



2026 | Employee Plan

Benefits Guide



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Disclaimer: The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Benefits Team.

Welcome

We understand that your life extends beyond the workplace. That’s why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

How to Enroll

- **Current Employees:** Open enrollment is your once-a-year opportunity to adjust benefit coverages and update any dependents and beneficiaries.
- **New Hires:** Once eligible, you must complete your enrollment within 30 days. Some benefits have “guarantee issue” at your first opportunity only, so please carefully consider this before you decline any coverage.



Learn More on our Benefits Microsite!

Scan QR code or visit www.cbmicrosite.com/saginawchippewa

How to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event. Examples include:

- Marriage, divorce, legal separation, or death of a spouse
- Birth, adoption, or death of a child
- Change in child’s dependent status
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan



Medicare Part D Notice: If you or your dependents are on Medicare or will be eligible within 12 months, federal law offers more prescription drug coverage options. Refer to page **28-26** for details.

New this Year!



Protect Your
Family

- **Family Advantage Health Plan:**

In partnership with BCC, we are very excited to introduce an innovative new benefit known as the Family Advantage Health Plan—or FAHP for short.

- **What is the FAHP?**

The Family Advantage Health Plan is a voluntary health plan option that provides eligible employees and their family members the opportunity to have no deductibles, copays, or coinsurance for eligible out-of-pocket medical and pharmacy expenses. **Effectively, creating a 100% health plan for those that enroll!**

- **Why are we offering this new benefit?**

We're offering the Family Advantage Health Plan because it is a win-win-win benefit offering for you, your family, and Saginaw Chippewa as a whole:

- Better coverage for you and your family members when you need care.
- Lower healthcare costs for your family.
- More affordable costs for the organization, as the reimbursements for the FAHP are considerably less than the cost of primary insurance coverage.

- **Where can I learn more?**

To learn more about the Family Advantage Health Plan, watch our introduction video and pages 12 & 13 of this guide for more information:

[FAHP Introduction Video](#)

-

Open Enrollment

How to Enroll: Action Required!

To ensure you are covered appropriately, everyone is required to complete open enrollment between **October 1, 2025-October 31, 2025.**



Learn More & Enroll!

Scan QR code or visit
www.cbmicrosite.com/saginawchippewa

How to Enroll

Over the Phone with Assistance:

- Visit www.nepenroll.me/saginaw
- Select the week that works for you (10/13/2025-10/24/2025).
- Choose an enroller (or select 'anyone').
- Select the time you'd like to meet with an enroller.
- Add your personal details.
- Press "Book" and your appointment will be scheduled.

Online, on your Own:

- Visit nw12.ultiopro.com/Login.aspx
- Log in to UKG.
- Go to Menu > Myself > Open Enrollment
- Update personal and dependent information.
- Choose your benefits.
- Review your elections, sign, and submit. You may save a copy for your records.



Contacts

Saginaw Chippewa Indian Tribe of Michigan Benefits Contact

Saginaw Chippewa	Benefits Team	989-775-5770
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Coverage	Carrier	Phone Number	Website/Email
Medical Insurance	UMR	866-494-4502	www.UMR.com
Dental Insurance	Delta Dental	800-524-0149	www.deltadentalmi.com
Vision Insurance	Delta Vision <i>(Administered by VSP)</i>	800-877-7195	www.vsp.com
Life/AD&D Insurance	Symetra	800-796-3872	www.symetra.com
Disability Insurance	Symetra	800-796-3872	www.symetra.com
Accident Insurance	Symetra	800-796-3872	www.symetra.com
Critical Illness Insurance	Symetra	800-796-3872	www.symetra.com
Hospital Indemnity Insurance	Symetra	800-796-3872	www.symetra.com



**Learn More
on our Benefits Microsite!**

Scan QR code or visit
www.cbmicrosite.com/saginawchippewa



Eligibility

Employee Eligibility

All full-time employees working 32 or more hours per week will be eligible for benefits. As a new employee, you have to apply for benefits within your waiting period (of 90 days).

- **Medical, Dental, Vision:** These coverages will take effect after 90 days of employment (referred to as your “waiting period”).
- **Basic Life:*** All other coverages will take effect on the first of the month following 180 days of employment.
- **Other Coverages:** Eligibility rules may vary based on employee classification & status. Please reference benefit summaries for more information on eligibility.

* **IMPORTANT:** These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

Dependent Eligibility

If you are enrolled in coverage, you may also have the option to enroll your dependents in coverage.

Definition of “Eligible Dependents”

Medical, Dental, and Vision Coverage dependents include:

- **Your legally married spouse.** Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, “spouse” shall not mean a common law spouse or domestic partner.
- **Your dependent children under age 26.** This includes natural, step, foster, adopted, or other children under your legal guardianship.
- For additional eligibility details, please refer to the policy contract or summary plan documents.

Other Coverages: See page 16 for definitions of an “eligible dependent” under the Voluntary Life/AD&D Policy. Please note that benefit-eligible employees cannot be enrolled as a “spouse”, and dependent children cannot be covered more than once. Please refer to the policy certificate or HR for more information.



Employee Contributions

If you elect coverage, your premiums will be conveniently deducted from your paycheck bi-weekly. Please contact the Employee Benefits Team regarding any questions or concerns.

STANDARD/NON-WELLNESS - Medical, Dental & Vision (Bundled)

Employee Only	\$64.38
Employee + 1	\$151.70
Family	\$193.90

WELLNESS - Medical, Dental & Vision (Bundled)

Employee Only	<i>Rate lock at time of completed wellness enrollment</i>
Employee + 1	
Family	

Dental

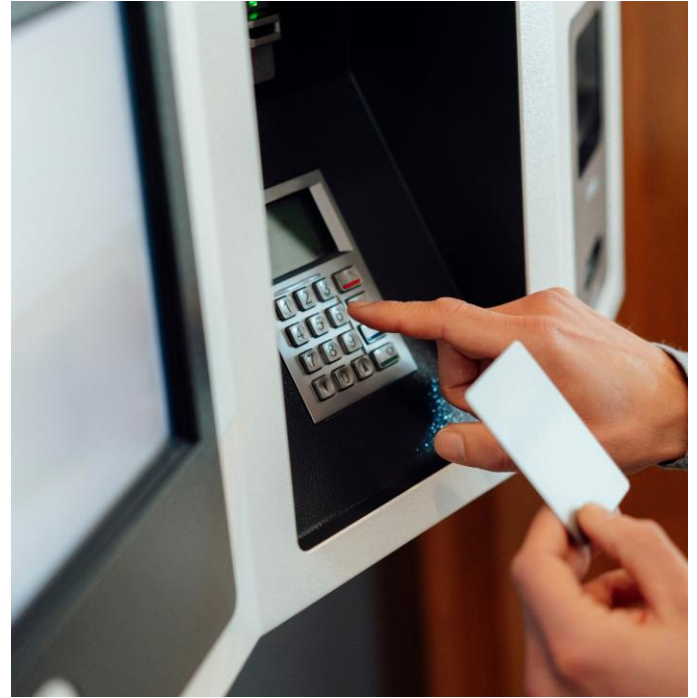
Employee Only	\$14.52
Employee + 1	\$28.30
Family	\$39.19

Vision

Employee Only	\$2.58
Employee + 1	\$5.03
Family	\$6.97

Delta & Vision

Employee Only	\$17.10
Employee + 1	\$33.33
Family	\$46.16



Life/AD&D	Basic	Term
Employee Only	100% Company-Paid <i>(after 6 months of employment)</i>	To view your personalized rates, log in to UKG
Employee + Spouse	N/A	To view your personalized rates, log in to UKG
Employee + Child(ren)	N/A	To view your personalized rates, log in to UKG
Family	N/A	To view your personalized rates, log in to UKG

Disability	Short-Term	Long-Term
Employee Only	To view your personalized rates, log in to UKG	100% Company Paid

Accident, Critical Illness & Hospital Indemnity

Employee Only	To view your personalized rates, log in to UKG
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Understand Your UMR ID Card

After you've completed enrollment, SCIT has approved it and after any waiting period has passed, your benefits will be effective. Your UMR ID Card will be on its way to you soon. The card shows UMR as your health plan administrator. Keep it in your wallet and carry it with you.

What does the stuff on your ID card really mean?

Here's a sample of what you might see.

The number assigned specifically to you to track all of your benefits and claims information.

The number assigned to identify your group health plan.

A list of the family members who are covered under your plan.

Information about your prescription drug plan. Pharmacists use this to process your

Your medical provider network, also referred to as your preferred provider organization (PPO). Going to doctors, clinics and hospitals in your network will save you money.

Look for important contact information, including the customer service phone number to call for answers to claims or benefit questions. You can also go to www.umar.com to check your benefits, claim status, accumulators, and eligibility.

Your in-network (In-Net) and out-of-network (Out of Net) medical individual and family deductibles (Ded) and out-of-pocket maximums (OOPM) information.

Call this number only when you need medical services, and your plan requires prior authorization for those services.

Call this number when you have questions about pharmacy benefits.

UMR Portal Resources

Make umr.com your first stop

You want managing your health care to be fast and easy, right? You got it. At www.umar.com, you'll find everything you want to know – and need to do – as soon as you log in. No hassles. No waiting. Just the answers you're looking for anytime, night or day!

Log in now to:

- View **Things to do**, your personalized benefits to-do list
- Check your benefits and see what's covered
- Look up what you owe and how much you've paid
- Find a doctor in your network
- Learn about medical conditions and your treatment options
- Access tools and trusted resources to help you live a healthier life

Fictionalized data

Logging in is easy

Ready to pop in and take our site for a spin? Visit www.umar.com on your desktop or tablet device. If you already have an account, simply click the **Login/Register** button in the upper-right corner.

If it's your first time visiting us, click the **Login/Register** button in the upper-right corner to open an account. Make sure you have your ID card handy and follow the steps to get started.

Health cost estimator

The next time you're in the market for a new doctor or are wondering how much you'll pay for a possible medical procedure, visit www.umar.com first.

Your online services make it easy to look up UnitedHealthcare network providers and health care facilities and find cost estimates for different services – all in one place.

You'll get the information you need to make the right choices for you and your family and know what to expect before making an appointment.



Find an In-Network Provider

With www.umar.com, you have anytime access to a searchable directory of UnitedHealthcare network providers in your area. Choosing a doctor or facility in the network ensures your benefits are paid at the highest level, so you can expect to pay less out of your own pocket. And when you go to a network provider for preventive services, there's typically no cost to you.

You can narrow your search to primary care providers or look up physicians by specialty. Then select a physician from your search results to learn more about where they went to school, where they practice and how to schedule an appointment.

Order Replacement ID cards

Click **ID card** from **myMenu** to see a copy of your card. With a couple more clicks you can have a new card mailed to your home. Can't wait for the mailman? Print a temporary copy from our desktop site. Or, use your smart phone to view your ID card or fax a copy to your doctor's office.

Healthcare Tips

Get the Most Out of Your Care

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

- **In-Network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Out-of-Network Provider**—A provider who is not contracted with your health insurance company.

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network. If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.






Where Should I Go for Care?
www.cbmicrosite.com/video/knowwheretogo

Billing & Claim Differences

Because in-network and out-of-network providers are treated differently by your insurance company, you will be billed differently depending on the type of provider you use for your care.

<p>Provider</p> <p>The patient receives treatment.</p> <p>The doctor then sends the bill to the insurance company.</p>	>	<p>In-Network Discount</p> <p>Appropriate discount for using an in-network provider is applied.</p> <p><small>Please note: discounts may vary based on PRC Eligibility.</small></p>	>	<p>Bill</p> <p>The bill for services is presented to the insurance company.</p> <p>Payment responsibilities are calculated and divided between the patient and the insurance company.</p>
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<p>Patient</p> <p>Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.</p>	<	<p>Insurance Company Payments, Explanation of Benefits (EOB)</p> <p>Insurance pays for its portion of the bill from the provider.</p> <p>A summary of charges and insurance payments is sent to the patient via the insurance company.</p>
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Take advantage of preventive care

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.



Know Where to Go for Care

Keeping your health care costs in check could be as simple as making the right choice when you need medical care. When you have an illness or suffer an injury, you understandably want to feel better fast, but making the wrong choice about where to receive care can cost you.

The average outpatient emergency room (ER) visit costs \$1,917, according to the Health Care Cost Institute. This means that if you head to the ER when you don't really need emergency care, your wallet is going to feel the pain.

Where Should I Go?

Sometimes, it can be difficult to know where to draw the line when it comes to choosing if you should go to the ER, urgent care, or your primary doctor. Here are a few guidelines to help you know where to go next time you're sick or injured.

Emergency Room (\$\$\$\$)

A visit to the ER is the most expensive type of outpatient care and should only occur if there is a true emergency, or a life-threatening illness or injury. Examples of conditions that should be addressed in the ER include, but aren't limited to:

- Chest pain
- Uncontrollable bleeding
- Shortness of breath
- Poisoning



Where Should I Go for Care?
www.cbmicrosite.com/video/knowwheretogo

Urgent Care (\$\$\$)

Urgent care centers handle non-emergency conditions that require immediate attention—those for which delaying treatment could cause serious problems or discomfort. Urgent care visits are less expensive than ER visits but are typically more expensive than a visit to your primary care doctor. These conditions can usually be treated in urgent care centers:

- Sprains
- Ear infections
- High fevers

Doctor's Office (\$\$)

For most non-emergency illnesses or injuries, the best choice for medical care may be a visit to your primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. In addition, going to the doctor's office is usually the most cost-effective option.

Medical

UMR

This coverage allows you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider.

Medical	In-Network	Out-of-Network
Annual Deductible		
Individual	\$500	\$1,000
Family	\$1,000	\$2,000
Coinsurance		
Plan Pays	80%	60%
You Pay	20%	40%
Annual Out-of-Pocket Maximum		
Individual	\$3,000	\$6,000
Family	\$6,000	\$12,000
Services	In-Network	Out-of-Network
Preventive Care	Covered 100%	Covered 100%
Primary Care Office Visit	\$30	40% after deductible
Specialist Office Visit	\$60	40% after deductible
Urgent Care	\$30	40% after deductible
Emergency Room	\$250	40% after deductible
Hospitalization	20% after deductible	40% after deductible
Prescription Drugs	Cardinal Pharmacy	In-Network
Tier 1	\$0	\$10
Tier 2	\$20	\$30
Tier 3	\$40	\$60
Tier 4	20% (\$250 Max)	20% (\$250 Max)



Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

FAMILY ADVANTAGE HEALTH PLAN (FAHP)



Plan Benefits

There are several benefits of the FAHP:

- Reimbursement of any copays, deductibles, and coinsurance due on primary health insurance plan, up to the annual out-of-pocket maximums allowed by the Affordable Care Act. Effectively, this creates a **100% coverage plan** for most participants enrolled in the FAHP.
- No premium contribution deducted from employee's paycheck to enroll in the FAHP.
- Ongoing monthly payroll bonus of \$50 per member enrolled in FAHP to help offset any additional premium costs of alternative employer coverage.

Eligibility Criteria

To be eligible, the member¹ (e.g. employee, spouse, and/or child) must meet two criteria:

1. Member has been enrolled on the company medical plan for at least 12 months prior to the FAHP effective date.²
2. Member has access to enroll in alternative employer-sponsored medical plan (e.g. via spouse, parent, 2nd job, etc.).

¹ Each member is individually eligible for the plan if they meet the eligibility criteria (i.e. spouse and children can enroll without employee).

² New employees must satisfy eligibility requirements, which will be evaluated annually at FAHP open enrollment.

IRS Rules

If eligible for the FAHP, it is important that you comply with IRS rules:

1. You may be enrolled in a Health Reimbursement Account (HRA) or Flexible Spending Account (FSA). However, you cannot be reimbursed from both the FAHP and your HRA or FSA.
2. Employees are not eligible for the FAHP if their alternate coverage:
 - has an active contribution to a Health Savings Account (HSA) – you can deny these contributions and then participate in FAHP; or
 - is Medicare, Medicaid, Tricare, an Individual Policy, a Limited Benefit Health Plan, or any non-employer-sponsored insurance.

How to Enroll

If you are interested in the FAHP, here is what to do next:

1. Verify eligibility for the FAHP with your HR department.
2. Evaluate current coverage vs combination of other employer alternative coverage + FAHP. Use BCC Cost Comparison worksheet.
3. Enroll applicable members in alternative employer coverage. Ensure no HSA dollars are received or contributed if the alternative employer coverage is an HDHP.
4. Waive coverage on UMR medical plan (Saginaw Chippewa Employee Plan) for next year and complete the FAHP enrollment and attestation forms.

When to Enroll

Eligible members may enroll in the FAHP:

1. During annual open enrollment period, as long as other employer coverage has same open enrollment period or allows mid-year enrollment;³ or
2. Due to a qualifying event, such as spouse's open enrollment or change in status (e.g. marriage, birth of child, etc.).

³ **Note:** If the other employer-sponsored option has a different open enrollment period, try to request mid-year enrollment or you will have to wait until their open enrollment to waive Saginaw Chippewa's medical plan, enroll in your alternative coverage, and enroll in FAHP at that time.

Premium Payroll Bonus

Your payroll bonus is calculated by the number of family members enrolled (including yourself, if also enrolled) in the FAHP, multiplied by **\$50** to get to a monthly bonus amount earned. This bonus is paid via standard payroll earnings and is considered taxable income. Payments start the first period after your FAHP effective date and are paid by Saginaw Chippewa.

Submitting & Receiving Claims Reimbursement

For point-of-service payments (i.e. copays), present your FAHP Debit Card to the provider and they will swipe the card to cover costs immediately. For other payments, you will receive an Explanation of Benefit (EOB) statement from the carrier—keep these in case of verification.

If you do not pay your bill with your FAHP Debit Card, complete the following steps:

1. Make a copy of the EOB and attach it to your completed Reimbursement Form.
 - Reimbursement Forms are available from your HR Department, or at www.benxcel.com.
 - A separate claim form must be filled out for each patient.
2. Submit your completed Request for Reimbursement Form and the claim substantiation to BCC:
 - Email: bcc-claims@benXcel.com; or
 - Mail: Benefit Coordinators Corporation
Attn: Claims
Two Robinson Plaza, Suite 200
Pittsburgh, PA 15205

3. Once received, BCC will process and substantiate the claim for reimbursement, sending you payment via check or direct deposit.

Questions

BCC has a dedicated team of advisors to help answer any questions you have.

Pre-Enrollment

Submit questions, including the name of the organization you work for, to either of the following:

Email: customersupport@bccbenefitsolutions.com

Call: (412) 446 4651

BCC will review your questions, compile answers and ensure you get informed either directly or through group communication.

Post-Enrollment

Advisors are available to assist you with your needs, including:

Filing or receiving claims reimbursements

Premium payroll bonus issues

Debit card questions

Anything related to FAHP Benefits

BCC Customer Service Center:

Call: 1-800-685-6100

M-TH: 8 am – 8 pm (ET), 5 am – 5 pm (PT)

F: 8 am – 6 pm (ET), 5 am – 3 pm (PT)

Email: bcc-claims@benXcel.com

Medicare Education

Next Level Planning through our partnership with Cottingham & Butler

As people approach retirement, a common concern is the answer to the question:

“What happens to my health insurance?”

Next Level Planning makes it easy!

- Get advice from licensed insurance agents at no cost or obligation to enroll.
- Explore plans from numerous health insurance companies.
- Learn more about Medicare and be guided through the process.
- Receive 1 on 1 assistance with benefit and financial planning.



Connect with a Medicare consultant.

(414) 369-6620 | www.nlpm.com



Want NLP to reach out?

Scan QR code or visit:

<https://app.smartsheet.com/b/form/9f83ac0937fe480b8d110c7c09a77ed3>



How else can Next Level Planning assist you?



Financial, Retirement & Estate Planning



Health Insurance



Business Planning & Executive Benefits



Insurance & Investments



Financial Education

Telemedicine

Teladoc

Available to employees enrolled in the medical plan.

Teladoc gives you round-the-clock access to U.S. board-certified doctors, from home or on the go. Call or connect online or using the Teladoc mobile app for affordable medical care when you need it.

In some cases, doctors can write a prescription to a local pharmacy near you.¹

Teladoc can help with:

- Cold & flu symptoms
- Allergies
- Pink eye
- General Medicine
- Respiratory infections
- Sinus problems
- Dermatology / Skin problems
- Mental / Behavioral Health
- Anxiety
- Trauma and PTSD
- And more!

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



Don't Wait!

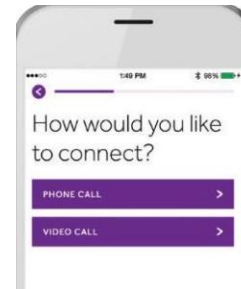
Log in to your account or register. Registering for an account now will save you time later.

- App: Teladoc
- Phone: 1-800-835-2362
- Website: Teladoc.com

It's Convenient & Easy:

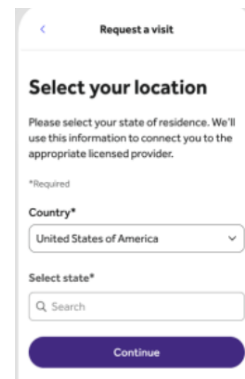
1

Choose how you'd like to talk with a provider.



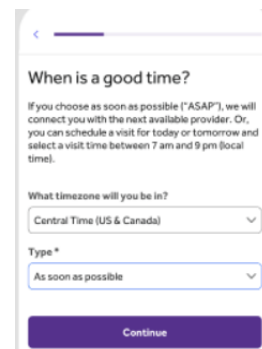
2

Select the state you're currently in so a provider licensed in that state can speak with you.



3

Choose what time you would like to talk with a provider.



¹Prescription services may not be available in all states.



Talk to a doctor
anytime, anywhere



Receive quality
care virtually



Quick
treatment



Treatment for
everyone



Your choice of
Pharmacy



Costs less than the
ER or urgent care

Flexible Spending Account

UMR

FSAs can save you money on eligible expenses because you don't have to pay taxes on the amount contributed to the account. However, using an FSA does require careful planning to reap the financial benefits.

Health FSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Copays
- Coinsurance
- Other health-related expenses

2026 annual contribution limit	\$3,000
NEW! 2027 carryover limit	\$660



Is a Health FSA Right for You?
www.cbmicrosite.com/video/healthfsa

Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the plan administrator or The Employee Benefits Team to learn more.

Dependent Care FSA

Set aside tax-free money to care for children under age 13 or an elderly, dependent parent who is unable to care for themselves. Cover care expenses while you work, such as:

- Preschool
- Before and after school programs
- Summer day camp
- Elder care

2026 Saginaw Chippewa contribution limit	Married (Filing separately)	\$2,500
	Single/Married (Filing jointly)	\$5,000



Visit www.irs.gov and search for IRS Publications 502 (Medical and Dental) and 503 (Dependent Care) to learn more about eligible expenses.

FSA Example:

The following chart illustrates the financial benefits of participating in these accounts when you have out-of-pocket medical and dependent care expenses. In this example, an employee with an annual salary of about \$35,000 who puts aside \$200 per month in the medical and dependent care FSAs will bring home **\$600 more per year** than they would without the FSAs! This is an example for your reference only and actual amounts will vary based on your income, expenses, FSA election amount, and tax rates.

	Without FSA	With FSA
Your Annual Income	\$2,917 Per Month	\$2,917 Per Month
You Set Aside (Pre-Tax)	\$0 Per Month	\$200 Per Month
The IRS Taxes You On (25%)	\$2,917 Per Month	\$2,717 Per Month
You Bring Home (After tax and medical expenses)	\$26,256 Per Year	\$24,456 Per Year
You Have This Much Set Aside for FSA Expenses	\$0 Per Year	\$2,400 Per Year
Your Savings Each Year	\$0 Per Year	\$600 Per Year

Note: This is an example for illustration purposes only, based on a 25% tax rate. Your personal income and tax savings will vary based on your income, tax rate, and the amount of money you contribute to your FSA. Consult your financial advisor.

Dental Insurance

Delta Dental

In addition to protecting your smile, dental insurance helps pay for dental care. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

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

Dental	Delta Dental PPO	Delta Dental Premier	Non-Participating Dentist
Annual Deductible	None		
Annual Benefit Maximum	\$1,500 per individual		
Orthodontia Lifetime Maximum	\$1,000		
Preventive Care	100%	100%	100%
Basic Services	75%	75%	75%
Major Services	50%	50%	50%
Orthodontia Services (18 y/o & under)	50%	50%	50%

Access your Dental Benefits Online

Stay informed about your dental and vision benefits in one, convenient location at www.memberportal.com.

Use our secure online tool, Member Portal, to access both your dental and vision benefits information, including eligibility information, benefits and plan coverage details, find a provider, claims information, and more.

1. Visit www.memberportal.com
2. Log in with your Member Portal credentials or click the Sign up! link to register. You will need the primary subscriber's Social Security number or member ID number. Complete all required fields and follow the on-screen instructions to finish creating your account.
3. Member Portal features single sign-on functionality, allowing members to access their vision benefits information without creating a separate account with VSP. Click the DeltaVision Login button to access your vision benefits information.

Vision Insurance

Delta Vision

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Did you know that Eye Doctors & Dentists are both trained to detect early signs of many conditions, which can lead to earlier intervention and better overall health. In fact, VSP network doctors are first to report diabetes 34 percent of the time, high cholesterol 62 percent of the time and hypertension 39 percent of the time.

Vision	In-Network	Out-of-Network
Exam Once every 12 months	\$5 Copay	Up to \$35
Lenses Once every 12 months	\$60 Copay	Up to \$50
Frames Once every 12 months	\$0 Co-pay; \$130 allowance; 20% off balance over \$130	Up to \$65
Contact Lenses (Disposable) Once every 12 months; in lieu of lenses/frames glasses	\$0 Co-pay; \$130 allowance; plus balance over \$130	Up to \$105

Access your benefits online

Stay informed about your vision and dental benefits in one, convenient location at www.memberportal.com.

Use our secure online tool, Member Portal, to access both your vision and dental benefits information, including eligibility information, benefits and plan coverage details, find a provider, claims information, and more.

4. Visit www.memberportal.com
5. Log in with your Member Portal credentials or click the Sign up! link to register. You will need the primary subscriber's Social Security number or member ID number. Complete all required fields and follow the on-screen instructions to finish creating your account.
6. Member Portal features single sign-on functionality, allowing members to access their vision benefits information without creating a separate account with VSP. Click the DeltaVision Login button to access your vision benefits information.

How to find a VSP Network (In-Network) Eye Doctor

- Online: Log in to Member Portal or visit www.vsp.com/eye-doctor to view results by city, state, ZIP code, provider's name or specialty.
- Member Services: Call VSP's member services team toll-free at 800-877-7195 to find a participating VSP provider.
- Mobile app: Download VSP's mobile app for Apple or Android devices. To download, visit the App Store (Apple) or Google Play (Android) and search for "VSP".
- Contact provider: Members should call their provider's office and ask if they participate in the VSP Choice network.

Life/AD&D

Symetra

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if you die or experience other covered catastrophic loss due to a covered accident.

Basic Life/AD&D

Benefit Amount	Employee: 1x your annual compensation (minimum \$50,000 to a maximum of \$300,000)*
Benefit Cost	Employer-paid – No cost to you!

Voluntary Term Life/AD&D

Benefit Amount	<p>Employee: \$10,000 increments, to a maximum of the lesser of \$500,000 or 5 x annual earnings.</p> <p>Spouse[^]: \$5,000 increments, to a maximum of the lesser of \$250,000 or 100% of Supplemental Employee Coverage.</p> <p>Dependent child(ren) (age at death): [^]</p> <ul style="list-style-type: none"> Live birth to age 26: \$2000 increments to \$10,000 maximum
Guaranteed Issue Amount^B	<p>Employee: \$200,000</p> <p>Spouse: \$50,000 (not to exceed 50% of supplemental employee coverage)</p>
Reduction Schedule	65% at age 70 and 50% at age 75
Benefit Cost	To view your personalized rates, log in to UKG.

Dependent Delayed Effective Date:

Dependents may have a delayed effective date based on his/her health status at time of the effective date. Please refer to the policy certificate or HR for more details.

Definition of “Eligible Dependents”

It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies.

- **Spouse:** Eligibility may terminate at Spouse age 70.
- **Child:** Eligibility terminates earliest of age 26, married, or employed full time, or no longer a Full Time Student. Terms may vary for children with special needs. Benefits may be limited for children under age 6 months.

Please refer to the policy certificate or HR for more information.



Remember to update your beneficiaries.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

Benefits may be reduced for employees over age 65 per ADEA.

Actively-At-Work Requirement:

New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

* The value of employer-funded life insurance benefits in excess of \$50,000 is taxable to you.

[^] Dependent elections require employee enrollment and may be limited by employee volume.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Disability

Symetra

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement of lost income.

Saginaw Chippewa Indian Tribe of Michigan believes that protecting your income is important, that is why you will be automatically enrolled in short-term and long-term disability coverage once eligible. To opt-out, please contact The Employee Benefits Team.

Voluntary Short-Term Disability

Benefit Amount	The lesser of 60% of an Employee's weekly Covered Earnings rounded to the nearest dollar or the Maximum Disability Benefit of \$1,000 per week.
Benefit Begins	Accident: 14 days Sickness: 14 days
Benefit Duration	11 weeks or 90 days
Pre-Existing Condition	3-month look back period 12 month exclusion

Short-term disability excludes work-related injury or illness.



Pre-Existing Condition Limitations:

If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the look back period. If so, benefits may be denied.

Actively-At-Work Requirement:

New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.



Supplemental Health

Symetra

The following benefits may protect your financial security in the event of an unexpected medical expense.

Accident

Helps cover the cost of expenses if you are injured in a non-work-related, covered accident.

Benefit Amount	Benefit amounts vary by severity. See schedule of benefits for details.	
Common Covered Injuries	Dislocations Fractures	Concussions Lacerations
Common Medical Services	Ambulance Emergency room visits Hospital admission	Surgical benefits Follow-up treatments
Other Benefits	Travel Lodging Child organized sports-rider	Accidental death and dismemberment

Critical Illness

Helps cover the cost of expenses if you are diagnosed with a covered condition.

Benefit Amount	Employee: Up to \$50,000 in \$10,000 increments Spouse[^]: Up to \$50,000 in \$10,000 increments Child[^]: Up to \$25,000 in \$5,000 increments	
Guaranteed Issue^B	Employee: \$50,000 Spouse: \$50,000 Child: \$25,000	
Common Covered Conditions	Cancer Heart attack Stroke	Major organ failure Degenerative neurological disorders



Hospital Indemnity

Helps cover the cost of hospital stays—including pregnancy and childbirth.

Hospital Confinement	\$1,000 first day, \$200 day 2+, 90 incident(s) pp/pcy
Intensive Care Unit	\$1,000 first day, \$400 day 2+, 30 incident(s) pp/pcy
Substance Abuse Facility	\$200 per day, 30 day(s) pp/pcy

Hospital Indemnity

Mental Health Facility	\$200 per day, 30 day(s) pp/pcy
Nursing Facility^^	\$200 per day, 30 day(s) pp/pcy

Supplemental Health Cost

To view your personalized rates, log in to UKG.

Actively-at-Work Requirement:

New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-at-Work/eligible status.

Dependent Delayed Effective Date:

Dependents may have a delayed effective date based on his/her health status at the time of the effective date. Please refer to the policy certificate or HR for more details.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Benefit Terms

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a \$1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is \$800. Because John hasn't paid anything toward his deductible yet this year, and because the \$800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.

- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

Saginaw Chippewa Indian Tribe of Michigan Health Plan: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage. ❖

Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your The Employee Benefits Team Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State

Medicaid or CHIP office to find out if premium assistance is available.

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

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

Employees living in one of the following States may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2024. V 0.4.0. The most recent CHIP notice can be found at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra>. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid

Website: <http://myalhipp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid

AK Health Insurance Premium Payment Program
Website: <http://myakhipp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
<https://dhss.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

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+)

Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+ Website: <https://hcpf.colorado.gov/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/State Relay 771
Health Insurance Buy-In Program (HIBI) Website: <https://www.mycohibi.com/>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: <https://www.in.gov/medicaid/>
<http://www.in.gov/fssa/dfr/>
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: [iowa Medicaid | Health & Human Services](http://iowa.gov/health-human-services)
Medicaid Phone: 1-800-338-8366
Hawki Website: [Hawki - Healthy and Well Kids in Iowa | Health & Human Services](http://iowa.gov/health-human-services)
Hawki Phone: 1-800-257-8563
HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](http://iowa.gov/health-human-services)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – 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: KIHIPPPROGRAM@ky.gov
 KCHIP Website: <https://kynect.ky.gov>
 Phone: 1-877-524-4718
 Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

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

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

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>
 Phone: 1-800-862-4840
 TTY: 711
 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/>
 Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
 Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
 Phone: 1-800-694-3084
 Email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
 Phone: 1-855-632-7633
 Lincoln: 402-473-7000
 Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcnp.nv.gov>
 Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
 Phone: 603-271-5218
 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
 Phone: 1-800-356-1561
 CHIP Premium Assistance Phone: 609-631-2392
 CHIP Website: <http://www.njfamilycare.org/index.html>
 CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
 Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>
 Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>
 Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
 Phone: 1-888-365-3742

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
 Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>
 Phone: 1-800-692-7462
 CHIP Website: www.pa.gov/childrens-health-insurance-program-chip (pa.gov)
 CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
 Phone: 1-855-697-4347 or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
 Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>
 Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
 Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: <https://medicaid.utah.gov/upp/>
 Email: upp@utah.gov
 Phone: 1-888-222-2542
 Adult Expansion Website: <https://medicaid.utah.gov/expansion/>
 Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>
 CHIP Website: <https://chip.utah.gov/>

VERMONT – Medicaid

Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>
 Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

Website: <https://www.hca.wa.gov/>
 Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

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

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
 Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>
 Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since July 31, 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 ❖

Patient Protection Notice

If the Saginaw Chippewa Indian Tribe of Michigan Health Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact The Employee Benefits Team. ❖

Women's Health and Cancer Rights Act of 1998

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.
- 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. ❖

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). ❖

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure

governing QMCSO determinations from the Plan Administrator without charge. ❖

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?

Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 8.39% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

Note: If a health plan is purchased through the Marketplace instead of accepting health coverage offered by an employer, then the Employee may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as the employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax

purposes. Any Employee payments for coverage through the Marketplace are made on an after-tax basis.

How Can Individuals Get More Information?

For more information about coverage offered by the Employer, please check the summary plan description or contact The Employee Benefits Team.

The Marketplace can help when evaluating coverage options, including 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 the area.

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. ❖

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)

If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become

effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP. ❖

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices

The Saginaw Chippewa Indian Tribe of Michigan Group Medical Plan (the “Plan”), which includes medical and dental coverages offered under the Saginaw Chippewa Indian Tribe of Michigan Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA’s privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures Saginaw Chippewa Indian Tribe of Michigan has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual’s Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA’s privacy rule) for:

1. Payment and Health Care

Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual’s coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations,

such as the administration of the Plan and to provide coverage and services to the Plan’s participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor:

As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law:

When required to do so by any federal, state or local law.

4. Health Oversight Activities:

To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety:

As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual’s health or safety or to the health and safety of the public.

6. Judicial and Administrative

Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes:

To a law enforcement official for certain

enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation:

If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions:

For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers’ Compensation:

As necessary to comply with workers’ compensation or other similar programs.

12. Distribution of Health-Related

Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach

Saginaw Chippewa Indian Tribe of Michigan is required to maintain the privacy of PHI; to provide individuals with this notice of the Plan’s legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does

Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information.

However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including

subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to Personal Health Information: Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at Saginaw Chippewa Indian Tribe of Michigan, 7070 East Broadway Rd., Mt Pleasant, Michigan 48858, (989) 775-4000.

Right to Inspect and Copy Individual Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at Saginaw Chippewa Indian Tribe of Michigan, 7070 East Broadway Rd., Mt Pleasant, Michigan 48858, (989) 775-4000. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to

HIPAA Privacy Officer, at Saginaw Chippewa Indian Tribe of Michigan, 7070 East Broadway Rd., Mt Pleasant, Michigan 48858, (989) 775-4000. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of Disclosures: An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at Saginaw Chippewa Indian Tribe of Michigan, 7070 East Broadway Rd., Mt Pleasant, Michigan 48858, (989) 775-4000. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at Saginaw Chippewa Indian Tribe of Michigan, 7070 East Broadway Rd., Mt Pleasant, Michigan 48858, (989) 775-4000. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice: Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at Saginaw Chippewa Indian Tribe of Michigan, 7070 East Broadway Rd., Mt Pleasant,

Michigan 48858, (989) 775-4000 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person: If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at Saginaw Chippewa Indian Tribe of Michigan, 7070 East Broadway Rd., Mt Pleasant, Michigan 48858, (989) 775-4000. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated. ❖

Important Notice from Saginaw Chippewa Indian Tribe of Michigan Health Plan about Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Saginaw Chippewa Indian Tribe of Michigan 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. Saginaw Chippewa Indian Tribe of Michigan has determined that the prescription drug coverage offered by the Saginaw Chippewa Indian Tribe of Michigan Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare 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.

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 Saginaw Chippewa Indian Tribe of Michigan coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Saginaw Chippewa Indian Tribe of Michigan coverage, be aware that you and your dependents will 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 Saginaw Chippewa Indian Tribe of Michigan 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 the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Saginaw Chippewa Indian Tribe of Michigan 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).

Date: October 2024
Name of Entity/Sender: Saginaw Chippewa Indian Tribe of Michigan
Contact--Position/Office: The Employee Benefits Team
Address: 7070 East Broadway Rd., Mt Pleasant, Michigan 48858
Phone Number: (989) 775-4000 ❖

