



HOUSE of REPRESENTATIVES
STATE OF MICHIGAN

Benefits Handbook

2025



This handbook provides a summary of the benefits offered by the House of Representatives. This information is provided in summary form. Although the House of Representatives expects to continue such benefits and/or provisions, it reserves the right to modify, suspend or terminate them in whole or in part at any time.

For specific details regarding insurance coverage, limitations, and exclusions, please contact Human Resources. If there is any conflict between the information summarized here and the official plan, in all cases, the actual policy contract provisions will govern.

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OVERVIEW

MEDICAL, INCLUDING RX

BCBSM Community Blue PPO Plan I
BCBSM Community Blue PPO Plan II
Simply Blue & Health Savings Account (HSA)

VISION

Vision Service Plan (VSP) through BCBSM

DENTAL

Delta Dental Comprehensive Plan
Delta Dental Modified Plan

LIFE INSURANCE

Minnesota Life Insurance - two (2) times annual pay

DEPENDENT LIFE INSURANCE

Minnesota Life Insurance (multiple options)

LONG TERM DISABILITY (employees only)

Mutual of Omaha Insurance Company - 67% of bi-weekly, 90 day wait

PLAN YEAR - The plan year begins January 1, 2025, and ends December 31, 2025.

During open enrollment, eligible employees may enroll, re-enroll, or change their current enrollments in health (prescription drug included), dental, vision, life insurance, long-term disability plan, and flexible spending accounts. Your benefit choices are selected and submitted on-line through HouseNet. If you do not make any changes, your coverage will remain the same as current year, except flexible spending accounts which require annual enrollment. If you are a newly hired eligible employee, you can enroll yourself and your eligible dependents 30 days after your hire date. Your selections will remain in effect for the remainder of the benefit year.

Member and employees contribute toward the House Benefit Plan through pre-tax payroll deductions, see chart for rates. Eligible Members/employees may opt out of the entire Benefit plan and receive \$2,990 or \$115 per pay period. The opt-out dollars are considered taxable income. To receive the \$2,990 employees must opt out of the entire plan. Employees may choose to opt out of individual plans but will not receive opt-out dollars. Members and employees who opt-out of the House Benefit Plan or any medical plan must sign an opt-out declaration (see page 19).

MEDICAL PLANS

Medical coverage is provided to you by the House to help pay for a wide range of health care services. The plan assists you with both minor medical costs and large medical expenses. The Medical Plan Comparison chart provides detailed plan information.

PLAN TERMS

- **Deductible** - the amount you pay annually before services are covered
- **Co-Insurance** - the percentage or portion of expenses you pay
- **Annual Out-of-Pocket** - the maximum you would pay in a plan year for eligible medical expenses, including your deductible, office visit co-payments and prescription drug co-payments.

BCBSM COMMUNITY BLUE PPO MEDICAL COVERAGE - PLAN 1

Community Blue, offered through Blue Cross and Blue Shield of Michigan (BCBSM), is a preferred provider organization (PPO) with out-of-network options. Members of Community Blue do not have to choose a primary care physician but may use any physician in the Community Blue network and receive the program's benefits. The physician network includes over 17,000 physicians statewide. In addition, plan participants may also use physicians outside of the Community Blue network and still receive benefits at a reduced level.

Community Blue PPO offers in-network preventive services with no co-pay while also offering treatment of illness and injury, with the nationwide recognition of the BCBSM logo on the identification card.

The advantages of this program are that it allows some of the freedom of choice allowed by traditional insurance plans, while reducing the amount of paperwork members have to complete for reimbursement of services. It offers the convenience and benefit level of an HMO, while still allowing out-of-network services. And, for those employees who have family members outside of the Lansing area, it offers flexibility.

BCBSM COMMUNITY BLUE PPO MEDICAL COVERAGE - PLAN 2

Community Blue PPO Plan 2 offers the same high level of coverage as PPO Plan 1 but comes at a lower, bi-weekly cost to the Member/employee while carrying a higher deductible and out-of-pocket copay maximums.

SIMPLY BLUE MEDICAL COVERAGE WITH HEALTH SAVINGS ACCOUNT

Blue Cross Blue Shield of Michigan offers a high deductible health care option (Simply Blue) to serve in conjunction with a health savings account. This option offers health coverage at a reduced cost for both the employer and employee.

In a health savings account, funds are contributed into an account which are not subject to federal income taxes at the time of deposit. Unlike a flexible spending account, funds roll over and accumulate year-to-year, if not spent. HSAs are owned by the individual and may be used to pay for qualified medical expenses at any time without tax liability or penalty. Both the employer and employee may contribute to the account up to combined annual maximums of \$4,300 for single coverage and \$8,550 for two person and family coverage.

For details on specific covered services, please see the Medical Plan Comparison chart and Summary of Benefits and Coverage (SBCs).

TELADOC VIRTUAL CARE (COVERED UNDER ALL MEDICAL PLANS)

GENERAL MEDICAL (24/7 Care) – Need care for non-urgent and common conditions? Get same day appointments with a certified clinician from wherever you are. Clinicians diagnose, treat, and even prescribe medicine if needed.

MENTAL HEALTH – Have real conversations and see progress with a therapist or psychiatrist of your choice. Available 7 days a week from the privacy of your own home.

Set up your account or log in to schedule a visit. Visit TeladocHealth.com or call 1-800-Teladoc (800-835-2362) or download the app.

TELADOC HEALTH (COVERED UNDER ALL MEDICAL PLANS)

Get support for conditions with personalized guidance and care plans.

Diabetes Management	Hypertension Management	Diabetes Prevention Program	Weight Management Program
A personalized way to manage diabetes. <ul style="list-style-type: none">• Receive a connected blood glucose meter• Unlimited strips and lancets• Tips, action plans and one-on-one coaching• Real-time support for out-of-range readings	Make managing your blood pressure easier. <ul style="list-style-type: none">• Receive a connected blood pressure monitor• One-on-one support from expert coaches• Personalized tips on nutrition and activity	Reduce your risk of type 2 diabetes. <ul style="list-style-type: none">• Team of expert coaches to support you• Receive a smart scale that syncs to the app• All-in-one weight, activity, and food-tracking program	Improve nutrition, exercise, and weight loss. <ul style="list-style-type: none">• Receive an advanced smart scale• Personalized action plan• Ongoing expert coaching• Full nutrition, exercise, and weight loss support

To enroll, visit [Teladoc Health.com/Smile/BCBSM](https://TeladocHealth.com/Smile/BCBSM) or call 800-835-2362 and use registration code: BCBSM.

FAMILY BUILDING & WOMEN'S HEALTH SOLUTIONS (COVERED UNDER ALL MEDICAL PLANS)

Through their partnership with Maven, Blue Cross offers comprehensive and inclusive support to guide members through the family building journey from family planning, fertility, pregnancy, postpartum, return to work and parenting.

Family Building Support Solution

- 12-month program
- Preconception care
- Egg Freezing
- IUI & IVF
- Adoption and surrogacy

Maternity Support Solution

- 21-month program
- Prenatal and postnatal
- NICU
- High risk pregnancy care management
- Postpartum and return to work
- Loss

Parenting & Pediatrics Support Solution

- 12-month program
- Pediatric care
- Parent coaching
- Special needs
- Childcare navigation

Menopause & Ongoing Care

- 12-month program
- Early intervention
- Symptom management
- Mental health

To enroll, go to mavenclinic.com/join/getstarted or download the Maven Clinic app.

HEALTH SAVINGS ACCOUNTS (HSAs)

An HSA is a tax-advantaged savings account that can help you pre-fund and pay for your medical expenses with tax-free dollars. To be eligible for an HSA, you:

- Must be covered under a high-deductible health plan (HDHP) as defined by the IRS. The BCBSM Simply Blue HDHP meets this criterion:
- Cannot be covered by any other non-HDHP medical coverage (e.g., be covered as a dependent under a spouse's non-

HDHP plan or receive coverage under a Tricare Plan);

- Cannot be covered by any part of Medicare, including Part A; and if you receive benefits from the Veterans Administration or Indian Health Services, other than dental, vision or preventive services, you must discontinue contributions to your HSA for a period of three calendar months following the calendar month in which services were received.

- Cannot be claimed as a dependent on another person's federal income tax return. Note: Your child can be covered as an eligible dependent under the HDHP. However, if he or she does not qualify as a dependent on your federal income tax return or if you do not provide at least 50% of his or her support, you cannot use your HSA funds for the child's qualified medical expenses.

HSAs are designed to help you pay current and future medical expenses. Here's how the HSA works: When you elect the HDHP with an HSA, you are electing to set up a Lake Michigan Credit Union HSA account in your name. You may contribute to your HSA on a before-tax basis through payroll deductions. You can elect and change the payroll deduction amount at any time. Note: Your election will continue from year to year.

If you elect the HDHP option, the House will make quarterly contributions (annual amounts are \$1000 for "employee only" coverage and \$2000 for "employee plus one or more" coverage for 2025) to your HSA on your behalf. The annual statutory maximum contribution amount that may be contributed to a HSA is set by the IRS, varies from year to year and is based upon your level of coverage (coverage for yourself only, or coverage for you and your family). If you're over age 55 and aren't enrolled in Medicare, you can make additional catch-up contributions to your HSA each year. For additional information, see Publication 969 at www.irs.gov or consult your tax or financial advisor. If your spouse also contributes to an HSA, your maximum amount you can contribute to an HSA will be reduced. Consult your tax or financial advisor for information before making your contribution for the year. You can also make after-tax contributions to an HSA which are deductible on your federal income tax return, and you can contribute after-tax funds at any time prior to the due date of your income tax return for that tax year. Any money you take out of your HSA to pay eligible medical expenses is not subject to federal income taxes.

You can take money out of your HSA for reasons other than eligible medical expenses. However, such withdrawals are subject to regular income tax plus a penalty tax. There's no "use or lose" rule in an HSA. Any money remaining in your HSA at the end of the year can be rolled over for use in future years. Your HSA always belongs to you — it's not dependent upon your employment at The Michigan House of Representatives. If you stop participating in an HDHP, you can use the funds remaining in your HSA for qualified medical expenses, but you cannot make any new contributions to the HSA. The House HSA program is voluntary. You're the account holder, and you're responsible for reporting HSA contributions and distributions (whether by you or on your behalf) to the IRS. You should consult your tax or financial advisor to make sure you're eligible for an HSA, to see if an HSA would be advantageous to you and to ensure that you understand all of the tax implications. To learn more about HSAs, see Publication 969 at www.irs.gov. NOTE: You cannot be covered by any part of Medicare and contribute to an HSA. HSA contributions should cease as of the date your Medicare benefit commences.

FLEXIBLE SPENDING ACCOUNTS (administered through the State of Michigan)

The State of Michigan offers two types of FSAs. Health Care FSAs allow you to put aside pre-tax dollars for health care expenses not covered by any medical, dental, or vision care plan. Dependent Care FSAs allow you to put aside pre-tax dollars to cover child/elder care expenses (such as day care) for your eligible dependents so you can work.

If you are a participant in the Health Savings Account, you cannot participate in the Health Care FSA.

When you elect a Health Care FSA, your account is funded with the full amount you've chosen at the beginning of the year. A Dependent Care FSA works a lot like a Health Care FSA, except funds are available as contributions are deducted from your paycheck.

For information on flexible spending accounts, go to http://www.michigan.gov/mdcs/0,4614,7-147-22854_6095---,00.html.

Please note: This site will instruct employees to enroll through MI HR Self Service during open enrollment; however, House employees enroll through the House electronic submission process available on Housenet.

PRESCRIPTION DRUG PLAN

Prescription drug coverage is an important part of your health care coverage. The House provides a prescription drug plan that incorporates a co-payment for each prescription filled.

ABOUT THE PLAN

The Prescription Drug Plan is a separate benefit administered by Blue Cross and Blue Shield of Michigan (BCBSM). To receive the maximum available benefit, you will be required to purchase your prescriptions from the Blue Cross and Blue Shield of Michigan Preferred Prescription Network of Pharmacies. If you go outside the network, you will be reimbursed 75% of the approved amount after your co-pay. The plan covers prescriptions which require a physician's prescription order.

PPO #1 AND PPO #2

- TIER 1** \$15 co-pay for generic or prescribed over the counter drugs
These drugs have a proven record of safety and effectiveness and offer the best value. Tier 1 drugs require the lowest co-payment, making them your most cost-effective option for treatment. All generic drugs are formulary preferred.
- TIER 2** \$30 co-pay for formulary brand-name drugs
These brand-name drugs have a record of safety and effectiveness. Because more cost-effective therapy or a generic alternative is usually available, drugs in Tier 2 require a higher co-payment.
- TIER 3** \$50 co-pay for non-formulary brand-name drugs
Non-formulary brand-name drugs are not included in the BCBSM Custom Formulary. Tier 3 drugs may not have a proven record for safety, or their clinical value may not be as high as the drugs in Tier 1 or Tier 2. Formulary alternatives are available.

SIMPLY BLUE / HEALTH SAVINGS ACCOUNT (co-pays apply after deductible is met)

- TIER 1** \$10 co-pay for generic or prescribed over the counter drugs
These drugs have a proven record of safety and effectiveness and offer the best value. Tier 1 drugs require the lowest co-payment, making them your most cost-effective option for treatment. All generic drugs are formulary preferred.
- TIER 2** \$60 co-pay for formulary brand-name drugs
These brand-name drugs have a record of safety and effectiveness. Because more cost-effective therapy or a generic alternative is usually available, drugs in Tier 2 require a higher co-payment.

Note: If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated "Dispensed As Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic plus the applicable co-payment.

90-DAY RETAIL PHARMACY BENEFIT

This allows you to receive a 90-day prescription refill from participating pharmacies for the same co-pay as the current 30-day refill. You must be on your medication for a period of at least 60 days out of the past 120 days before using this option.

MAIL ORDER PRESCRIPTION DRUGS

A mail order program is available to anyone who enrolls in the BCBSM Standard Prescription Drug Plan. This program is designed to reduce expenses and provide maintenance prescriptions that you and your family need on an ongoing basis. The mail order program provides maintenance prescription medications used to treat chronic conditions such as arthritis, diabetes, high blood pressure, asthma, etc. When utilizing the mail order program, you pay a \$15 (generic), \$30 (brand

name) or \$50 (non-formulary) co-payments.

When ordering your prescription(s) through the mail, there are no claim forms to file and no waiting for reimbursement. Your medication is delivered free of charge via the U.S. Postal Service or UPS (signature required for controlled substances). You will receive your medication within 10 to 14 days from the date your order is postmarked, along with a new prescription request card. Go to <https://www.optumrx.com> for more information.

VISION PLAN

VSP Vision Plan - The vision plan provides coverage for you and your dependents in maintaining proper eye care. VSP provides an annual vision exam with a \$5 co-pay. The plan provides either glasses or contact lenses. The benefit for glasses requires a \$7.50 co-pay for lenses and up to \$400 for eyeglass frames. The benefit for contact lenses which are medically necessary (the recipient is unable to wear eyeglasses) requires a \$7.50 co-pay. For contact lenses which are not medically necessary, a maximum of \$400 is paid to participating providers.

COVERED SERVICES

- Vision Examinations
- Testing for Glaucoma
- Lenses for Correcting Vision
- Eyeglass Frames

DENTAL PLAN

Delta Dental Plan – Two options: Comprehensive Plan or Modified Plan

The dental plan provides four types of services.

- **Class 1 Benefits** - includes diagnostic and preventive services (such as examinations and cleanings), and x-rays.
- **Class 2 Benefits** - includes fillings, oral surgery, crowns, periodontic and endodontic procedures.
- **Class 3 Benefits** - includes procedures for bridges, implants, and partial/complete dentures.
- **Class 4 Benefits** - includes orthodontic services to remedy an imperfection of the bite.

<u>PLAN SERVICES</u>	<u>COMPREHENSIVE PLAN</u>	<u>MODIFIED PLAN</u>
Class 1 Benefits	100%	50%
Class 2 Benefits	90%	50%
Class 3 Benefits	75%	50%
Class 4 Benefits	75%	50%
Annual Max - Class 1, 2, 3	\$2,000	\$1,000
Life Max - Class 4	\$4,000	\$1,000

EMPLOYEE LIFE INSURANCE

Group term life insurance is provided through Minnesota Life, and is administered by the State of Michigan, Department of Civil Service, and Benefits Division. **If you are covered under more than one plan of life insurance provided by the State of Michigan, your amount of coverage will only be that of the plan providing the highest amount of coverage. The State of Michigan plan includes the following: House of Representatives, Office of Retirement Services, Civil Service, etc.** Benefit coverage is at two (2) times pay (maximum benefit of \$200,000).

If you opt out of the House Benefit Plan you cannot purchase Dependent Life Insurance. In addition, you will be automatically disqualified from participation in the Accidental Death coverage, which is available at no cost. If you retire from House employment during the coming plan year under the Defined Benefit Plan or the Defined Contribution Premium Subsidy Plan, your level of employee life insurance (up to two times salary) at the time of retirement will affect the life insurance coverage you will have as a State of Michigan Retiree (contact Human Resources for more information).

TAX CONSIDERATIONS

Current federal tax law states that the first \$50,000 of employer-paid life insurance protection is not subject to taxes. Amounts more than \$50,000 are taxable. The government assigns a value to these amounts and this value is added to your W-2 earnings. These amounts are called imputed income. This is the amount which would be shown on your W-2 form and on your bi-weekly statement of earnings as "taxable benefits". Current federal tax law also states that benefits received in the event of your death are not taxable to your beneficiaries.

ACCIDENTAL DEATH

This coverage is provided in addition to the Employee Life Insurance coverage which is a part of the House Benefit plan. This coverage pays \$100,000 to your beneficiary in the event of your death resulting from accidental personal injuries arising out of or in the course of your employment with the House (This does not include traveling between work and your home). **To be covered, you must be enrolled in the Employee Life plan.**

DEPENDENT LIFE INSURANCE

Dependent Life Insurance is an optional benefit available to assist you should you experience the death of an enrolled family member (spouse or a dependent child) and you are faced with unexpected expenses. To participate in Dependent Life Insurance coverage, you must also be covered for Employee Life Insurance. If you are married to a State/Legislative employee or retiree who also has Employee Life Insurance, you cannot cover your spouse as a dependent for Dependent Life Insurance. Children can be covered by either parent, but not both. Options are listed below:

- \$50,000 spouse and/or \$15,000 per child
- \$25,000 spouse and/or \$10,000 per child
- \$10,000 spouse and/or \$5,000 per child
- \$5,000 spouse and/or \$2,500 per child
- \$1,500 spouse and/or \$1,000 per child
- \$15,000 child(ren)
- \$10,000 child(ren)
- No Coverage

If you do not select coverage for your dependents when you are first eligible, you may enroll only during subsequent annual enrollments, subject to evidence of good health or after a life event. Your lawful spouse and your unmarried children are eligible. Children are covered from fourteen days after birth up to their twenty-third birthday. The definition of children includes legally adopted children, stepchildren who live with you and children under your legal guardianship who are living with you and are chiefly dependent on you for support.

LONG TERM DISABILITY INSURANCE

The House Benefit Plan includes Long Term Disability coverage for participating employees which provides income in the event you are disabled and unable to work. A disability is an injury or illness which initially prevents you from performing your normal job. Benefits may continue until you recover, reach age 65, or upon death. Disabilities which begin after age 60 are paid for varying lengths of time, depending on the age you become disabled. **Long term disability coverage is not available to Representatives.**

OPTIONS

The Long-Term Disability plan provides you a benefit equivalent to 66 2/3% of your pay after a 90 day wait from the onset of your disability. The amount of insurance is determined by your annual rate of pay as of the eligibility cutoff date for the plan year and remains unchanged for the plan year. The maximum monthly benefit is \$6,381, and other benefits you receive may reduce the amount of your long-term disability benefit.

PRE-EXISTING CONDITIONS

A pre-existing condition means any injury or illness for which a covered employee received medical treatment, advice, consultation, care, or services including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to the day the covered employee became insured under the policy. The policy will not provide benefits for disability caused by, contributed to by, or resulting from a pre-existing condition; and which begins in the first 12 months after the covered employee is continuously insured under the policy.

TAXATION OF LTD BENEFITS

Any amounts of disability pay received through an insurance policy that is part of an employer's benefits program are included in the employee's gross income to the extent such amounts were attributable to contributions made by the employer and not included in the employee's gross income. Contributions by the employer may include insurance premiums paid or payments made to a separate trust or insurance fund. Therefore, if an employer pays 100% of insurance premiums for a disability policy maintained on behalf of all employees, the disability benefits when received, are included in the employee's gross income and are subject to standard income tax.

OTHER BENEFITS

DEFERRED COMPENSATION (VOYA)

Separate from your House Benefits, the State of Michigan currently provides the following plans to help you save for retirement: 401(k) Plan, Roth 401(k) Plan, and 457 Plan.

The 457 and 401(k) plans allow you to set aside part of your current salary in before-tax dollars (Social Security taxes are deducted) and defer taxes until retirement when you will potentially be in a lower tax bracket. With the Roth 401(k), your contributions are taxed before being put in your account. If you don't withdraw from your Roth 401(k) account for at least five years and before the age 59 ½, you do not pay any more taxes on your contributions or investment earnings. Review the plans carefully to learn each plans special features. For more information, visit the following website (<https://stateofmi.voyaplans.com>).

LUCET EMPLOYEE ASSISTANCE PROGRAM (www.eap.lucethealth.com)

800-624-5544 (Company code: MHR)

Personal and workplace challenges can negatively affect wellness—which can then affect job performance. The New Directions Employee Assistance Program (EAP) gives employees and their loved ones free, confidential access to the programs and services they need to increase their happiness and healthiness.

BENEFITS CONTINUATION COVERAGE NOTICE (COBRA)

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.

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;
- 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 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."

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;
- 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 Mark Meyer, Human Resources.

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.

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, Medicaid, 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.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. 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

Mark J. Meyer, Human Resources Director, Michigan House of Representatives, 517-373-3069.

OTHER IMPORTANT NOTICES

Newborns' Act Disclosure

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).

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits 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.

Our plan complies with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by the patient and her physician. Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information about WHCRA required coverage, you can contact the plan administrator at 517-373-9556.

Michelle's Law Notice

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan. For the protections of Michelle's Law to apply, the child must:
 - Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
 - Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan. If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary. If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Mark Meyer, Human Resources, (517) 373-9556.

Medicare Part D Credible Coverage Notice

This notice is for all current House employees and dependents with prescription drug coverage under a health plan offered by the Michigan House of Representatives who are Medicare-eligible or will become Medicare-eligible within the next 12 months.

IF YOU ARE NOT MEDICARE-ELIGIBLE AND WILL NOT BECOME MEDICARE-ELIGIBLE IN THE NEXT 12 MONTHS, YOU MAY DISREGARD THIS NOTICE.

If you are eligible for Medicare, you can enroll in a Medicare Part D prescription drug plan (Part D Plan) when you first become eligible for Medicare and each year thereafter between October 15 and December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan. All Part D Plans provide at least a standard level of coverage set by Medicare. You must decide whether to enroll in a Part D Plan **or** keep your House health plan prescription drug coverage. This notice gives important information to help you decide:

1. The Michigan House of Representatives has determined that the prescription drug coverage provided under its health plans is, on average for all plan participants, expected to pay out at least as much as the standard Medicare prescription drug coverage and is, therefore, considered creditable coverage.
2. Because the prescription drug coverage under the House health plan is creditable coverage, you can keep your House health plan prescription coverage; you do not have to enroll in a Part D Plan.
3. If you decide to enroll in a Part D Plan, you will not have to pay a penalty to enroll for Part D Plan coverage, unless you do not join the Part D Plan within 63 days after your House health plan prescription drug coverage ends. 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 January to join.
4. Your current House health plan coverage pays for other health expenses (hospitalizations, doctor visits, etc.) in addition to prescription drugs. You will still be eligible to receive these other benefits if you choose to enroll in a Part D Plan.
5. If you decide to enroll in a Part D Plan, your prescription drug coverage under the House health plan will stop and we cannot guarantee that you will be eligible to restore coverage if you later discontinue your Part D Plan.
6. You do not need to take any action if you wish to continue your prescription drug coverage under your current House health plan.

Please keep this Notice. If you enroll in a new Part D Plan approved by Medicare, you may be required to provide a copy of this Notice to avoid paying a higher premium amount.

This Notice of Creditable Coverage is provided by the Michigan House of Representatives, Human Resources, P.O. Box 30014, Lansing, MI 48909-7514.

For questions regarding **this notice only** (and not general Medicare information), please call Human Resources at (517) 373-9556. You will receive this notice annually.

WHERE TO GET MORE INFORMATION ABOUT MEDICARE PART D:

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

1. Visit www.medicare.gov for personalized information. The "Medicare & You" booklet is also available for download on this site.
2. Call 1-800-MEDICARE (1-800-633-4227) or 1-877-486-2048 (TTY).
3. Call your State Health Insurance Assistance Program for personalized help. Michigan residents may call 1-800-803-7174. For other states, look in the "Medicare & You" handbook for telephone numbers.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available online from the Social Security Administration (SSA) at www.socialsecurity.gov, or by phone at 1-800-772-1213 or 1-800-325-0778 (TTY).

HIPAA Notice

HIPAA NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION OF GROUP HEALTH PLANS OF THE MICHIGAN HOUSE OF REPRESENTATIVES

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

This notice gives you information about the duties and practices to protect the privacy of your medical or health information for each group health plan for Michigan House of Representative employees that is administered and self-insured by the House of Representatives ("Plan"). Each Plan is sponsored by the Michigan House of Representatives ("Plan Sponsor"). Each Plan is required by law to maintain the privacy of protected health information and to provide enrollees with a notice of its legal duties and privacy practices with respect to protected health information. Each Plan provides health benefits to you as described in your summary plan description. Each Plan receives and maintains health information in providing these benefits to you. Each Plan hires business associates to help provide these benefits. These business associates also receive and maintain health information related to you while assisting each Plan.

The effective date of this notice is April 14, 2003. Each Plan is required to follow the terms of this notice until it is replaced. Each Plan reserves the right to change the terms of this notice at any time. If a Plan amends this notice, the Plan will send a new notice to all subscribers covered by the Plan. Each Plan reserves the right to make the new changes apply to all your health information maintained by the Plan before and after the effective date of the new notice.

When a Plan may use or disclose your medical or health information without your consent or authorization

The following categories describe when a Plan may use or disclose your medical or health information without your consent or authorization. Each category includes general examples of the type of use or disclosure, but not every use or disclosure that falls within a category will be listed:

Treatment. For example, a Plan may disclose health information at your doctor's request to facilitate receipt of treatment.

Payment. For example, a Plan may use or disclose your health information to determine eligibility or plan responsibility for benefits; confirm enrollment and coverages; facilitate payment for treatment and covered services received; coordinate benefits with other insurance carriers; and adjudicate benefit claims and appeals.

Health Care Operations. For example, a Plan may use or disclose your health information to conduct quality assessment and improvement activities; underwriting, premium rating, or other activities related to creating an insurance contract; data

aggregation services; care coordination, case management, and customer service; auditing, legal, and medical reviews of the Plan; and to manage, plan, or develop a Plan's business.

Health Services. A Plan or its business associates may use your health information to contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

To Business Associates. A Plan may disclose your health information to business associates that assist the Plan in administrative, billing, claims, and other matters. Each business associate must agree in writing to ensure the continuing confidentiality and security of your health information.

To Plan Sponsor. A Plan may disclose to the Plan Sponsor, in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. A Plan may also disclose to the Plan Sponsor that you are enrolled in or disenrolled from the Plan. A Plan may disclose your health information to the

Plan Sponsor for authorized administrative functions that the Plan Sponsor provides for the Plan. The Plan Sponsor will not use or disclose your health information for employment-related activities or any other benefit plan.

As Required by Law. A Plan may use or disclose your personal health information for other important activities permitted or required by state or federal law, with or without your authorization. These include, for example:

- To the U.S. Department of Health and Human Services to audit Plan records.
- As authorized by state workers' compensation laws.
- To comply with legal proceedings, such as a court or administrative order or subpoena.
- To law enforcement officials for limited law enforcement purposes.
- To a governmental agency authorized to oversee the health care system or government programs.
- To public officials for lawful intelligence, counterintelligence, and other national security purposes.
- To public health authorities for public health purposes.

Each Plan may also use and disclose your health information as follows:

- To a family member, friend, or other person, to help with your health care or payment for health care, if you are in a situation such as a medical emergency and cannot give your agreement to a Plan to do this.
- To your personal representatives appointed by you or designated by applicable law.
- To consider claims and appeals regarding coverage, exclusion, cost, and privacy issues.
- For research purposes in limited circumstances.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.

Uses and disclosures with your permission

Each Plan will not use or disclose your health information for other purposes unless you give a Plan your written authorization. If you give a Plan written authorization to use or disclose your health information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your health information a Plan maintains unless the Plan has taken action in reliance on your authorization.

Your rights

You may request in writing that a Plan do the following concerning your health information that the Plan maintains:

- Put additional restrictions on a Plan's use and disclosure of your health information. A Plan does not have to agree to your request.
- Communicate with you in confidence about your health information by a different means or at a different location than a Plan currently does. Your request must specify the alternative means or location to communicate with you. A Plan does not have to agree to your request.
- See or receive copies of your health information. A Plan may charge a reasonable fee to cover expenses associated with your request. In limited cases, a Plan does not have to agree to your request.
- Amend your health information. In some cases, a Plan does not have to agree to your request.
- Receive a list of disclosures of your health information from a stated period during the prior years (but not before April 14, 2003) that the Plan made for certain purposes. This listing will not include disclosures made to you; for treatment, payment, or health care operation purposes; or other exceptions. In some cases, the Plan may charge a nominal, cost-based fee to carry out your request.
- Send you a paper copy of this notice.

To exercise any right described in this notice or for a detailed explanation of the fee structure for possible fees for receiving information, please contact the Privacy Official in Human Resources at (517) 373-9556.

Complaints

If you believe your privacy rights have been violated by the Plan, you have the right to complain in writing to the Plan or to the Secretary of the United States Department of Health and Human Services. You may file a written complaint with the Plan at the address listed below. We will not retaliate against you if you choose to file a complaint with the Plan or the Department of Health and Human Services.

Contact office

To request additional copies of this notice or more information about Plan privacy practices, please contact the Privacy Official for the Michigan House of Representatives group health plans at the following Contact Office:

Contact Office: Michigan House of Representatives, Human Resources, Mark Meyer (Privacy Official)
Telephone: (517) 373-9556 Fax: (517) 373-5816
E-mail: humanresources@house.mi.gov
Address: 124 North Capitol Avenue, Lansing, MI 48933

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or

www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

You can view eligibility, by state, at the following site: [Children's Health Insurance Program \(CHIP\)](#).

CONTACT INFORMATION

HUMAN RESOURCES

517-373-3069
10th Floor House Office Building

BLUE CROSS & BLUE SHIELD OF MICHIGAN

Group # 007001928
877-354-2583
www.bcbsm.com

DELTA DENTAL PLAN OF MICHIGAN

Group #1750-0001 & 0002
800-482-8915
www.deltadentalmi.com

VISON SERVICE PLAN (VSP)

800-877-7195
www.vsp.com

LUCET EMPLOYEE ASSISTANCE PROGRAM

800-624-5544
www.eap.lucethealth.com
Company code: MHR

VOYA 401(K) AND 457 PLANS

800-748-6128
<https://stateofmi.voyaplans.com>

APPENDIX 1

DEPENDENT ELIGIBILITY GUIDELINES

ELIGIBLE DEPENDENTS

Eligible children up to the end of the calendar year of age 26 may be enrolled in your health, dental and vision coverage, regardless of marital or student status or dependency upon you for support. To be eligible for coverage, your child must meet one of the following criteria:

- Your child(ren) by birth, legal adoption, or legal guardianship.
- Step-child(ren).
- Foster child(ren) placed in your home by a state agency or the court.

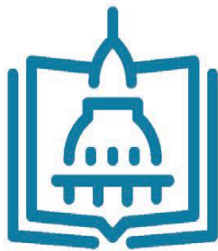
DEPENDENT LIFE INSURANCE

Eligible dependents are unmarried children between the ages of 14 days and 23 years for whom you provide at least 50% of their support. These dependents are not required to be enrolled in school. Your spouse is also eligible if he or she is not a state employee or state retiree.

CANCELING DEPENDENT OR ADULT CHILD COVERAGE

You must immediately notify Human Resources to cancel your dependent coverage when he or she no longer meets the definition of an eligible dependent. Ex-spouses are not eligible and must be removed from coverage effective the date of divorce.

APPENDIX 2



HOUSE of REPRESENTATIVES STATE OF MICHIGAN

HUMAN RESOURCES/ 10 SOUTH Health Care Coverage Waiver Declaration

EMPLOYEE NAME

On behalf of myself and my eligible dependents (if any), I waive the option to enroll in the Michigan House of Representatives Health Care Plan (the "Plan") offered at this time for the following reason:

- I am covered under another plan as a spouse or dependent. I understand that I will have to wait until next open enrollment to participate in the Plan unless I experience a change event (as explained in the **Notice of Enrollment Rights** below).
- I do not wish to participate in the Plan at this time, but am not covered by another plan. I understand that I will have to wait until next open enrollment or a family status change as provided in the Internal Revenue Code (i.e., marriage, birth, adoption or divorce) to participate in the Plan.

If you are declining to enroll in the Plan at this time because of other health insurance coverage, please provide the following information:

SUBSCRIBER NAME

CARRIER NAME

GROUP/POLICY NUMBER

I affirm that the assertions in this form are true and complete to the best of my knowledge.

EMPLOYEE SIGNATURE

DATE

EMPLOYER SIGNATURE

DATE

NOTICE OF ENROLLMENT RIGHTS

If you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and your dependents in the Plan, if you request enrollment within 30 days of your coverage involuntarily ending (or cessation of employer contributions). In addition, if you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.