LifeWays Community Mental Health Employee Benefit Enrollment Guide

Effective January 1, 2021

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44 NORTH

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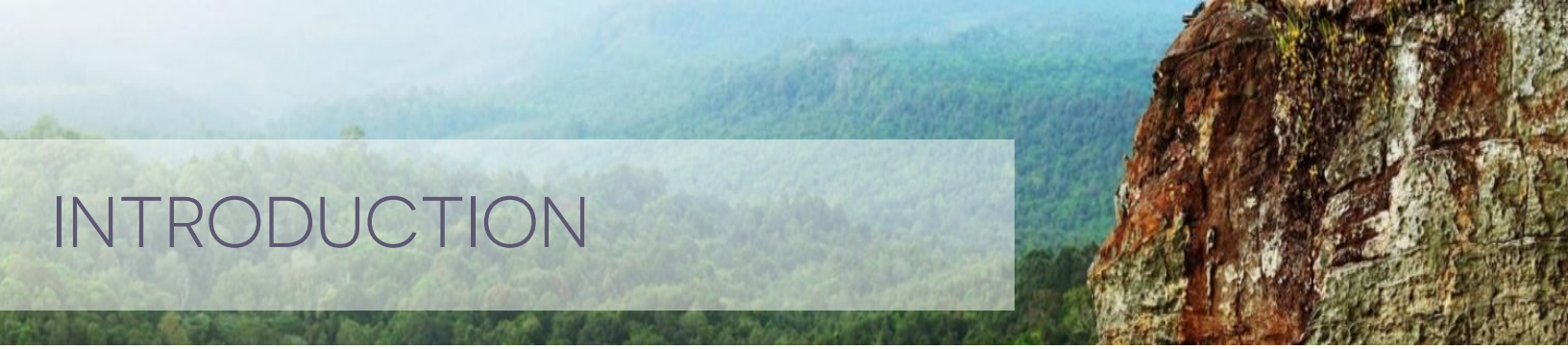


INTRODUCTION

THE FOLLOWING PLAN OPTIONS ARE EFFECTIVE:
January 1, 2021 through December 31, 2021

All employees are required to:

- Elect or waive coverage

Medical/Prescription
Blue Cross Blue Shield of Michigan (BCBSM) will remain your medical insurance provider. 44North will continue to administer the HRA.

Preventive Care that is performed in-network is payable at 100%

Dental
The dental carrier will remain the same and the dental options will remain the same

- Delta Dental

Vision
The vision coverage will remain the same:

- EyeMed

Life & Disability Coverage
The Life & Disability carrier will remain the same:

- Mutual of Omaha

Provider Contact Information

PROVIDER	BENEFIT	CONTACT INFORMATION
44North	HRA 24/7 Patient Advocacy	855-306-1099 www.44N.com
Blue Cross Blue Shield of Michigan	Medical & Prescription Drug	877-790-2583 www.bcbsm.com
Delta Dental of Michigan	Dental	800-524-0149 www.DeltaDentalMI.com
EyeMed	Vision	866-804-0982 www.eyemed.com
BASIC	FSA COBRA	800-444-1922 www.basiconline.com
Mutual of Omaha	Life & AD&D Voluntary Life & AD&D Short Term & Long Term Disability FMLA	800-877-5176 www.mutualofomaha.com
Teladoc	24/7 Physician Access	800-835-2362 www.Teladoc.com
Allstate	Accident Critical Illness	800-521-3535 www.allstatebenefits.com/mybenefits
Employee Wellness Resources	Wellness Resources	http://www.intranet.lifewayscmh.org/Wellness.html

LifeWays Community Mental Health CONTACT INFORMATION

Nikki Thomsen	HR Generalist	517-780-3335 nikki.thomsen@lifewayscmh.org
Cathie Simmons	HR Generalist	517-780-3350 cathie.simmons@lifewayscmh.org

Insurance Eligibility

Insurance Plan Year:

January 1, 2021 ⟶ December 31, 2021

Employee Eligibility

Full-time employees who work 30 hours or more per week are eligible to participate in the insurance plans.

Benefit Effective Date

- Life & Disability coverage begins date of hire. Medical, Dental, Vision and Flexible Spending Account (FSA) coverage begins first of the month following date of hire.

Dependent Eligibility

A dependent is defined as the legal spouse and/or dependent child(ren) of the participant. The term "child" includes any of the following:

- Natural child or Stepchild
- Legally adopted child
- Other child for whom the team member has permanent legal custody

Dependent Child Age Requirements

- Medical, Dental and Vision: Dependent children are covered to the end of the calendar year in which they turn 26
- Voluntary Life & AD&D: Dependent children are covered to age 19 or 25 if they are a full time student.

What if I Separate From Employment?

Medical, Dental, Vision and FSA coverage will end at the end of the month of separation. Disability coverage will end on the date of separation. COBRA Continuation of coverage my be available as applicable by law.

Qualifying Events & IRS Code Section 125

IRS Code Section 125

Premiums for medical, dental, vision insurance and contributions to FSA accounts (Heath Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to your pre-tax benefits can be made ONLY during the Open Enrollment period unless you or your qualified dependents experience a qualifying event (Marriage, Death, Birth, Adoption or loss of coverage) and the request to make a change is made within 30 days of the qualifying event. If the Qualifying Event is a divorce or the dependent ages out of the eligibility, you are allowed 60 days to notify Human Resources.

Under certain circumstances, you may be allowed to make changes to your benefit elections during the plan year, if the event affects your own, your spouse's or your dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125.

Examples of Qualifying Events:

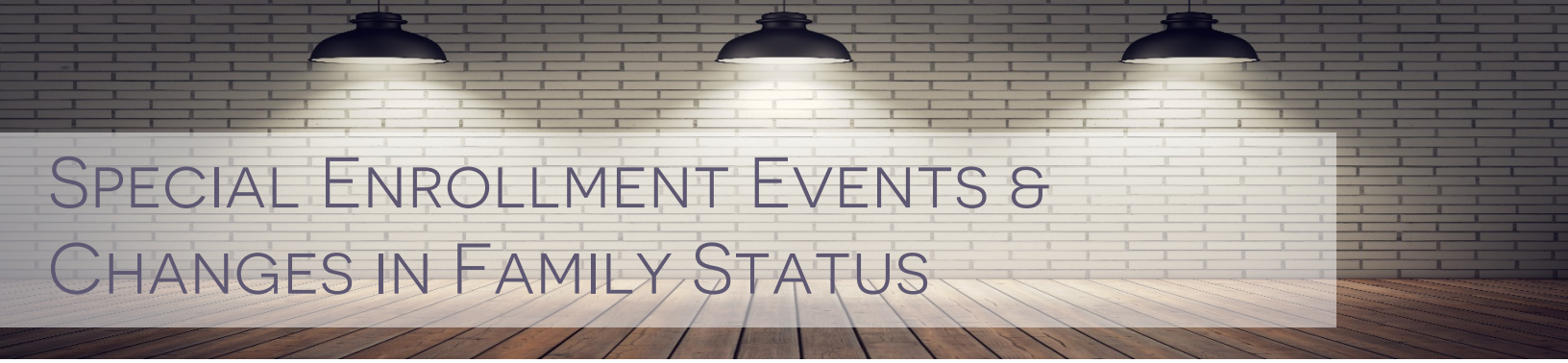
- Legal marital status
    - Marriage
    - Divorce
- Number of eligible dependents
    - Birth
    - Death
    - Adoption
- Employment status
- Change in employment status
- A covered dependents status
- Loss of other coverage
- Enrollment in another health plan

Qualifying Events, which ARE NOT available for Dependent Care FSA or Health Care FSA program:

- Coverage by your spouse or other covered dependent permitted under the spouse's or covered dependent's employer's benefit plan due to a Change Event;
- The availability of benefit options or coverage under any of the Benefit Programs under the Plan
- An election made by your spouse or other covered dependent during open enrollment period under your spouse's or other covered dependent's employer's benefit plan that relates to a period that is different from the Plan Year for this Plan (for examples, your spouse's open enrollment period is in July and your spouse changes coverage); or
- The cost of coverage during the Plan Year, but only if it is a significant increase or decrease

Available for Dependent Care FSA only

- Your dependent care provider or cost of dependent care (a significant increase or decrease)



Special Enrollment Events & Changes in Family Status

IMPORTANT

If you are declining enrollment in the group health plan 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 experience a Qualified Event.

If you experience a qualifying event you must contact Human Resources within 30 days of the qualifying event to make the appropriate changes to your coverage. If the Qualifying Event is a divorce or dependent ages out of eligibility, you are allowed 30 days to notify Human Resources. Beyond 30 days, requests will be denied and you may be responsible both legally and financially for any claims and/or expense incurred as a result of the employee or a dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes will take place on the date of the qualifying event. You will be required to furnish valid documentation supporting a change in status or “Qualifying Event”.

If you or your eligible dependents are eligible for, but not enrolled in, the group health plan and your coverage or the coverage of your spouse or other eligible dependent under a Medicaid plan or state Children’s Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, you must notify Human Resources no later than 60 days after the date the Medicaid or CHIP coverage terminates. If you, your spouse or other eligible dependent become eligible for a premium subsidy in this Plan under a Medicaid plan or state CHIP (including any waiver or demonstration project) you must contact Human Resources to request coverage under this Plan no later than 60 days after the date you are determined to be eligible for such assistance. Your enrollment will take effect no later than the first of the month following your loss of coverage and the date the company receives your request for enrollment, as long as your request to enroll on or before the date that is 60 days after the lost of coverage.

To request special enrollment or obtain additional information, please contact Human Resources.

Medical Insurance:

	BCBSM Base Plan In-Network	HRA Bronze Plan In-Network	HRA Gold Plan In-Network
Preventive Services	Covered at 100% - Copays & Deductible Do Not Apply		
Plan Year Deductible			
Individual	$5,000	$1,000	$250
Family	$10,000	$2,000	$500
Deductible Reset	Calendar Year	Calendar Year	Calendar Year
Coinsurance			
Member Responsibility	20% after deductible	0% after deductible	0% after deductible
Annual Out-of-Pocket Maximum - Deductible, Coinsurance, Copays & Prescription Drug Copays			
Individual	$6,600	$6,600	$6,600
Family	$13,200	$13,200	$13,200
Provider Costs			
Primary Care	$30	$30	$30
Chiropractic – 12 visits per year	$30	$30	$30
Specialist	$30	$30	$30
Urgent Care Facility	$30	$30	$30
Emergency Room	$150	$150	$150
Mental Health – Physician's office	80% after deductible	$30 copay until the HRA deductible is met then 100%. (copay does not apply to deductible.)	$30 copay until the HRA deductible is met then 100%. (copay does not apply to deductible.)
Prescription Drugs - 30 Day Supply			
Generic	$10		
Brand	$40		
Specialty	$80		
Prescription Drugs – 90 Day Supply			
	2 times the 30-day supply copay		

Cost Shares:

Medical	Bronze	Gold
Single	$22.02	$26.28
Two-Person	$131.23	$141.47
Family	$128.64	$141.44
Dental	**Base Plan**	**Buy-Up Plan**
Single	$0	$7.04
Two-Person	$0	$12.95
Family	$0	$22.64
Vision	**Base Plan**	**Buy-Up Plan**
Single	$0	$1.78
Two-Person	$0	$3.38
Family	$0	$4.95
Life & Disability Coverage		
Group Life & AD&D	Employer Paid	
Group Short Term Disability	Employer Paid	
Group Long Term Disability	Employer Paid	
Voluntary Life & AD&D	Rates are dependent upon age and coverage amount	

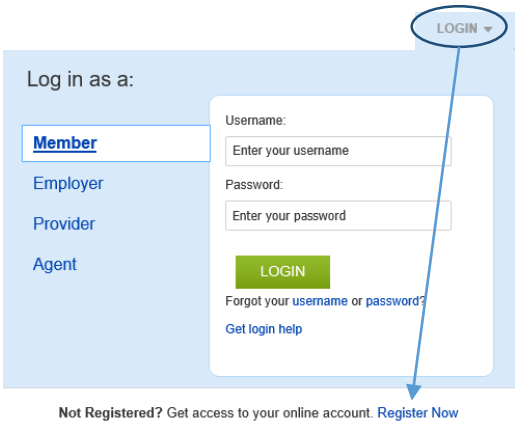
BCBSM Online Account Registration

How to register at bcbsm.com I **computer version**

Your online member account gives you the power to get the most from your healthcare plan. Use it to check your claims, coverage, find a provider, review member discounts and much more.

Have your BCBSM card handy:

1. Go to www.bcbsm.com
2. In the upper-right corner of the home pages, click the LOGIN tab.
3. In the pop-up menu below the login fields, click Register now



As you go through the registration screens, carefully:

- Type your information correctly.
- Read the privacy policy.
- Set up security questions and answer that you can easily remember
- Create a strong password with a minimum of eight characters, using at least one uppercase letter, one lowercase letter, and one number.

How to register at bcbsm.com I **mobile app**

Your online member account gives you the power to get the most from your healthcare plan. Use it to check your claims, coverage, find a provider, review member discounts and much more.

Have your BCBSM card handy:

1. Go to the App Store or Google play
2. Download the app
3. Tap the app icon.
4. Tap Register

As you go through the registration screens, carefully:

- Type your information correctly.
- Read the privacy policy.

Go digital:

- Sign up for paperless explanation of benefits statements.
- Register your phone number to receive text messages.
- Sign up to receive emails, and get helpful plan information online

Rx Discount Program

NEVER OVERPAY FOR PRESCRIPTIONS AGAIN

NOW THAT'S CLEVER.

IN PARTNERSHIP WITH CLEVER RX

Download your Clever RX App or use your Clever RX card to unlock exclusive savings.

Present your Clever RX App or Clever RX card to your pharmacist.

FREE to use. Save up to 80% off prescription drugs and beat copay prices.

START SAVING TODAY WITH CLEVER RX

- 100% FREE to use
- Save up to 80% off prescription drugs – often beats the average copay
- Unlock discounts on thousands of medications
- Accepted at most pharmacies nationwide

STEP 1:

Download the FREE Clever RX App. From your App Store search "Clever RX" and hit download. Be sure to enter in Group ID and Member ID to complete the process. This will unlock exclusive savings for you and your family!

STEP 2:

Find where you can save on your medication. Using your zip code, when you search for your medication Clever RX checks which pharmacies near you offer the lowest price. Savings can be up to 80% compared to what you're currently paying.

STEP 3:

Click the voucher with the lowest price, closest to you, and/or at your preferred pharmacy. Show the voucher on your screen to the pharmacist when you pick up your medication. Click "share" to text yourself the voucher for easy access when you are ready to use it.

STEP 4:

Share the Clever RX App. Click "Share" on the bottom of the Clever RX App to send to your friends, family, and anyone else you want to help receive instant discounts on their prescription medications. Over 70% of people can benefit from a prescription savings card.

NOW THAT IS NOT ONLY CLEVER, IT IS CLEVER RX.

DID YOU KNOW?

70%

Over 70% of people can benefit from a prescription savings card due to high deductible health

30%

Over 30% of prescriptions never get filled due to high

40%

40% of the top ten most prescribed drugs have increased by

70%

Clever RX prices are lower than competitor prices 70% of the

CLEVER RX

SAVE CLEVER | WWW.CLEVERRX.COM/LifeWaysCMH

*If you use CleverRx, your prescriptions do not run through insurance and do not apply to your out of pocket maximum

Dental Insurance:

Delta Dental			
	Delta PPO Base Plan	**Delta <u>PPO</u> Buy-Up Plan**	**Delta <u>Premier</u> Buy-Up Plan**
Maximum Benefit			
Per Member/Per Calendar Year	$1,000	$1,500	$1,000
Class I Services: Preventive & Diagnostic			
Routine Oral Exam – Twice per calendar year	75%	100%	100%
Routine Cleanings – Twice per calendar year			
Bitewing X-Rays –Once per calendar year			
Fluoride – Twice per calendar year to age 19			
Class II Services: Basic Restorative			
Minor Restorative – Fillings	50%	80%	80%
Oral Surgery Services			
Repair & Adjustments to Prosthetics			
Endodontics (Root Canals)			
Periodontics Services –			
Class III Services: Major Restorative			
Emergency Palliative Treatment	50%	50%	50%
All other Radiographs			
Major Restorative Services – Crowns			
Prosthodontic Services			
Class IV Services: Orthodontia – Up to age 19			
Lifetime Maximum	$1,000 per covered member		
Braces	50%		

Vision Insurance:

EyeMed		
Services	**Base Plan In Network**	**Buy-Up Option- In Network**
Eye Exam	$0 Copay	$0 Copay
Frequency: Once every 12 months		
Lenses		
Single Vision	$0 Copay	$0 Copay
Bifocal		
Trifocal		
Polycarbonate	$40 Copay	$40 Copay
Standard Progressive	$65 Copay	$65 Copay
Premium Progressive (Tiers 1—3)	$85-$110 Copay Tier 4- $65 Copay, 20% off charge less $120 allowance	$85-$110 Copay Tier 4- $65 Copay, 20% off charge less $120 allowance
Frequency: Once every 12 months (in lieu of contacts)		
Frames		
Allowance	• $130 allowance for a wide selection of frames • 20% off your balance over $130	• $200 allowance for a wide selection of frames • 20% off your balance over $200
Frequency: Once every 12 months		
Contacts		
Allowance	• $130 allowance for contacts • 15% off anything over allowance	• $200 allowance for contacts • 15% off anything over allowance
Frequency: Once every 12 months (in lieu of lenses)		

Flexible Spending Account

If you have predictable medical expenses for yourself or your family, such as deductibles and copays, or any work-related day care expenses. FSAs may be right for you. FSAs allow you to set aside money for reimbursement of health care and day care expenses you regularly pay. The amount you set aside is not taxed and is automatically deducted from your paycheck and deposited into the FSA. During the year, you have access to this account for reimbursement of some expenses that are not covered by Insurance. An FSA not only results in substantial tax savings, it also increases your spending power.

General purpose Flexible spending account

- Your FSA elections will be in effect from January 1 through December 31.
- This account allows you to set aside up to an annual maximum of $2,750
- All eligible health care expenses – from medical and prescription drug to dental and vision – can be reimbursed from your general purpose FSA account.
- At the end of each plan year, you are able to carryover up to $550 into the next plan year. Anything over the $550 will be forfeited.

Dependent Care Flexible Spending Account

- By IRS rules, married individuals who file separate tax returns are limited to a $2,500 contribution annually. You may contribute up to $5,000 if you are married and file a joint tax return.
- Unused contributions are forfeited
- The dependent care account reimburses dependent care expenses necessary while you (and your spouse, if you are married) are attending school on a full-time basis or working
- Typically, these would be day care expense for children but you can also use this account to reimburse day care for other dependents, such as spouse, parents, or grand parents, who cannot care for themselves. Your dependent must live in your home at least eight hours a day.
- Examples of allowable expenses include those for care provided in your home, a sister's home, day care facility, nursery school, pre-school, pre-kindergarten, before and after school care, and day camp (provided it is not overnight). Expenses for certified all-day kindergarten programs are not eligible.
- You may only claim dependent care expense on children age 12 and younger, unless the dependent is disabled.
- Unlike the Health Care FSA, you will only be reimbursed up to the amount that have been deducted from your paycheck for Dependent Care expenses.

TELADOC :

Teladoc gives you 24/7/365 access to a doctor through the convenience of phone or video consults. It's an affordable option for quality medical care.

TALK TO A DOCTOR ANYTIME, ANYWHERE YOU HAPPEN TO BE

RECEIVE QUALITY CARE VIA PHONE OR ONLINE VIDEO

PROMPT TREATMENT, AVERAGE CALL BACK IN 16 MIN

NETWORK OF DOCTORS THAT CAN TREAT CHILDREN OF ANY AGE

SECURE, PERSONAL AND PORTABLE ELECTRONIC HEALTH RECORD (EHR)

NO LIMIT ON CONSULTS, SO TAKE YOUR TIME

And with 44 North's service team you get:

- Onsite employee education and registration assistance
- Assistance with resolving eligibility and service issues
- Webex meetings and recordings for on demand tutorials
- Utilization campaigns to ensure employees are informed about the benefits of the service.

TALK TO A DOCTOR ANYTIME FOR FREE

Teladoc.com

Facebook.com/Teladoc

1-800-Teladoc

Teladoc.com/mobile

10E-110A
0914

WHEN CAN I USE TELADOC?

- When you need care now
- If your doctor is unavailable
- If you're considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Bronchitis
- Skin problems
- Respiratory infection
- Sinus problems
- And more!

SHARE WITH YOUR PCP

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

Powered By 44 NORTH
FOLLOW US . WE KNOW THE WAY
www.44n.com

TELADOC REGISTRATION:

Online Registration Process

44North's 24/7 physician access is provided to you by Teladoc. You should **register** with Teladoc and enter your medical history before you use the service, to ensure all will go smoothly when you need a consult.

Immediate registration is strongly encouraged to help your first consult go smoothly. No one likes answering basic health information when they or their dependents are sick.

Instructions:

1. Go to **Teladoc.com** and select "Set up account"
2. Select "Register Online", or you may call 1-800-Teladoc to register over the phone.
3. Enter your First Name, Last Name, and Date of Birth, along with an email and primary phone number. *Please note: due to HIPAA Privacy Law, name and date of birth must be **exactly** what Teladoc has on file from registration. For instance: if you are Tim and your information is not located, you may want to try Timothy, if that is your proper name.*
    - Select "No, I do not know my username"
    - Keep "My employer or insurance provider offers me access to Teladoc" selected
    - Type your employer into "Who is your employer or insurance provider" and continue
4. On the next screen, enter your contact information and create a unique user name and password, along with selecting a security question.
5. You're in! You will need to take a few minutes to fill out your Medical History. Remember, this information needs to be entered prior to seeking treatment. **You do not need to enter payment information – this service is free!**
6. To add your dependents select the "My Family" tab and their information. *Anyone over the age of 18 will need to register under their own account after you have added them.*
7. To request a consult for treatment after you have registered, please do so online from the portal or by calling (800) Teladoc.

Registration Checklist: Have this information on hand when registering:

Medications, PCP info, Health Conditions, Height/Weight, Allergies & Family History

Disability Benefits:

Mutual of Omaha

Short-Term Disability (STD)

Everyday illnesses or injuries can interfere with your ability to work. Even a few weeks away from work can make it difficult to manage household costs. Short Term Disability coverage provides financial protection for you by paying a portion of your income, so you can focus on getting better and worry less about keeping up with your bills.

Employer Funded	• Benefit is equal to 60% of your base weekly earnings to a maximum benefit of $600 per week • Benefits begin on the 15th day of sickness and/or injury • Duration of benefit: 24 weeks or until LTD begins, whichever is earlier **Definition of Disability:** • Total Disability means your inability, due to Sickness or Injury, to perform each of the Main Duties of your Own Occupation. A Person engaging in any employment for wage or profit is not Totally Disabled. The loss of a professional license, an occupational license or certification, or a driver's license for any reason does not, by itself, constitute Total Disability. • Partial Disability means that, due to an Injury or Sickness, you: (1) are unable to perform one or more of the Main Duties of your Own Occupation, or are unable to perform such duties Full-Time; and (2) are engaged in Partial Disability Employment.

Long-Term Disability (LTD)

Serious illness or accidents can come out of nowhere. They can interrupt your life, and your ability to work for months or even years. Long Term Disability provides financial protection for you by paying a portion of your income, so you have financial support to manager your disability and your household.

Employer Funded	• Benefit is equal to 70% of your base monthly earnings to a maximum of $6,000 per month • Benefits begin following a 180 day elimination period • Maximum benefit period: up to your Social Security Normal Retirement Age

Mutual of Omaha

Group Term Life & AD&D

Eligibility: All Active Full-Time Employees working a minimum of 40 hours per week

Employee Life Benefit Amount 1 times annual salary to a maximum of $50,000, plus $150,000, with a minimum of $10,000

Employee Benefit Reduction: At the age of 70, your benefit will reduce by 50%.

Accidental Death & Dismemberment: This benefit provides the employee with additional insurance coverage for the loss of life or injuries sustained in an accident and is equal to the Life Benefit.

Voluntary Life & AD&D

What are the coverage amounts?

Employee Coverage: An employee can elect up to $250,000 in increments of $10,000; not to exceed 5 times their annual salary. Amounts in excess of the $100,000 guarantee issue benefit limit are subject to satisfactory Evidence of Insurability.

Spousal Coverage: An employee can elected up to $125,000 in increments of $5,000 on their spouse; not to exceed 50% of the employee benefit. Amounts in excess of the $25,000 guarantee issue benefit limit are subject to satisfactory Evidence of Insurability.

Child(ren) Coverage: An employee can elect up to $10,000 on their dependent child(ren), in increments of $1,000.

Accidental Death & Dismemberment: This benefit provides the employee with additional insurance coverage for the loss of life or injuries sustained in an accident and is equal to the Life Benefit.

New Coverage:

For employees applying for new coverage, you must complete your enrollment within 31 days of your eligibility period. If you apply for coverage after 31 days, or if you choose coverage over the amount you are guaranteed, you will need to complete a medical questionnaire.

If you and your eligible dependents are not currently enrolled in the plan, you may apply for coverage during the enrollment period and will be required to answer health questions for any amount of coverage.

Active Coverage:

If you are currently enrolled in the coverage, you can increase you coverage by $20,000, not to exceed the Guarantee issue amount of $100,000, without having to complete evidence of insurability.

Important: You can change your beneficiary anytime throughout the year. Always remember to keep your beneficiary information updated.

Voluntary Accident

Off-the Job

Allstate

With Accident Insurance from Allstate Benefits, you can gain the advantage of financial protection, thanks to cash benefits paid directly to you. You also gain the financial empowerment to seek the treatment needed to get well.

Here's How it Works
Allstate Benefits will pay a cash benefit that corresponds with a variety of covered occurrences, such as: dislocation or fracture; hospital confinement; ambulance services and more. The cash benefits can be used to help pay for deductibles, treatment, or your every day expenses.

Benefit Amounts (See Allstate Brochure for a full list of payable benefits)

Emergency Room Services	$200	Physical Therapy (daily amount; 6 day max)	$60
Ambulance – Ground	$200	Blood and Plasma	$600
Ambulance – Air	$600	Appliance	$250
Daily Hospital Confinement (pays daily)	$200	Medical Supplies	$10
Accident Physician's Treatment	$100	Medicine	$10
X-Ray	$200	Prosthesis – 1 device	$1,000
Lacerations (pays once/year)	$100	Prosthesis – 2 or more devices	$2,000
Burns (excludes Sun Burns) < 15% of body	$200	Rehabilitation Unite (Pays daily)	$200
Burns (excludes Sun Burns) > 15% of body	$1,000	Non-Local Transportation	$800
Open Abdominal or Thoracic Surgery	$2,000	Family Member Lodging	$200
Eye Surgery	$200	Post-Accident Transport. (Pays once/year)	$400
General Anesthesia	$200	Accident Follow-up Treatment	$100

Additional Rider Benefit

Outpatient Physician's Benefit (up to 2 claims per enrolled person with a max of 4 claims per family)	$50

Voluntary Critical Illness

Allstate

Allstate Benefits coverage helps offer financial support if you are diagnosed with a covered critical illness. With the expense of treatment often so high, seeking the treatment you need seems like a heavy financial burden. The Allstate Benefits plan, you can gain the power to make treatment decision without putting your finances at risk.

Here's How it Works
If you are diagnosed with a covered critical illness, you will receive a cash benefit based on the percentage payable for the condition. This plan will provide cash benefits for family members as well, should you choose to cover them.

Benefit Amounts (See Allstate Brochure for a full list of payable benefits)
** Covered Dependents receive 50% of your benefit amount

Heart Attack (100%)	$10,000	Advanced Alzheimer's Disease (100%)	$10,000
Stroke (100%)	$10,000	Advanced Parkinson's Disease (100%)	$10,000
Coronary Artery Bypass Surgery (25%)	$2,500	Benign Brain Tumor (100%)	$10,000
Major Organ Transplant (100%)	$10,000	Coma (100%)	$10,000
End Stage Renal Failure (100%)	$10,000	Complete Blindness (100%)	$10,000
Invasive Cancer (100%)	$10,000	Complete Loss of Hearing (100%)	$10,000
Carcinoma in Situ (25%)	$2,500	Paralysis (100%)	$10,000

Additional Rider Benefit

Wellness Benefit (pays annually when one of 23 screening exams is performed)	$50

- Biopsy for Skin Cancer
- Blood test for triglycerides
- Bone Marrow Testing
- CA15-3, CA125, CEA and PSA
- Chest X-Ray
- Colonoscopy
- Doppler screenings for carotids and peripheral vascular disease
- Echocardiogram
- EKG
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- HPV Vaccination
- Lipid panel
- Mammography
- Pap Smear
- Serum Protein Electrophoresis
- Stress Test on Bike or treadmill
- Thermography
- Ultrasound screening (abdominal aortic aneurysms)

BenefitHub

Family Protection

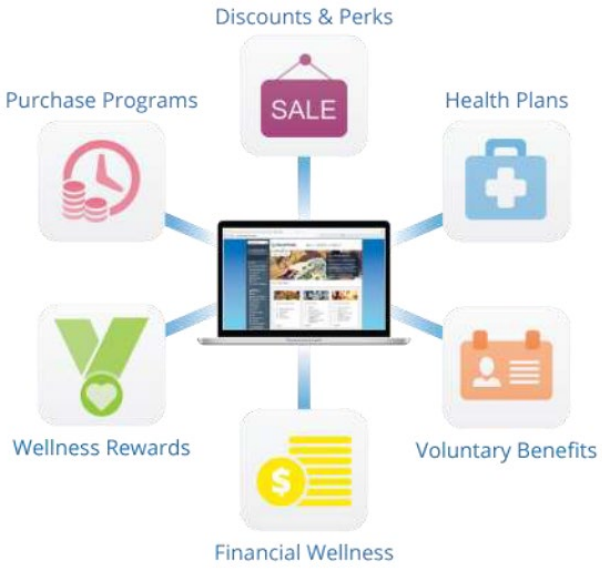
- Life Insurance
- Disability Insurance
- ID Theft Protection
- Legal Plan
- Home Security
- Pet Insurance

Property Protection

- Auto Insurance
- Home Insurance
- Boat Insurance
- Renters Insurance
- Motorcycle Insurance
- Product Warranties

Financial Wellness

- Student Loan Tools
- Budgeting Tools
- Personal Finance
- Pay Over Time
- 401k Assistance
- Money Transfers



FEDERAL MANDATED NOTICES:

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, contact the Plan Administrator.

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

In addition, if you have a new dependent as a result 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.

To request special enrollment or obtain more information, contact Nikki Thomsen, HR Generalist, 517-780-3335, nikki.thomsen@lifewayscmh.org.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices (the "Notice") describes the legal obligations of (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. HIPAA requires us to provide this Notice of Privacy Practices to you.

FEDERAL MANDATED NOTICES:

This Notice of Privacy Practices (the "Notice") describes the legal obligations of (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. HIPAA requires us to provide this Notice of Privacy Practices to you.

The HIPAA Privacy Rule protects certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:
your past, present or future physical or mental health or condition;
providing health care to you; or
making past, present or future payments for providing health care to you.

If you have any questions about this Notice or about our privacy practices, please contact Nikki Thomsen, HR Generalist, 517-780-3335, nikki.thomsen@lifewayscmh.org.

Effective Date
This Notice is effective 11/17/2020.

Our Responsibilities
We are required by law to:

- maintain the privacy of your protected health information;
- notify you of any breach of unsecured protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

How We May Use and Disclose Your Protected Health Information
We may use or disclose your protected health information in certain situations without your permission.
The main reasons for which we may use and may disclose your Protected Health Insurance are to evaluate and process any requests for coverage and claims for benefits. Your Protected Health Information (PHI) may be used:

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may share your protected health information with health care provider in connection with the payment of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for plan operations. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. If medical information is used for underwriting, genetic information may not and will not be used or disclosed for this purpose.

FEDERAL MANDATED NOTICES:

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to follow appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

To Plan Sponsors. We may disclose protected health information to certain employees of the Employer so that they can administer the plan. Those employees will only use or disclose PHI as needed to perform plan administration functions or as otherwise required by HIPAA, unless you have specifically authorized other disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

Special Situations
Although unlikely, it is also possible that we may use and disclose your protected health information in these situations:

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs.
Public Health Risks. We may disclose your protected health information for public health actions. These actions generally would be:

- to prevent or control disease, injury, or disability;
- to report births and deaths;

FEDERAL MANDATED NOTICES:

- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Research. We may disclose your protected health information to researchers when:

- the individual identifiers have been removed; or
- when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

We are required to make disclosures of your protected health information in these situations:

Government Audits. We must disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. If you request, we must disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. If you request, we also must provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed due to your specific authorization.

- you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or
- treating such person as your personal representative could endanger you; and
- in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative

FEDERAL MANDATED NOTICES:

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

To request restrictions, you must make your request in writing to the Employer Contact listed at the end of this Notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Employer Contact listed at the end of this Notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Employer Contact listed at the end of this Notice.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., if you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact Nikki Thomsen, HR Generalist, 517-780-3335, nikki.thomsen@lifewayscmh.org. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

We may change the terms of this Notice and make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any significant change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by regular mail and/or electronically.

FEDERAL MANDATED NOTICES:

Employer Contact: Nikki Thomsen
HR Generalist
1200 N. West Ave.
Jackson, MI 49202
517-780-3335
nikki.thomsent@lifewayscmh.org

Date: 11/17/2020

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

FEDERAL MANDATED NOTICES:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to LifeWays Community Mental Health, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events: The end of employment or reduction of hours of employment;
Death of the employee;
Commencement of a proceeding in bankruptcy with respect to the employer; or
The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

LifeWays Community Mental Health
Attn: Nikki Thomsen
1200 N. West Ave.
Jackson, MI 49202
P: 517-780-3335
E: nikki.thomsen@lifewayscmh.org

How is COBRA continuation coverage provided?

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

FEDERAL MANDATED NOTICES:

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

FEDERAL MANDATED NOTICES:

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
LifeWays Community Mental Health
Attn: Nikki Thomsen
1200 N. West Ave.
Jackson, MI 49202
P: 517-780-3335
E: nikki.thomsen@lifewayscmh.org

FEDERAL MANDATED NOTICES:

DISCRIMINATION IS AGAINST THE LAW

LifeWays Community Mental Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. LifeWays Community Mental Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

LifeWays Community Mental Health :

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact:
LifeWays Customer Service
1200 N. West Ave.
Jackson, MI 49202
866-630-3690 or 517-780-3332

If you believe that LifeWays Community Mental Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

LifeWays Customer Service
1200 N. West Ave.
Jackson, MI 49202
866-630-3690 or 517-780-3332

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, LifeWays Customer Service is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and 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 or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

FEDERAL MANDATED NOTICES:

SECTION 1557 NONDISCRIMINATION

English
ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-630-3690.

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-630-3690.

Arabic
ملحوظة:اذإ كنت تتحدذا ثكرا للغة، فإن خدماا تلمساعدا ةللغوية تتوافر لك بالمجان. اتصل برقم 1-866-630-3690

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-630-3690.

Assyrian
1-ܟܬܝܢ ܟܠ ܥܡ .ܒܗܟܢ ܟܬܚ ܟܠܝܬ ܟܡܒܢܬ ܟܡܟܠܝ ܥܡܠܒܥ ܥܡ ܒܗ ܟܝ ،ܟܬܐܡܗ ܟܠܝܬ ܥܡܒܟܡܚ ܟܝ ܥܡܒܟ ܟܝ :ܟܬܐ 866-630-3690.

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-630-3690.

Albanian
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-630-3690.

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-630-3690.

Bengali
ল য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পােরন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল আেছ। েফান করন ১-1-866-630-3690.

Polish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-630-3690.

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-630-3690.

Italian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-630-3690.

FEDERAL MANDATED NOTICES:

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-630-3690.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. воните 1-866-630-3690.

Serbo-Croatian
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-866-630-3690.

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-630-3690.

44North's Patient Advocacy

In the complex world of health insurance, members need an advocate with the industry expertise to get the most out of their benefits.

44North Patient Advocates are the 1 phone call members make for:

- Navigating healthcare bills
- Understanding carrier explanation of benefits
- Confirming out of pocket costs for procedures
- Finding network providers
- Filing claims appeals
- Working directly with providers, insurance company, billing and collections agencies

Do any of these situations sound familiar?

Common opportunities our advocates have to assist members:

- A mother was taking her daughter into surgery and during intake was asked to pay thousands of dollars up front before the procedure could be performed, when they only had a $500 family deductible.

- A member standing in line at the pharmacy attempting to fill their prescription was told they weren't covered for the maintenance drug they'd been taking for years.

- A retiree received a bill for their annual mammogram when it should have been covered 100% under their preventative benefits.

- A member's son was in a terrible accident and had to be airlifted to the nearest hospital. Afterwards they received bills stating they had no coverage and eventually were sent to collections.

"Chris was friendly, professional and easy to ask questions of. She responded to my question quickly. I will never hesitate to call 44NORTH. What an awesome experience. Thank you Chris!"

855-306-1099


Powered By
44 NORTH
Follow Us . We Know the Way
www.44n.com