment guide.

Tell Us When You're Medicare Eligible

Please notify Human Resources when you or your dependents become eligible for Medicare. We are required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the health plan pays primary. You must also contact Medicare directly to notify them that you have health coverage through an employer group. Privacy laws prohibit anyone other than the Medicare beneficiary, or their legal guardian, to update or change Medicare records. The toll-free number to contact Medicare Coordination of Benefits Contractor is 1-800-999-1118.

HIPAA Notice of 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 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). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

The Children's Health Insurance Program Reauthorization

Act of 2009 added the following two special enrollment opportunities.

- The employee or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated because of loss of eligibility; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

It is your responsibility to notify Human Resources within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. More information on CHIP is provided later in this guide.

Michelle's Law

Michelle's Law is an act that requires health plans to allow college students who take a leave of absence or reduce their class load because of illness to retain their dependent status under their parent's health plan for up to one year. Student's eligibility for dependent coverage will continue for one year (unless the student would otherwise lose eligibility within the year). To qualify for protection under Michelle's Law, the following requirements must be met; the student must have written certification from a treating physician that the leave of absence or reduced schedule is necessary due to a severe illness or injury, and the leave or reduced schedule must have triggered the loss of student status under the health plan. If the plan sponsor changes group health plans during a medically necessary leave and the new health plan offers coverage of dependent children, the new plan will be subject to the same rules.

Summary of Material Modification

The information in this guide applies to the Comfort Keepers Benefit Plan Information. This information meets the requirements for a Summary of Material Modification as required by the Employee Retirement Income Security Act (ERISA).

Summary of Benefits and Coverage (SBC)

For group health plan coverage, the regulations provide that, for disclosures with respect to participants and beneficiaries who enroll or re-enroll through an open enrollment period (including late enrollees and re-enrollees), the SBC must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the SBC must be provided beginning on the first day of the first plan year that begins on or after September 23, 2012.

Disclosure About The Benefit Enrollment Communications

The benefit enrollment communications (Enrollment Guide) contains only a summary of your benefits. We have worked to ensure the accuracy of these materials, but if there is any discrepancy between the benefits discussed in these materials and the official plan documents, the official plan documents will rule. Actual benefits will be paid in accordance with the carrier contracts and any amendments to those contracts in place at the time of the claim. Please refer to the carrier booklets for details regarding your coverage, including benefit limitation and exclusions. Comfort Keepers reserves the right to amend, modify or terminate any plan at any time and in any manner.

In addition, please be aware that information contained in these materials is based on the current understanding of the federal health care reform legislation signed into law in March 2010. The interpretation of this complex legislation continues to evolve, as additional regulatory guidance is provided by the U.S. Government. Therefore, we defer to the actual carrier contracts, processes, and the law itself as the governing documents.

How to activate your online Blue Cross member account

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

- Check your balance and plan's benefits.
- Track your claims and explanation of benefits statements.
- Find care and look up costs.
- Get answers fast to questions about your plan with MIBlue Virtual Assistant℠,
- an interactive, automated chat feature.
- Show your member ID card, and order more for family members on your plan.

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

ACTIVATE YOUR ACCOUNT IN ONE OF THREE WAYS:

Go online.

1. Go to **bcbsm.com/register** and select *Register Now*.
2. Once your account is activated, you can set up one for each of your dependents.

Use our app.

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

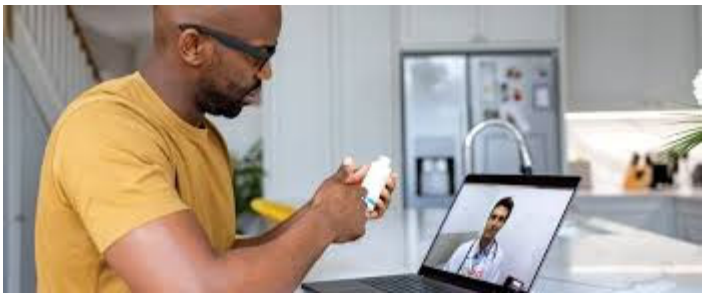
Text us.

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

*Message and data rates may apply. Visit **bcbsm.com** for our *Terms and Conditions of Use* and *Privacy Practices*. Apple and the Apple logo are trademarks of Apple Inc., registered in the U.S. and other countries. App Store is a service mark of Apple Inc., registered in the U.S. and other countries. Google Play and the Google Play logo are trademarks of Google LLC.

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations

WHAT IS VIRTUAL CARE?



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

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

HOW DO I SIGN UP?

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

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

WHEN WOULD I USE 24/7 CARE?

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

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

Your primary care provider may offer virtual visits. Talk to your provider about the services he or she offers. If your life is at risk, call 911 or go to the nearest emergency room.

HOW DO I HAVE A VIRTUAL VISIT?

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

HOW DO I HAVE A VIRTUAL VISIT?

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

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

HOW DO I HAVE A VIRTUAL VISIT?

Medical care is available 24/7 without an appointment.

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

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

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

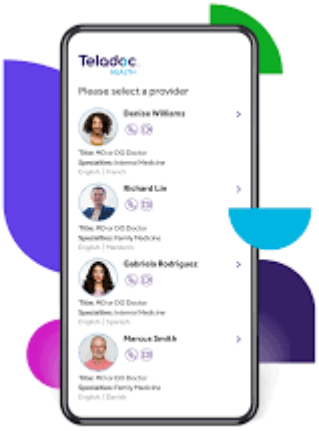
WILL I GET A PRESCRIPTION DURING A VISIT?

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

Doctors don't prescribe controlled substances.

WHAT IF I NEED HELP WITH VIRTUAL CARE?

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



What do I need to know about the changes to Michigan's no-fault auto insurance law?

The new Michigan no-fault auto insurance law means that residents are no longer required to buy unlimited personal injury protection, or PIP, with their auto insurance.

You'll have the option of choosing from different levels of personal injury protection coverage. What you choose is important because PIP covers more than medical expenses – it includes things like attendant care, housing modifications and lost wages due to an accident.

Note: The no-fault auto insurance law is not a health insurance law, therefore, you should discuss PIP coverage or other auto coverage with your auto insurer or agent.

What type of information could my auto insurer request?

A letter showing proof that you meet the requirements for qualified health coverage or QHC may be asked for by your auto insurer. They may also request a coordination of benefits letter that shows how your health insurance and auto insurance work together to pay auto accident claims.

How can I get a QHC letter?

There are several ways you can request a QHC letter.

- You can log in to your online member account to see if you have a QHC letter to download. Once logged in, navigate to the QHC letter in the Proof of Insurance section at the bottom of the page.
- You can call the number on the back of your member ID card.
- If you don't see a QHC letter online or are unable to get one through calling the number on the back of your card, you can reach out to your employer to request the letter.

What if I have an accident in another state?

If you're involved in a car accident outside Michigan, your Blue Cross coverage remains unchanged. Claims are processed according to your benefits and the laws in effect in the state where you reside. If you're injured by a driver in an at-fault state, reimbursement is pursued from the at-fault driver's auto insurance provider.

Where can I get more information?

Your auto insurer can help if you have questions about how the changes to the no-fault auto law affect your auto coverage.

The Department of Insurance and Financial Services (DIFS) can also help answer your questions.

Website: www.michigan.gov/autoinsurance

Phone: 1-833-ASK-DIFS (275-3437)

Email: autoinsurance@michigan.gov

Blue Cross Blue Shield Blue Care Network of Michigan

GROUP MEDICAL INSURANCE COVERAGE

Plan Year – January 1st through December 31st

Deductible/Out of Pocket Reset:
Calendar Year

NOTES:

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This is intended as an easy-to-read-summary. It is not a contract. For complete detail of benefits, limitations and exclusions please see your benefits contract.

Blue Care Network of Michigan

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

Comfort Keepers

2026 BCN HSA Silver Option 3

Coverage for: All Contract Types | **Plan Type: HMO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsm.com or call (800) 662-6667 . For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at (https://www.healthcare.gov/sbc-glossary) or call (800) 662-6667 to request a copy.

Important Questions	Answers: Member / Family	Why This Matters:
What is the overall deductible?	$5,000/$10,000	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes.Preventive care and routine maternity care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$7,500/$15,000	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance billed charges and health care this plan does not cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit
Will you pay less if you use a network provider?	Yes. See (www.BCBSM.com) or call customer service for a list of network providers and out-of-state coverage. (800) 662-6667	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	No charge for medical online visits with a BCN participating online provider. Deductible does not apply to preventive services.
	Specialist visit	No charge	Not covered	Requires referral/30 combined visits for spinal manipulations performed by a chiropractor or osteopathic physician
	Preventive care/screening/immunization	No charge, Deductible does not apply	Not covered	Deductible does not apply to preventive services. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	May require preauthorization for non-preventive services
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Requires preauthorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at (www.bcbsm.com/2026-select-hmo-druglist)	Preferred Generic Tier	$15 copay/30 days	Not covered	Prior-auth & step therapy may apply. Drugs for sexual dysfunction, weight loss, cough & cold and compounds are excluded. No charge for Preferred Generic contraceptives and preventive drugs. 84-90 day retail & 31-90 day mail order copays are 3x the 30-day copay minus $10. Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum.
	Non-Preferred Generic Tier	$40 copay/30 days	Not covered	
	Preferred Brand Tier	$80 copay/30 days	Not covered	
	Non-Preferred Brand Tier	$100 copay/30 days	Not covered	
	Preferred Specialty Tier	20% coinsurance (Max $200)	Not covered	$200 copay max. Specialty drugs are covered only when obtained from the BCN Exclusive Specialty Pharmacy Network. Limited to a 30 day supply.
	Non-Preferred Specialty Tier	20% coinsurance (Max $300)	Not covered	$300 copay max. See Preferred Specialty Tier for network and day supply limits. Limited to a 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	May require preauthorization/50% coinsurance for weight reduction, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy.
	Physician/surgeon fees	No charge	Not covered	See "Outpatient surgery facility fee"
If you need immediate medical attention	Emergency room care	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	Non-emergent transport is covered when preauthorized
	Urgent care	No charge	No charge	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization is required. 50% coinsurance for weight reduction procedures, TMJ, orthognathic surgery, reduction mammoplasty, male mastectomy
	Physician/surgeon fee	No charge	Not covered	See "Hospital stay facility fee"
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	No charge	Not covered	None
	Inpatient services	No charge	Not covered	Preauthorization is required
If you are pregnant	Office visits	No charge for routine prenatal and postnatal	Not covered	Deductible does not apply to routine maternity services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services, cost share may apply.
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Requires preauthorization. Custodial care not covered.
	Rehabilitation services	No charge	Not covered	Requires preauthorization/Limited to 30 visits per calendar year for PT/OT combined / 30 visits per calendar year for speech therapy/30 visits per calendar year for pulmonary/cardiac.
	Habilitation services	No Charge	Not covered	Requires preauthorization/limited to 30 visits per calendar year for PT/OT combined. 30 visits per calendar year for speech therapy.
	Skilled nursing care	No charge	Not covered	Requires preauthorization/Limited to 45 days per calendar year. Custodial care not covered.
	Durable medical equipment	50% coinsurance	Not covered	Requires preauthorization and must be obtained from a BCN supplier. Convenience and comfort items not covered. Diabetic supplies covered in full. Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.
	Hospice services	No charge	Not covered	Inpatient care requires preauthorization. Housekeeping and custodial care not covered.
If your child needs dental or eye care	Children's eye exam	No Charge	Difference between approved amount and provider's charge.	Limited to once/calendar year through the last day of the year in which the individual turns age 19
	Children's glasses	No Charge	Difference between approved amount and provider's charge.	Frames and lenses covered once/calendar year through the last day of the year in which the individual turns age 19.
	Children's dental check-up	Contact your benefit administrator for coverage information.	Contact your benefit administrator for coverage information.	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (Limited to one per lifetime. Requires preauthorization)
- Chiropractic care
- Infertility treatment (Coverage includes diagnosis/counseling/treatment of infertility when medically necessary and preauthorized by BCN. See Certificate of Coverage for exclusions)

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform., or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact : Blue Care Network, Appeals and Grievance Unit, MC C248, P.O. Box 284,Southfield, MI 48086 or fax. 1-866-522-7345. For state of Michigan assistance contact the Department of Insurance and Financial Services, Office of General Counsel-Appeals Section, 530 W. Allegan Street, 7th Floor, P. O. Box 30220, Lansing, MI 48909-7720, http://www.michigan.gov/difs; call 1-877-999-6442 or fax: 517-284-8838.

For Department of Labor assistance contact the Employee Benefits Security Administration at 1-866-444- EBSA (3272) or www.dol.gov/ebsa/healthreform

Additionally, a consumer assistance program can help you file your appeal. Contact the Michigan Health Insurance Consumer Assistance Program (HICAP), Department of Insurance and Financial Services, P. O. Box 30220, Lansing, MI 48909-7720, http://www.michigan.gov/difs or difs-HICAP@michigan.gov

Does this Plan Provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Plan Meet the Minimum Value Standard? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace. (IMPORTANT: Blue Care Network of Michigan is assuming that your coverage provides for all Essential Health Benefits (EHB) categories as defined by the State of Michigan. The minimum value of your plan may be affected if your plan does not cover certain EHB categories, such as prescription drugs, or if your plan provides coverage for specific EHB categories, for example, prescription drugs, through another carrier.)

Translation available

To get help reading in your language call the customer service number on the back of your ID card.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$5000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,070**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$5000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,110**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$5000
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

If you are also covered by an account-type plan such as an integrated health reimbursement arrangement (HRA), and/or an health savings account (HSA), then you may have access to additional funds to help cover certain out-of-pocket expenses-like deductible, copayments, or coinsurance or benefits not otherwise covered.

The plan would be responsible for the other costs of these EXAMPLE covered services.

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

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

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

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

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

ئەگەر تۆ یان کەسێک کە یارمەتی دەدەیت پێویستی بە یارمەتی هەیە، مافی ئەوەت هەیە بە خۆڕایی یارمەتی و زانیاری بە زمانەکەت وەربگریت. بۆ قسەکردن لەگەڵ وەرگێڕ، پەیوەندی بە ژمارەی خزمەتگوزاری بەکارهێنەرانەوە بکە کە لەسەر کارتەکەت هەیە، یان 877-469-2583 TTY: 711 ئەگەر هێشتا ئەندام نیت.

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

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

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

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

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

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

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

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

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

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

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

Important disclosure

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

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

Blue Care Network of Michigan

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

Benefits-at-a-Glance
2026 BCN HSA Silver Option 3
Comfort Keepers
Effective Date: 01/01/2026

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 to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan. Services must be provided or arranged by the member's primary care physician or health plan.

Preauthorization for Select Services - Services listed in this summary are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCN except in an emergency.

Note: A list of services that require approval **before** they are provided is available online at **https://bcbsm.com/priorauth**.

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

Benefits	
Deductible **Note:** The Deductible will apply to all services except preventive services	$5,000 per member/$10,000 per family per calendar year (no 4th quarter carry-over)
The deductible is combined for both medical and prescription drug coverage.	The deductible is embedded. The deductible paid by all Members will be combined to satisfy the family deductible. However, one individual member cannot contribute more than the individual deductible amount toward the family deductible
Coinsurance **Note:** Coinsurance applies once the deductible has been met	50% for select services as noted below
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$7,500 per member/$15,000 per family per calendar year The out-of-pocket maximum is embedded. For members with more than one person on the contract, if the one member maximum is met even if the family maximum is not, that member does not pay any more cost-sharing for the rest of the year

Preventive services

Benefits	
Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening	100%
Well-Baby and Well-Child Visits	100%
Immunizations	100%

Preventive services (continued)

Benefits	
Prostate Specific Antigen (PSA) Screening - laboratory services only - laboratory services only	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Sterilization of Female Reproductive Organs	100%
Breast Pumps (DME guidelines apply.)	100%
Routine Maternity Prenatal and Postnatal Care	100%

Physician office services

Benefits	
PCP Office Visits **Note:** Applicable cost sharing applies when other services are received in the office	100% after deductible
Medical Online Visits - when performed by a BCN participating provider or BCN designated online vendor **Note:** Not all services delivered virtually are considered an online visit but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	100% after deductible
Referral Physician Visits - when referred	100% after deductible

Emergency medical care

Benefits	
Hospital Emergency Room	100% after deductible
Urgent Care Center	100% after deductible
Retail Health Clinic	100% after deductible
Ambulance Services - medically necessary	100% after deductible

Diagnostic services

Benefits	
Laboratory and Pathology Tests	100% after deductible
Diagnostic Tests and X-rays	100% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	100% after deductible
Radiation Therapy	100% after deductible

Maternity services provided by a physician

Benefits	
Routine Prenatal and Postnatal Care Visits	100%
Delivery and Nursery Care	100% after deductible

Hospital care

Benefits	
General Nursing Care, Hospital Services and Supplies	100% after deductible
Outpatient Surgery - see member certificate for specific surgical coinsurance	100% after deductible

Alternatives to hospital care

Benefits	
Skilled Nursing Care	100% after deductible Up to 45 days per calendar year
Hospice Care	100% after deductible
Home Health Care	100% after deductible

Surgical services

Benefits	
Surgery - includes all related surgical services and anesthesia.	100% after deductible
Voluntary Sterilization of Male Reproductive Organs - see Preventive Services for Voluntary Sterilization of Female Reproductive Organs	50% after deductible
Elective Abortion Services	Not covered
Human Organ Transplants (subject to medical criteria)	100% after deductible
Reduction Mammoplasty (subject to medical criteria)	50% after deductible
Male Mastectomy (subject to medical criteria)	50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	50% after deductible
Orthognathic Surgery (subject to medical criteria)	50% after deductible
Weight Reduction Procedures (subject to medical criteria) - Limited to one procedure per lifetime	50% after deductible

Behavioral health services (mental health and substance use disorder treatment)

Benefits	
Inpatient Mental Health Care	100% after deductible
Residential Substance Use Disorder	100% after deductible
Outpatient Mental Health Care includes online and telemedicine visits **Note:** For diagnostic and therapeutic services, see the Diagnostic Services section above for applicable cost sharing.	100% after deductible
Outpatient Substance Use Disorder	100% after deductible

Autism spectrum disorders, diagnoses and treatment

Benefits	
Applied behavioral analysis (ABA) treatment **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)	100% after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	100% after deductible
Other covered services, including mental health services, for autism spectrum disorder	See your outpatient mental health, medical office visit and preventive benefit.

Other services

Benefits	
Allergy Testing and Therapy	100% after deductible
Allergy Injections	100% after deductible
Chiropractic Spinal Manipulation - when referred	100% after deductible Limited to 30 visits per calendar year
Rehabilitative Services -subject to meaningful improvement within 90 days	100% after deductible Rehabilitative outpatient physical and occupational therapy - limited to a combined benefit maximum of 30 visits per calendar year. Rehabilitative outpatient speech therapy - limited to 30 visits per calendar year.
Habilitative Services	100% after deductible Habilitative outpatient physical and occupational therapy - limited to a combined benefit maximum of 30 visits per calendar year Habilitative outpatient speech therapy - limited to 30 visits per calendar year
Outpatient Cardiac and Pulmonary Rehabilitation	100% after deductible Cardiac and pulmonary rehab limited to 30 visits combined per calendar year
Infertility Counseling and Treatment	50% after deductible (excludes in-vitro fertilization)
Durable Medical Equipment	50% after deductible
Prosthetic and Orthotic Appliances	50% after deductible
Diabetic Supplies **Note:** Certain diabetic supplies are covered through the pharmacy benefit. Applicable pharmacy cost-sharing will apply.	100% after deductible
Pediatric Vision - Eye exam and prescription glasses (chosen from a select collection) limited to once per calendar year through the last day of the year in which an individual turns 19.	100%
Hearing Aid	Not Covered

Prescription drugs

Benefits	
Preferred Generic Tier	$15 copay after deductible
Nonpreferred Generic Tier	$40 copay after deductible
Preferred Brand Tier	$80 copay after deductible
Nonpreferred Brand Tier	$100 copay after deductible
Preferred Specialty Tier	20% coinsurance (max $200) after deductible
Nonpreferred Specialty Tier	20% coinsurance (max $300) after deductible
Contraceptives	Women's Contraceptives - Preferred Generic - 100%, Non-Preferred Generic- Copayment/Coinsurance above applies after deductible, Preferred Brand -Copayment/Coinsurance above applies after deductible, Non-Preferred Brand - Copayment/Coinsurance above applies after deductible
Drugs for the Treatment of Sexual Dysfunction, Weight Loss, Cough & Cold	Not covered
Mail Order Prescription Drugs	30 day supply or less - applicable tiered copay/coinsurance, 31-90 day supply - 3x's the 30 day copay/coinsurance minus $10 after deductible.
Diabetic Supplies	Select diabetic supplies and equipment are covered, applicable cost sharing will apply. Cost sharing may not apply to certain preferred glucometers as defined on the drug list.
Specialty Drug Pharmacy	Specialty drugs are covered only when purchased through the BCN Exclusive Pharmacy Network for Specialty Drugs
Variable Cost Share Coupon Program	Your plan includes a prescription drug discount program for certain medications. When a manufacturer coupon is used through the BCN discount program, the amount paid after the discount applies toward the out of pocket maximum.
Prescription Drug Deductible	Prescription drug deductible integrated with the medical deductible
Custom Select Drug List	The list of prescription drugs that have been approved by the U.S. Food and Drug Administration and approved by the BCBSM/BCN Pharmacy and Therapeutics Committee. The list represents the clinical judgment of Michigan physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health. Medications are selected based on clinical effectiveness, safety and opportunity for cost savings. Some drugs included in the Custom Select Drug List require prior authorization and/or step therapy by BCN before they are covered. The Custom Select Drug List may be modified by BCN as needed to remove or add a covered drug or to modify the requirements for authorization of a covered drug. The list may be found at https://www.bcbsm.com/druglists

For Internal Purposes Only
Benefits Selected - HDHPSM : 5000HD,75OMHD,90D3X,EDEPM,P1548D,PVSN,RXVAR

Affordable Prescription Programs

Many drug store chains offer significant savings by utilizing their prescription drug programs. Drug store chains are using the strengths of their business to drive down the cost of health care and bring their customers the lowest prices on the products and services they need to stay healthy. Eligible drugs differ for each company and many of the drugs in these programs are generic. Generic drugs contain the same high quality active ingredients as their brand-name counterparts and are equally effective but cost significantly less. Generic medicines generally cost between 30 percent to 60 percent less than equivalent brand-name products.

Interested in saving money on prescriptions? Ask your doctor if a generic is available and is right for you.

Available Retail Programs May Include:

- $4 for up to a 30-day supply (Wal-mart,Kroger, Sam's Club)
- $10 for up to a 90-day supply (Wal-mart, Kroger, Sam's Club)
- Walgreens Saver90 Program
- Cash Back Rewards – ExtraCare Program (CVS/Pharmacy)

Get Free Antibiotics and Pre-Natal Vitamins at your Meijer Pharmacy!

The Meijer antibiotic pharmacy program covers leading, oral generic antibiotics with a special focus on the prescriptions most often filled for children. The following are **FREE** with your doctor's prescription, regardless of insurance or co-pay:

- Amoxicillin
- Cephalexin
- SMZ-TMP
- Ciprofloxacin
- Ampicillin
- Penicillin VK

The **FREE** pre-natal vitamin program features several leading brands of pre-natal vitamins. See a Meijer pharmacist for details.

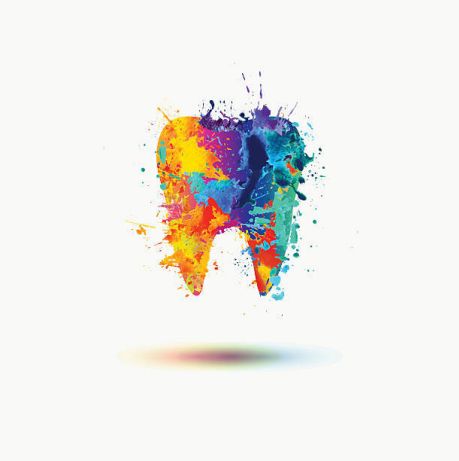
Please contact your local retail pharmacy or visit their website for current and specific drug coverage programs.

Did You Know?

- **Goodrx.com** provides prescription drug coupons, comparison shopping and a convenient mobile application to help you save on your prescription drug cost?
- **Rx Pharmacy Coupons. Com** (www.rxpharmacycoupons.com) provides script savings on your medications through the pharmacy manufactures and vendors? The Prescription Assistance Program, RxPharmacyCoupons, is partnered with companies that negotiate discounts directly with the pharmacies on over 20,000 name and generic brand drugs. Because their program is able to send such a high volume of cash-paying customers to pharmacies, they can provide group rate prescription discounts. These wholesale prices are passed directly on to patients.

How do I use the Prescription Discount Coupons?

1. Select a pharmacy: RxPharmacyCoupons is valid at over 68,000 network pharmacy locations nationwide. In most cases, your current pharmacy will be part of our network. Use their Pharmacy Locator Service if you need help finding a participating pharmacy.
2. Submit your prescription: Present your prescription to the pharmacist. If you need to transfer a prescription, bring your empty prescription bottle or label with you to the pharmacy.
3. Present RxPharmacyCoupons: Your coupon/card's unique code provides the pharmacist with the appropriately discounted prescription price. The price on the prescription is based on the pharmacy's contracted agreement with RxPharmacyCoupons and their partners.
4. You Save: Your savings will be clear once the pharmacist enters your filled prescription into the register.



DENTAL INSURANCE COVERAGE

BCBSM Adult Dental
Plan Year – January 1st through December 31st

NOTES:

Dental Benefit Summary

Comfort Keepers

Plan: SmartPremium

Policy effective date: 01/01/2026
Policy length: 12 months
Group number: MI02183

Plan coverage

	In-network (PPO fee)	Out-of-network* (90th percentile UCR)
Preventive & Diagnostic **Diagnostic and preventive**: exams, cleanings, fluoride, space maintainers, x-rays, and sealants	100%	100%
Basic **Emergency palliative treatment**: to temporarily relieve pain **Minor restorative**: fillings **Prosthetic maintenance**: relines and repairs to bridges and dentures	80%	80%
Major **Endodontics**: root canals **Implants**: endosteal in lieu of a 2 or 3 unit bridge **Major restorative**: crowns, inlays, and onlays **Oral surgery**: extractions and dental surgery **Periodontics**: to treat gum disease **Prosthetics**: bridges **Prosthodontics**: dentures	50%	50%
Orthodontia **Child Orthodontics**: braces with age limit of 19	50%	50%

Plan maxes

Annual maximum applies to diagnostic & preventive, basic services, and major services. Lifetime maximum applies to orthodontic services.
Annual max based on calendar year.

Annual max (In network) **Benefit period:** calendar year	$1,000/yr
Annual max (Out of network) **Benefit period:** calendar year	$1,000/yr
Ortho lifetime max	$1,000/lifetime

Plan deductible

The deductible is waived for diagnostic & preventive services.

Individual	$50/yr
Family	$150/yr

Claims Information

Beam Insurance Administrators LLC	Electronic payer ID	NEA ID	Fax number	Phone number	Claim form accepted
PO Box 75372 Cincinnati, OH 45275	BEAM1	BEAM1	(844) 688-4821	(800) 648-1179	ADA form 2006 or later

Beam Dental PPO Standard coverages, as of August 1, 2019

Questions?

If you have questions, call us at (800) 648-1179. We'd love to help! Visit app.beambenefits.com and login to view more info. Please check your Certificate of Insurance for a description of coverage, limitations, and exclusions under the plan. Some services require prior authorization.

Disclaimer

* Member may have out of pocket expenses if using an out-of-network provider.

This benefit summary is not a complete description of the insurance coverage. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

Dental insurance product underwritten by National Guardian Life Insurance Company (NGL), Madison, WI, marketed by Beam Insurance Services LLC (Beam Benefits Insurance Services LLC, in CA). Dental policy form number NDNGRP 2020. Dental product underwritten by Nationwide Life Insurance Company, Columbus, OH in CT, DE, ID, LA, ME, NC, NH, NM, NY, OH, TX, and UT. Dental coverage applicable to policy form GDTL AO L20, or state equivalent. Dental product administered by Beam Insurance Administrators LLC (Beam Dental Insurance Administrators LLC, in Texas). Not all Products Available in All States. Limitations and exclusions apply.

THIS IS AN EXCEPTED BENEFITS POLICY. IT PROVIDES COVERAGE ONLY FOR THE LIMITED BENEFITS OR SERVICES SPECIFIED IN THE POLICY.

Two life groups made up of only a husband-wife, domestic partners or same-sex couple are not eligible for coverage.

National Guardian Life Insurance Company, Madison, WI, is not affiliated with The Guardian Life Insurance Company of America, a.k.a. The Guardian, or Guardian Life.

Nationwide and Beam Insurance Services LLC are separate and non-affiliated companies.

National Guardian Life Insurance Company, Two East Gilman, Madison, Wisconsin 53703

Nationwide Life Insurance Company, One Nationwide Plaza, Columbus, OH 43215

VISION INSURANCE COVERAGE

Plan Year – January 1st – December 31st.

NOTES:

Vision Benefit Summary

Comfort Keepers

Frequency

Contacts (instead of glasses)	12 months
Exams	12 months
Frames	24 months
Lenses	12 months

Copayments

Contact lens fitting & evaluation[1]	Up to $60 copay
Exams	$10
Materials	$25

In network allowances

Covered Lens Enhancements	Polycarbonate for children
Elective Contact Lenses	$150
Retail Frame Value[2,3,4]	$150 / 20% savings on amount over allowance

[1]Patient will pay 85% of doctor's U&C fees or $60, whichever is less.
[2]Extra $20 allowance on featured brands. Featured frame brands and promotion subject to change.
[3]Frame allowance backed by a wholesale guarantee, meaning VSP fully covers more frames than retail allowance plans.
[4]Allowance may differ at Walmart, Sam's Club and Costco, however it is of equivalent value.

Value added programs

Diabetic Eyecare Plus Program SM	Included
Diabetic exam reminder letters	Included
Health-focused care	Included
Hearing aid discounts	Included
Low vision	Included

Out-of-network allowances*

Bifocal lenses, up to	$50
Elective contact lens materials and fitting/evaluation, up to	$105
Examination, up to	$45
Frame, up to	$70
Lenticular lenses, up to	$100
Single vision lenses, up to	$30
Trifocal lenses, up to	$65
Necessary contact lenses, up to	$210

Extra discounts & savings

Additional pairs of glasses[5]	20% savings
Laser vision correction (LVC)	Average 15% Discount
Lens enhancements	Average savings of 30% on other lens enhancements

[5]20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam®.

Disclaimer

* Member may have out of pocket expenses if using an out-of-network provider.

This benefit summary is not a complete description of the insurance coverage. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater details. Should there be a difference between this summary and the contract, the contract will govern.

Vision insurance product underwritten by National Guardian Life Insurance Company (NGL), Madison, WI, marketed by Beam Insurance Services LLC (Beam Benefits Insurance Services LLC, in CA). Policy form number NVIGRP 2020. Vision product underwritten by Nationwide Life Insurance Company, Columbus, OH in CT, DE, ID, LA, ME, NC, NH, NM, NV, NY, OH, TX, and UT. Vision coverage applicable to policy form GVIS AO L20, or state equivalent. Vision insurance products underwritten by Vision Service Plan (VSP) in WA. Not all products available in all states. Vision product administered by Vision Service Plan Insurance Company. VSP is a registered trademark of Vision Service Plan.

THIS IS AN EXCEPTED BENEFITS POLICY. IT PROVIDES COVERAGE ONLY FOR THE LIMITED BENEFITS OR SERVICES SPECIFIED IN THE POLICY.

Two life groups made up of only a husband-wife, domestic partners or same-sex couple are not eligible for coverage.

National Guardian Life Insurance Company, Madison, WI, is not affiliated with The Guardian Life Insurance Company of America, a.k.a. The Guardian, or Guardian Life. VSP is a registered trademark of Vision Service Plan.

Nationwide and Beam Insurance Services LLC are separate and non-affiliated companies.

National Guardian Life Insurance Company, Two East Gilman, Madison, Wisconsin 53703

Nationwide Life Insurance Company, One Nationwide Plaza, Columbus, OH 43215

Vision Service Plan Insurance Company, 3333 Quality Drive Rancho Cordova, CA 95670

Important Notice from Comfort Keepers About Your Prescription Drug Coverage and Medicare

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

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

CMS Form 10182-CC

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 Comfort Keepers coverage may be affected based on Medicare Secondary Payor rules. Medicare eligible individuals can keep this coverage if they elect Part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Comfort Keepers 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 Comfort Keepers and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact Justina Maisano at (586) 231-0526 for further information or email at Justinamaisano@comfortkeepers.com. 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 Comfort Keepers 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 Creditable Coverage 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, therefore, whether or not you are required to pay a higher premium (a penalty).

Comfort Keepers

42621 Garfield Road, Suite 101B
Clinton Township, MI 48038
Justina Maisano
586-231-0526

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

January 1, 2018

This Notice of Privacy Practices applies to the following organizations.

Creative Care Partners, Inc. DBA Comfort Keepers 799

Justina Maisano • 586-231-0526 • Justinamaisano@comfortkeepers.com

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. 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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: 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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://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 January 31, 2024, 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)

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

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

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

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact **JUSTINA MAISANO 586-231-0526**

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)
COMFORT KEEPERS	45-2675830
5. Employer address	6. Employer phone number
42621 GARFIELD ROAD, SUITE 101B	586-231-0526

7. City	8. State	9. ZIP code
CLINTON TOWNSHIP	MICHIGAN	48038

10. Who can we contact about employee health coverage at this job?	
JUSTINA MAISANO	
11. Phone number (if different from above)	12. Email address
	JUSTINAMAISANO@COMFORTKEEPERS.COM

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Each active, Full-Time employee, except any person employed on a temporary or seasonal basis.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse - Must be legally married. Verification may be required including, but not limited to, a marriage certificate. Dependent Child - Birth through age 25 (up to the end of the calendar year of the 26th birthday). Dependent Children must meet the IRS definition of a "Qualified Child".

☐ We do not offer coverage.

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

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

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

Phone (248) 778-6070 • Email: kruth@ajmassoc.com • Website: www.ajmassoc.com

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