HOWELL recreation

Regular Meeting
Tuesday, February 15, 2022
Oceola Community Center 7:00 p.m.

AGENDA

1. Call to Order
2. Pledge of Allegiance (all stand)
3. Approve Agenda
4. Approval – Organizational Board Meeting Minutes dated Tuesday, January 18, 2022
5. Approval – Regular Board Meeting Minutes dated Tuesday, January 18, 2022
6. Call to the Public (for any items not on the agenda)
7. Staff Comments
8. Discussion- Fillmore Park Lease/Use Agreement w/ Livingston County
9. Discussion/Approval- Burnham & Flowers BCBS Health Insurance Proposal
10. Discussion/Approval- 401K ICMA Retirement Payback
11. Review/Discussion - Check Register Report Ending January 31, 2022
12. Review/Discussion - Bank Statements Ending January 31, 2022
13. Review/Discussion – Financial Reports Ending January 31, 2022
14. Directors Report
    a. Audit
    b. Grant Updates for Bennett
15. Old Business
16. New Business
17. Next Meeting: Tuesday, March 15, 2022 - 7:00 PM
18. Adjournment

Howell Area Parks & Recreation Authority

Oceola Community Center

Organizational Board Meeting Minutes January 18, 2022

Call to Order

Chairman Sean Dunleavy called the meeting to order at 7:00 pm.

Pledge of Allegiance

Attendance

Board Members: Chairman Sean Dunleavy, Vice Chair Diana Lowe, Secretary Tammy Beal, Treasurer Jean Graham, and Trustee Nikolas Hertrich.

HAPRA Staff: Tim Church, Members of the Public: Kyle Tokan, Jordan Jones, Kevin Troshak, Chris Techentin, Jen Savage, Renee Baumgart

Public: None

Discussion/Approval – Officer Positions for 2022

Brief discussion was had concerning officer positions, it was decided that with the exception of secretary all officers would remain unchanged. 2022 Officer Positions: Sean Dunleavy – Chair, Diane Lowe - Vice Chair, Nikolas Hertrich – Secretary, Jean Graham – Treasurer, Tammy Beal – Trustee. Motion made by Diana Lowe and Supported by Jean Graham. Roll call vote: Jean Graham – Yes, Tammy Beal – Yes, Diana Lowe – Yes, Nikolas Hertrich – Yes, Sean Dunleavy – Yes. **Motion carried 5 – 0.**

Adjournment

Motion by Tammy Beal to Adjourn at 7:09 pm, supported by Nikolas Hertrich. **Motion carried 5-0**

_____ _____

Approved Date

Respectfully Submitted by: Nikolas Hertrich, Secretary

Howell Area Parks & Recreation Authority

Oceola Community Center

Regular Board Meeting Minutes January 18, 2022

Call to Order

Chairman Sean Dunleavy called the meeting to order at 7:10 pm.

Attendance

Board Members: Chairman Sean Dunleavy, Vice Chair Diana Lowe, Secretary Nikolas Hertrich, Treasurer Jean Graham, and Trustee Tammy Beal.

HAPRA Staff: Tim Church, Kyle Tokan, Jordan Jones, Kevin Troshak, Chris Techentin, Jen Savage, Renee Baumgart

Public: None

Approval of Agenda

Diana Lowe made a motion to approve the agenda, supported by Tammy Beal. **Motion carried 5 – 0.**

Approval – Regular Board Meeting Minutes dated Tuesday, December 21, 2021

Motion to approve the agenda the December 21, 2021 Board minutes made by Jean Graham and supported by Nikolas Hertrich. **Motion carried 5 – 0.**

Call to the Public

None Heard.

Staff Comments

Jordan Jones reported that Sweetheart Dance is coming up. Event will occur over four nights with a maximum of 200 participants per night. Approximately 200 people have registered for the event. Activity levels in all programs continue to increase. Brief discussion was had concerning WHMI article regarding ownership of the Melon Fest, HAPRA still owns the rights.

Discussion/Approval – Oceola Community Center Lease Renewal

Director Church provided an update, no comments have been received from the attorney regarding various additions made to the agreement and looking to keep the rent the same price as a result of the pandemic. A motion was made by Jean Graham to approve the Oceola Contract Extension as presented and supported by Diana Lowe. **Motion carried 5 – 0.** Lease was signed by Diana Lowe as HAPRA representative.

Discussion/Approval – ICMA 401 Contribution Payback from 2020 / 2021

Director Church provided background information related to the potential for ICMA 401 Contribution Payback for 2020 and 2021. Jen Savage supported the discussion with the number of employees that participated in the program during those years and the monetary values of the repayments. Because of questions concerning paybacks to individuals no longer in the organization and the uncertainty of the reimbursement amount it was suggested the item be postponed until the next meeting. A motion to postpone the agenda item was made by Tammy Beal and supported by Nikolas Hertrich. **Motion carried 5 – 0.**

Discussion/Approval – ICMA 401 & ICMA 457(b) Plan Contributions for 2022

Nikolas Hertrich inquired if there were other 401 and 457(b) options available that did not require annual review and would guarantee Staff a minimum contribution every year. A brief discussion was had and concluded with Director Church indicating that he could look into and evaluate other plans. Motion was made by Jean Graham and supported by Nikolas Hertrich to reinstate the 401 HAPRA contributions after they were suspended in 2020 due to the pandemic. Roll call vote was taken: Jean Graham – Yes, Tammy Beal – Yes, Diana Lowe – Yes, Nikolas Hertrich – Yes, and Sean Dunleavy – Yes. **Motion carried 5 – 0.**

Discussion/Approval – Payment in Lieu of Health Insurance 2022

Director Church provided background information on the proposed policy. A motion was made by Tammy Beal and supported by Diana Lowe to approve the proposed policy for Payment in Lieu of Health Insurance as presented and with the lump sum payment to be $ 250.00 per quarter. Said lump sum payment will be paid to the employee at the end of each full quarter that the employee has opted out of the Authority's plan. **Motion carried 5 – 0.**

Discussion/Approval – 2021 Audit Engagement Letter w/ Smith & Klaczkiewicz

Director Church informed the Board that new rules related to the audit have not yet been released so the audit letter has not been provided. The audit has historically been conducted in February. A motion to proceed with the audit was made by Diana Lowe and supported by Tammy Beal. **Motion carried 5 – 0.**

Review/Discussion – Check Register Report Ending December 31, 2021

No Questions

Review/Discussion – Bank Statements Ending December 31, 2021

No questions

Review Discussion – Financial Reports Ending December 31, 2021 (preliminary)

Director Church indicated that historically there are more expenditures in the beginning of the year followed by the revenues. Indicated to the Board that he thinks the end of the year will be positive and is excited for 2022. A request was made to include headers on each page of the Budget Updates if possible.

Directors Report

- Strategic Planning Session is currently scheduled for Friday April 15, 2022 from 09:00 – 13:00. As part of the process Staff will provide their input in February and moderation of the session will be assisted by an outside 3rd party. Director Church requested to be provided with the names of any individuals that the Board thinks should participate. One objective of the session will be to establish a position for a potential securing of a mileage. Nikolas Hertrich indicated that the City of Howell will be developing a Parks and Recreation Strategic plan and perhaps there is an opportunity for collaboration.
- Staff will be attending the mParks Conference between March 6, 2022, and March 9, 2022, in Traverse City. This is a great opportunity for Staff to get together, HAPRA will operate as normal during their absence.
- Appears that participation may have increased with insurance companies' now providing health and wellness benefits.
- There is new long term rental that will be using the facility every Wednesday.

Old Business

- Nikolas Hertrich thanked Jordan Jones for her participation during the January 10, 2022, Howell City Council Meeting commented on how well she did.
- Brief discussion was had on the status of bills for Board Members shirts.
- Director Church indicated that the agreement for the Countryside Veterinary Dog Park need to be reevaluated. A group will be formed to work on the update.

New Business

No new business

Closed Session: 2021 Executive Director Annual Evaluation

A motion was made by Diana Lowe and supported by Tammy Beal at 8:04 pm to proceed to Closed Session to conduct the 2021 Executive Director Annual Evaluation. Roll call vote was taken: Jean Graham – Yes, Tammy Beal – Yes, Diana Lowe – Yes, Nikolas Hertrich – Yes, and Sean Dunleavy – Yes. **Motion carried 5 – 0.**

Motion by Diana Lowe to return from Closed Session at 8:40 pm and supported by Jean Graham. **Motion carried 5 – 0.**

Next Meeting

Tuesday, February 15, 2002 at 7:00 PM at the Oceola Community Center

Adjournment

Motion to Adjourn meeting at 8:41 pm by Tammy Beal and supported by Jean Graham. **Motion carried 5-0**

_____ _____

Approved Date

Respectfully Submitted by: Nikolas Hertrich, Secretary

PROPERTY LEASE
LIVINGSTON COUNTY, HAPRA & SELCRA
FILLMORE COUNTY PARK RECREATIONAL FACILITIES

Livingston County, 304 E. Grand River Ave., Howell, MI, 48843 the Llessor, and the Howell Area Parks and Recreation Authority, 925 W Grand River Ave, Howell, MI 48843, (HAPRA) and the Southeastern Livingston County Recreation Authority, 125 S Church St, Brighton, MI 48116 (SELCRA) ~~the Howl & Bark Dog Park (a Michigan registered non-profit),~~ together the Llessees, enter into this lease subject to the following conditions:

1. Premises. ~~——~~The Llessor leases to the Llessees a portion of the property located in Genoa Township, Livingston County, described as follows:

   A 200-acre public park comprised of the following three parcels:
   Sec. 2 T2N R5E, E 1/2 of SE 1/4 80 Acres Tax Parcel No 4711-02-400-004
   Sec. 1 T2N R5E, E 1/2 of SW 1/4 80 Acres Tax Parcel No 4711-01-300-006
   Sec. 1 T2N R5E, SW 1/4 of SW 1/4 40 Acres Tax Parcel No 4711-01-300-005
   Excepting 2 acres as more particularly described in deed of record, and subject to easements and restrictions of record, and as more particularly depicted in Exhibit A

   ~~to the south/southeast of the County building in the East Complex that houses the Health Department, the Building Department and certain other County offices (2300 East Grand River Avenue, Howell, Michigan). The specific leased premises are approximate 2.5 acres of unused land that abuts the parking lot located at the back of the described County building and are further outlined on the attached aerial map upon which the lessee may construct a dog park to be enclosed by 6 foot fencing with additional structures including bench seating, gates, an open-sided covered structure (future) for shelter from weather, obstacles for dog exercise and training and other items that are commonly associated with dog parks. Lessee agrees that the final site design is subject to approval by the Lessor and Genoa Township.~~

   The property is known as Fillmore County Park, a multi-use passive recreation park owned by Livingston County and open to the general public. The portion of said property to be leased consists of the area designated as the Multi-Use Sports Field, as depicted in Exhibit A, and adjacent areas as necessary to support Lessee's recreation programming needs, and as may be mutually agreed to by the parties.

2. Terms. ~~-~~ The term of this lease shall be ~~twenty~~ ten (~~20~~ 10) years, commencing on the date on which this agreement is executed by the ~~second~~ third of the ~~two~~ three parties. ~~The Lessor reserves the right to withhold final approval of this lease pending the Lessor's satisfaction that the Lessee has secured not less than 50% the Phase I estimated construction cost, such costs being contained in the Lessee's submitted Dog Park proposal. Lessee agrees that construction of the Dog Park may not commence until this lease is consummated, and further agrees to begin construction of the Dog Park within 60 days of the consummation of this lease agreement.~~ Notwithstanding any other provisions of this lease to the contrary, Llessor shall have the right to cancel or terminate this lease by giving Llessees notification of such cancellation or termination not less that two (2) years prior to the effective date of such cancellation or termination. The term of the lease may be renewed or extended or modified for a period and upon terms and conditions mutually agreed~~able~~ to in writing by Llessor and Llessees.

3. Rent. ~~—~~The Llessees shall each pay to the Llessor $1.00 per year as rent for the leased premises, starting on the commencement date. A similar payment will be made on each anniversary date of this agreement thereafter.

4. Use, Operation, Maintenance, Costs and Scheduling.

The premises are to be used ~~and occupied~~ by the L~~l~~essees for their outdoor sports recreation programs including soccer, flag football, baseball or other activities ~~as a dog park. Lessee may construct seating within the dog park for users. The lessee shall install adequate fencing and gating to enclose the leased premises. The lessee may also construct within the dog park, obstacles and such other equipment that are commonly associated with dog parks. The lessee may construct a water fountain(s) and a dog washing station within the dog park. The lessee shall be allowed to construct an information kiosk at or very near the entrance to the dog park for the posting of notices, information, and other information pertinent to the operation of the dog park. The lessee and other users of the dog park shall be afforded adequate ingress and egress across lessor's other properties which surround or abut the leased premises.~~ Lessees shall be allowed to ~~use~~ access L~~l~~essor's existing ~~parking lot~~ facilities for Lessees' users of the ~~dog park~~sports field areas.

Fillmore Park Rules and Regulations: Lessees and their invitees shall comply with Fillmore County Park rules and regulations (attached as Exhibit B), as may be updated by Lessor from time to time.

Field Maintenance and Repair: Lessees shall provide all field maintenance and repair such as mowing, herbicide/pesticide application, turf maintenance and repair, and other work as required to support Lessees' activities, and to provide good and safe facilities for public use.

Field Equipment and Supplies: Lessees shall provide all equipment and supplies, including such items as field striping, nets, flags, cordons, etc. as is necessary to support Lessees' programs and activities.

Improvements: Improvements shall be by separate agreement, mutually agreed to in writing by the parties hereto.

Waterless Restroom: Lessor shall provide regular maintenance and cleaning, periodic tank cleaning, and repairs as necessary, of the waterless restroom.

Other Park Areas: Lessor shall provide maintenance, repair and improvements of all other Park areas which may or may not be used by Lessees or their invitees, including entrance lot and drive, walks and trails, natural areas and other improvements.

Utilities: No utilities (such as well, water, irrigation, electric, lighting, propane, communications or sanitary sewer) are available on the premises for connection or use by Lessees.

Field Use Fees, Revenues, Costs, Expenditures: Field use fees, cost/expenditure allocation, revenue allocation, cost accounting and budgeting between Lessees HAPRA and SELCRA shall be as mutually agreed to by separate written agreement of Lessees HAPRA and SELCRA, which agreement may be revised from time to time. A copy of said separate agreement shall be provided to Lessor. Lessees shall charge user fees to their invitees as they deem appropriate to cover Lessees' costs.

Field Use Scheduling: All scheduling of field use and activities shall be provided by Lessees. It is understood that under said separate agreement between HAPRA and SELCRA, HAPRA will maintain, regularly update, and make available at all times to the parties hereto, the schedule of activities and events for the premises.

Use of Sports Fields by Users Unaffiliated with Lessees: Individual users that are unaffiliated with Lessees HAPRA and SELCRA and their programs may use the sports fields during times when no activities of Lessees are scheduled.

~~Lessor shall permit lessee to have access to electricity and water services currently in place on lessor's property, providing such access to be at a location in reasonable proximity to the lease premises, all at lessee's sole expense.~~

~~However, lessee shall consult with and obtain written permission of lessor for any such improvements prior to commencement of any work on the same, which permission lessor shall not be unreasonably withheld. Lessee shall provide lessor with waivers of liens and other assurances reasonably requested by lessor to assure that all providers of labor and materials for any such improvement have been and are fully paid. In the event any such improvement is commenced but not promptly completed, lessor shall have the option to either remove the incomplete improvement in order to restore the premises to the original condition existing prior to the making of this lease at lessee's sole expense, or at lessor's sole discretion to complete the improvement at lessee's sole expense.~~

Lessees' Responsibility for Invitees Safety: Lessees shall be responsible for the safety and security of ~~persons~~ invitees permitted by L~~l~~essee to utilize the leased premises. Lessor shall not be required to provide any supervision ~~or other services of any kind for~~of the leased premises ~~or for its use as a dog park~~. ~~The hours of operation of the leased premises as a dog park shall be subject to the approval of the lessor, which approval shall not be unreasonably withheld. Lessee shall have the responsibility of assuring that the operation of the dog park is limited to times approved by lessor. It shall be the responsibility of the lessee to prominently post rules and regulations governing the use of the dog park.~~

Lessor's Use of Premises: Lessor shall have the right to utilize the subject premises, notwithstanding this lease agreement, so long as such use does not in any fashion interfere with the use of the property by L~~l~~essee as permitted by this lease.

~~3. Signage. The lessor agrees to allow lessee, at the lessee's sole expense, to install directional signage on the lessor's property so as to adequately direct dog park users to the park site. The lessee agrees to only install signage that meets the requirements of the lessor as to design, color, size, and location.~~

~~3. Repairs and Maintenance. The lessee shall be responsible for all maintenance and repair of the premises. The lessee must repair and maintain the premises at the lessee's expense. The premises shall be kept in good and safe condition, including any electrical wiring, plumbing, any system or equipment on the premises, structural members of all buildings, and other improvements on the premises.~~

~~4.~~5. Surrender of the Premises. ~~—~~The L~~l~~essees shall surrender the premises to the L~~l~~essor when this lease expires. Upon the expiration of the lease, or upon any vacation of the premises by the L~~l~~essees, the L~~l~~essor shall have the option, within its sole discretion, by written notice to the L~~l~~essees, to require that any building, structure, or other improvement, permanent or temporary, be removed by L~~l~~essee at L~~l~~essee's sole expense. The L~~l~~essee shall be responsible for making any repair necessary to restore the leased premises to the original condition existing prior to the date of this agreement, excepting, however, any improvement required by the L~~l~~essor to be left upon the premises by the L~~l~~essee.

~~5.~~6. Entry and Inspection. The L~~l~~essees shall permit the L~~l~~essor or the L~~l~~essor's agents to enter the premises at reasonable times and with reasonable notice, to inspect the premises or to access other properties owned by the L~~l~~essor that may lie outside the boundaries of the leased property.

~~6.~~7. Assignment and subletting. ~~—~~The L~~l~~essees may not assign, sublet, or otherwise transfer or convey its interest or any portion of its interest in the premises without written consent from the L~~l~~essor. The L~~l~~essor shall have total discretion on its approval of proposed assignments or subleases.

~~7.~~8. Insurance. ~~The lessee shall insure the premises, including all buildings and improvements, for the replacement cost of the buildings and improvements, against loss or damage under a policy or policies of fire and extended coverage insurance, including additional perils.~~ Lessees shall maintain adequate insurance, in form and in coverage acceptable to the L~~l~~essor, and shall hold L~~l~~essor harmless, for any liability or damage of any kind arising out of the use of the leased premises as described herein, shall name Lessor as additional insured with respect to their use of the premises, and shall provide Lessor with certificates of insurance evidencing the same~~.~~

~~8.~~9. ~~The L~~lessee~~'~~s' L~~l~~iability. ~~——~~All the L~~l~~essee~~'~~s' personal property~~, including trade fixtures,~~ on the premises shall be kept at the L~~l~~essee~~'~~s' sole risk, and the L~~l~~essor shall not be responsible for any ~~loss of business or other~~ loss or damage, with the exception of liability for the acts of L~~l~~essor's employees and/or agents for which L~~l~~essor is vicariously liable as employer and/or principal.

~~9.~~10. Indemnity. ~~—~~The L~~l~~essees agree~~s~~ to indemnify and defend the L~~l~~essor for any liability, loss, damage, cost or expense (including attorney fees) based on any claim, demand, suit, or action by any party with respect to any personal injury (including death) or property damages, from any cause, with respect to the L~~l~~essees ~~or~~ use of the premises, except for liability resulting from the intentional acts or gross negligence of the L~~l~~essor or its employees, agents, invitees, or ~~business~~ visitors. The L~~l~~essees reserve~~s~~ the right to defend the L~~l~~essor using the services of an attorney of the L~~l~~essee~~'~~s' choice and the L~~l~~essees reserve~~s~~ the right to settle any claim and/or pay damages with respect to any claim, without cost or liability to the L~~l~~essor, in such fashion as the L~~l~~essees deem~~s~~ necessary and reasonable under the circumstances.

~~10.~~11. Notices. ~~——~~Any notices required under this lease shall be in writing and served in person or sent by registered or certified mail, return receipt requested, to the addresses of the parties stated in this lease or to such other addresses as the parties hereto substitute by written notice. Notices shall be effective on the date of the first attempted delivery.

~~11.~~12. ~~The L~~lessee's P~~p~~ossession and E~~e~~njoyment. ~~—~~As long as the L~~l~~essees pay~~s~~ the rent as specified in this lease and performs all its obligations under this lease, the L~~l~~essees may peacefully and quietly hold and enjoy the premises for the terms of this lease.

~~12.~~13. Entire A~~a~~greement. ~~—~~This agreement contains the entire agreement of the parties with respect to its subject matter. This agreement may not be modified except by a written document signed by the parties hereto.

~~13.~~14. Waiver. ~~——~~The failure of the ~~l~~Lessor to enforce any condition of this lease shall not be a waiver of its rights to enforce every condition of this lease. No provision of this lease shall be deemed to have been waived unless the waiver is in writing.

~~14.~~15. Binding E~~e~~ffect. This agreement shall bind and benefit the parties hereto and their successors and permitted assigns.

~~15.~~16. Time is the E~~e~~ssence. Time is the essence in the performance of this lease.

~~16.~~17. Effective E~~d~~ate. This lease shall be effective on the date on which it is executed by the second of the parties hereto.

Lessor _____ Date _____ Lessee Howell Area Parks & Recreation Authority

Date _____ ~~Date~~

_____

_____

By: _____ By: Timothy Church

Title: _____ Title: Director

Lessee Southeastern Livingston County Recreation Authority Date

_____

_____

By: Michael Powers

Title: Director

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Proposal Request For:

Howell Area Parks & Recreation

MI 48843

Presented By:

JOHN P SCHMITZ

BURNHAM & FLOWER AGENCY

Requested Effective Date: 03/01/2022

Renewal Effective Date: 03/01/2022

Quote ID: 361764

Quote Name: Howell Area Parks & Rec

Quote Type: New

Howell Area Parks & Recreation

Total FTE: 3
Total Enrolled: 3
Requested Effective Date: 03/01/2022
Requested Renewal Date: 03/01/2022

Agent Name: JOHN P SCHMITZ
Sponsorship:
Area: D

Location/Subgroup Information:	
Name	All Employees
Address	MI, 48843
ZIP Code	48843
County	Livingston

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Company Name: Howell Area Parks & Recreation
Location/Subgroup: Howell Area Parks & Recreation

Small Group Rates

First Name	Last Name	Relationship	Age	Rating Area	Member	Simply Blue HRA PPO Gold $1500 w/ EA	BDPPO 100/80/50 (80/50/50)	Blue Vision 12-12-12 $5/$10
Christopher	Techentin	1-Employee	30	D	1-Regular	$444.76	$21.51	$5.08
Kimberly	Techentin	2-Spouse	30	D	1-Regular	$444.76	$21.51	$5.08
						$889.52	$43.02	$10.16
Kyle	Tokan	1-Employee	28	D	1-Regular	$425.95	$20.95	$5.05
						$425.95	$20.95	$5.05
Kevin	Troshak	1-Employee	34	D	1-Regular	$475.72	$22.77	$5.25
						$475.72	$22.77	$5.25
Total Monthly Premium						**$1,791.19**	**$86.74**	**$20.46**

First Name	Last Name	Relationship	Age	Rating Area	Member	Blue Vision 12-12-24 $5/$10	Blue Vision 24-24-24 $5/$10
Christopher	Techentin	1-Employee	30	D	1-Regular	$4.61	$3.42
Kimberly	Techentin	2-Spouse	30	D	1-Regular	$4.61	$3.42
						$9.22	$6.84
Kyle	Tokan	1-Employee	28	D	1-Regular	$4.57	$3.39
						$4.57	$3.39
Kevin	Troshak	1-Employee	34	D	1-Regular	$4.75	$3.53
						$4.75	$3.53

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Company Name: Howell Area Parks & Recreation
Location/Subgroup: Howell Area Parks & Recreation

First Name	Last Name	Relationship	Age	Rating Area	Member	Blue Vision 12-12-24 $5/$10	Blue Vision 24-24-24 $5/$10
Total Monthly Premium						**$18.54**	**$13.76**

*We reserve the right to adjust rates if any of the assumptions or calculations used in the quoting process are incorrect. Final rates will be determined based on actual group enrollment and participation.

*Plans and rates are not final until they have been approved by DIFS and CMS.

*Your agent is providing a Summary of Benefits and Coverage with this quote.

*To comply with the Patient Protection and Affordable Care Act, groups may be required to make changes to their health insurance coverage. This may result in an adjustment to the rates.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Company Name: Howell Area Parks & Recreation

Small Group Rate Grid

Age Band	Simply Blue HRA PPO Gold $1500 w/ EA	BDPPO 100/80/50 (80/50/50)	Blue Vision 12-12-12 $5/$10
0	$299.77	$28.56	$0.00
1	$299.77	$28.56	$0.00
2	$299.77	$28.56	$0.00
3	$299.77	$28.56	$0.00
4	$299.77	$28.56	$0.00
5	$299.77	$28.56	$0.00
6	$299.77	$28.56	$0.00
7	$299.77	$28.56	$0.00
8	$299.77	$28.56	$0.00
9	$299.77	$28.56	$0.00
10	$299.77	$28.56	$0.00
11	$299.77	$28.56	$0.00
12	$299.77	$28.56	$0.00
13	$299.77	$28.56	$0.00
14	$299.77	$28.56	$0.00
15	$326.42	$28.56	$0.00
16	$336.61	$28.56	$0.00
17	$346.80	$28.56	$0.00
18	$357.77	$28.56	$0.00
19	$368.74	$19.39	$5.34
20	$380.10	$19.39	$5.34
21	$391.86	$19.39	$5.26
22	$391.86	$19.57	$5.19
23	$391.86	$19.76	$5.14
24	$391.86	$19.98	$5.10
25	$393.43	$20.21	$5.07
26	$401.26	$20.44	$5.05
27	$410.67	$20.67	$5.05
28	$425.95	$20.95	$5.05
29	$438.49	$21.22	$5.06
30	$444.76	$21.51	$5.08
31	$454.17	$21.80	$5.11
32	$463.57	$22.11	$5.15

Age Band	Simply Blue HRA PPO Gold $1500 w/ EA	BDPPO 100/80/50 (80/50/50)	Blue Vision 12-12-12 $5/$10
33	$469.45	$22.44	$5.20
34	$475.72	$22.77	$5.25
35	$478.85	$23.12	$5.30
36	$481.99	$23.49	$5.37
37	$485.12	$23.85	$5.43
38	$488.26	$24.24	$5.50
39	$494.53	$24.65	$5.57
40	$500.80	$25.06	$5.64
41	$510.20	$25.48	$5.72
42	$519.21	$25.93	$5.80
43	$531.75	$26.38	$5.87
44	$547.43	$26.84	$5.95
45	$565.85	$27.33	$6.02
46	$587.79	$27.81	$6.09
47	$612.48	$28.31	$6.16
48	$640.69	$28.84	$6.23
49	$668.51	$29.36	$6.29
50	$699.86	$29.91	$6.35
51	$730.82	$30.47	$6.40
52	$764.91	$31.03	$6.45
53	$799.39	$31.61	$6.49
54	$836.62	$32.21	$6.52
55	$873.85	$32.81	$6.55
56	$914.21	$33.43	$6.56
57	$954.96	$34.07	$6.57
58	$998.46	$34.71	$6.57
59	$1,020.01	$35.37	$6.55
60	$1,063.51	$36.05	$6.53
61	$1,101.13	$36.73	$6.49
62	$1,125.81	$37.43	$6.44
63	$1,156.77	$38.15	$6.38
64	$1,175.58	$38.87	$6.30
65+	$1,175.58	$38.87	$6.21

Age Band	Simply Blue HRA PPO Gold $1500 w/ EA	BDPPO 100/80/50 (80/50/50)	Blue Vision 12-12-12 $5/$10
COMP	$991.20	$38.87	$6.21

*We reserve the right to adjust rates if any of the assumptions or calculations used in the quoting process are incorrect. Final rates will be determined based on actual group enrollment and participation.

*Plans and rates are not final until they have been approved by DIFS and CMS.

Small Group Rate Grid

Age Band	Blue Vision 12-12-24 $5/$10	Blue Vision 24-24-24 $5/$10
0	$0.00	$0.00
1	$0.00	$0.00
2	$0.00	$0.00
3	$0.00	$0.00
4	$0.00	$0.00
5	$0.00	$0.00
6	$0.00	$0.00
7	$0.00	$0.00
8	$0.00	$0.00
9	$0.00	$0.00
10	$0.00	$0.00
11	$0.00	$0.00
12	$0.00	$0.00
13	$0.00	$0.00
14	$0.00	$0.00
15	$0.00	$0.00
16	$0.00	$0.00
17	$0.00	$0.00
18	$0.00	$0.00
19	$4.84	$3.59
20	$4.84	$3.59
21	$4.77	$3.54
22	$4.71	$3.49
23	$4.66	$3.46
24	$4.62	$3.43
25	$4.59	$3.41
26	$4.58	$3.40
27	$4.57	$3.39
28	$4.57	$3.39
29	$4.59	$3.40
30	$4.61	$3.42
31	$4.63	$3.44
32	$4.67	$3.46

Age Band	Blue Vision 12-12-24 $5/$10	Blue Vision 24-24-24 $5/$10
33	$4.71	$3.49
34	$4.75	$3.53
35	$4.81	$3.57
36	$4.86	$3.61
37	$4.92	$3.65
38	$4.98	$3.70
39	$5.05	$3.75
40	$5.11	$3.80
41	$5.18	$3.85
42	$5.25	$3.90
43	$5.32	$3.95
44	$5.39	$4.00
45	$5.46	$4.05
46	$5.52	$4.10
47	$5.58	$4.14
48	$5.65	$4.19
49	$5.70	$4.23
50	$5.75	$4.27
51	$5.80	$4.31
52	$5.84	$4.34
53	$5.88	$4.36
54	$5.91	$4.39
55	$5.93	$4.40
56	$5.95	$4.41
57	$5.95	$4.42
58	$5.95	$4.42
59	$5.94	$4.41
60	$5.91	$4.39
61	$5.88	$4.36
62	$5.84	$4.33
63	$5.78	$4.29
64	$5.71	$4.24
65+	$5.62	$4.17

Age Band	Blue Vision 12-12-24 $5/$10	Blue Vision 24-24-24 $5/$10
COMP	$5.62	$4.17

*We reserve the right to adjust rates if any of the assumptions or calculations used in the quoting process are incorrect. Final rates will be determined based on actual group enrollment and participation.

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Blue Cross Blue Shield of Michigan

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

Company Name: Howell Area Parks & Recreation

Simply Blue[SM] HRA PPO Gold $1500 Medical Coverage with Prescription Drugs
Benefits-at-a-Glance

Effective for groups on their plan year

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

Note: A List of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo.** Select ***Approving covered services***.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals – BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician **must** contact BCBSM to request preauthorization of the drugs. If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

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Blue Cross Blue Shield of Michigan

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Company Name: Howell Area Parks & Recreation

Benefits	In-network	Out-of-network *
Member's responsibility (deductibles, copays, coinsurance and dollar maximums)		
Deductibles	$1,500 for one member $3,000 for the family (when two or more members are covered under your contract) each calendar year	$3,000 for one member $6,000 for the family (when two or more members are covered under your contract) each calendar year Out-of-Network deductible amounts also count toward the in-network deductible.
Flat-dollar copays	• $30 copay for office visits and office consultations with a primary care physician • $50 copay for office visits and office consultations with a specialist • $30 copay for chiropractic services and osteopathic manipulative therapy • $60 copay for urgent care visits • $150 copay for emergency room visits	$150 copay for emergency room visits
Coinsurance amounts (percent copays) **Note**: Coinsurance amounts apply once the deductible has been met.	• 20% of approved amount for most other covered services • 50% of approved amount for bariatric surgery	• 40% of approved amount for most other covered services • 50% of approved amount for bariatric surgery
Annual coinsurance maximums Applies to coinsurance amounts for all covered services – but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drugs cost-sharing amounts	$3,500 for one member $7,000 for the family (when two or more members are covered under your contract) each calendar year	$7,000 for one member $14,000 for the family (when two or more members are covered under your contract) each calendar year
Annual out-of-pocket maximums Applies to deductibles, copays and coinsurance amounts for all covered services – including prescription drugs cost-sharing amounts	$6,350 for one member $12,700 for two or more members each calendar year	$12,700 for one member $25,400 for two or more members each calendar year **Note**: Out-of-network cost-sharing amounts also apply towards the annual in-network and out-of-pocket maximums.
Lifetime dollar maximum	None	None
Preventive care services		
Health maintenance exam Includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note**: Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note**: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening Laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible

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Benefits	In-network	Out-of-network *
Preventive care services		
Prescription contraceptive devices Includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note**: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance. One per member per calendar year.	60% after out-of-network deductible **Note**: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider. One per member per calendar year.
Colonoscopy Routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy **Note**: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance. One per member per calendar year.	60% after out-of-network deductible One per member per calendar year.
Physician office services		

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Benefits	In-network	Out-of-network *
Physician office services		
Office visits Must be medically necessary	• $30 copay for each office visit with a primary care physician • $50 copay for each office visit with a specialist **Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible
Outpatient and home medical care visits Must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations Must be medically necessary	• $30 copay for each office consultation with a primary care physician • $50 copay for each office consultation with a specialist **Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible
Online visits **By physician must be medically necessary.** **Note**: Online visits by a non-BCBSM selected vendor are not covered.	100% (no deductible or copay/coinsurance	60% after out-of-network deductible
Urgent care visits		
Urgent care visits Must be medically necessary	$60 copay per urgent care visit **Note**: Simply Blue applies deductible and coinsurance to office services. Services include diagnostic (including complex), therapeutic and surgery. An office visit copay still applies to the exam. Cost-sharing may not apply if preventive or immunization services are performed during the office visit.	60% after out-of-network deductible
Emergency medical care		
Hospital emergency room	$150 copay per visit (copay waived if admitted)	$150 copay per visit (copay waived if admitted)
Ambulance services Must be medically necessary	80% after in-network deductible	80% after in-network deductible

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Benefits	In-network	Out-of-network *
Diagnostic services		
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible
Maternity services provided by a physician or certified nurse midwife		
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care	80% after in-network deductible	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible
Hospital care		
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note**: Nonemergency services must be rendered in a participating hospital.	80% after in-network deductible Unlimited days	60% after out-of-network deductible Unlimited days
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible
Alternatives to hospital care		
Skilled nursing care Must be in a participating skilled nursing facility	80% after in-network deductible Limited to a maximum of 120 days per member per calendar year	60% after in-network deductible Limited to a maximum of 120 days per member per calendar year
Hospice care	100% (no deductible or copay/coinsurance) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% (no deductible or copay/coinsurance) Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)
Home health care • must be medically necessary • must be provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization – consult with your doctor	80% after in-network deductible	80% after in-network deductible

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Benefits	In-network	Out-of-network *
Surgical services		
Surgery Includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males **Note**: For voluntary sterilizations for females, see “Preventive care services.”	80% after in-network deductible	60% after out-of-network deductible
Elective Abortions	Covered 80% after in-network deductible	Covered 60% after out-ofnetwork deductible
Bariatric surgery	50% after in-network deductible Limited to a lifetime maximum of one bariatric procedure per member.	50% after out-of-network deductible Limited to a lifetime maximum of one bariatric procedure per member.
Human organ transplants		
Specified human organ transplants Must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) In designated facilities only
Bone marrow transplants Must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible
Behavioral Health Services (Mental Health and Substance Use Disorder Treatment)		
Inpatient mental health care and inpatient substance use disorder treatment	80% after in-network deductible Unlimited days	60% after out-of-network deductible Unlimited days
Residential psychiatric treatment facility • covered mental health services must be performed in a residential psychiatric treatment facility • treatment must be preauthorized • subject to medical criteria	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: **• Facility and clinic**	80% after in-network deductible	80% after in-network deductible In participating facilities only
Outpatient mental health care: **• Online visits** **Note**: Online visits by a non-BCBSM selected vendor are not covered	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: **• Physician's office**	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment In approved facilities only	80% after in-network deductible	60% after out-of-network deductible (In-network cost-sharing will apply if there is no PPO network)
Autism spectrum disorders, diagnoses and treatment		

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Benefits	In-network	Out-of-network *
Autism spectrum disorders, diagnoses and treatment		
Applied behavioral analysis (ABA) treatment **When rendered by an approved board-certified behavioral analyst – is covered through age 18 subject to preauthorization.** **Note**: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	80% after in-network deductible	80% after in-network deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited.	60% after out-of-network deductible Physical, speech and occupational therapy with an autism diagnosis is unlimited.
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
Other covered services		
Outpatient Diabetes Management Program (ODMP) **Note**: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	• 80% after in-network deductible for diabetes medical supplies • 100% (no deductible or copay/coinsurance) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Rehabilitative care: **Outpatient physical and occupational therapy**	80% after in-network deductible Limited to a 30-visit maximum per member per calendar year	60% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered. Limited to a 30-visit maximum per member per calendar year
Rehabilitative care: **Chiropractic and osteopathic manipulation**	$30 copay per visit **Limited to a 30-visit maximum per member per calendar year** **Note**: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy	60% after out-of-network deductible **Limited to a 30-visit maximum per member per calendar year** **Note**: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy, occupational therapy, chiropractic services, and osteopathic manipulative therapy
Outpatient speech therapy – when provided for rehabilitative care	80% after in-network deductible Limited to a 30-visit maximum per member per calendar year.	60% after out-of-network deductible Limited to a 30-visit maximum per member per calendar year.

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Benefits	In-network	Out-of-network *
Other covered services		
Habilitative care: **Outpatient physical and occupational therapy (excludes chiropractic and osteopathic manipulation)**	80% after in-network deductible **Limited to a 30-visit maximum per member per calendar year** **Note**: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical and occupational therapy	60% after out-of-network deductible **Note**: Services at nonparticipating outpatient physical therapy facilities are not covered. Limited to a 30-visit maximum per member per calendar year Note: This 30-visit outpatient maximum is a combined maximum for all outpatient visits for physical therapy and occupational therapy.
Outpatient speech therapy - when provided for habilitative care	80% after in-network deductible Limited to a 30-visit maximum per member per calendar year.	60% after out-of-network deductible Limited to a 30-visit maximum per member per calendar year.
Durable medical equipment **Note**: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	Not covered	Not covered

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Prescription Drug Coverage
Benefits-at-a-glance
Effective for groups on their plan year

Prescription Drug Discount Program - Prescription drug manufacturers provide coupon programs for certain medications. Your benefit plan allows you to take advantage of BCBSM-approved coupon programs for select medications. This benefit may lower the cost-sharing typically required for these drugs. Your out-of-pocket expense will be no more than your benefit cost-sharing. When a manufacturer coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.

NOTE: Adjustments may be required to accurately reflect your annual out-of-pocket maximum to reflect your true out-of-pocket cost.

This program may be discontinued at any time if it is no longer supported by the vendor.

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. AllianceRx Walgreens Prime will handle mail order prescriptions only for specialty drugs. You may obtain specialty drugs through a Walgreens retail pharmacy as well as long as the drug is available at that location. You may want to call ahead to confirm availability at the location. ***If you go to a non-AllianceRx Walgreens Prime, you may be responsible for 100% of the cost of the specialty drug.*** Other mail order prescriptions for non-specialty medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a **90-Day Retail Network provider or** mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the initial quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at **bcbsm.com/pharmacy**.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copays and coinsurance amounts, are subject to the **same** annual

out-of-pocket maximum required under your medical coverage. The 25% member liability for covered drugs obtained from an out-of-network pharmacy will **not** contribute to your annual out-of-pocket maximum.

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic drugs	1 to 30-day period	You pay $15 copay	You pay $15 copay	You pay $15 copay	You pay $15 copay plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $30 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $35 copay	No coverage	No coverage

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
	84 to 90-day period	You pay $35 copay	You pay $35 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay $50 copay	You pay $50 copay	You pay $50 copay	You pay $50 copay plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $100 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $140 copay	No coverage	No coverage
	84 to 90-day period	You pay $140 copay	You pay $140 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay $70 or 50% of the approved amount (whichever is greater), but no more than $100	You pay $70 or 50% of the approved amount (whichever is greater), but no more than $100	You pay $70 or 50% of the approved amount (whichever is greater), but no more than $100	You pay $70 or 50% of the approved amount (whichever is greater), but no more than $100 plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $140 or 50% of the approved amount (whichever is greater), but no more than $200	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $200 or 50% of the approved amount (whichever is greater), but no more than $290	No coverage	No coverage
	84 to 90-day period	You pay $200 or 50% of the approved amount (whichever is greater), but no more than $290	You pay $200 or 50% of the approved amount (whichever is greater), but no more than $290	No coverage	No coverage
Tier 4 - Generic and preferred brand-name specialty drugs	1 to 30-day period	You pay 20% of the approved amount, but no more than $200	You pay 20% of the approved amount, but no more than $200	You pay 20% of the approved amount, but no more than $200	You pay 20% of the approved amount, but no more than $200 plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage
Tier 5 - Nonpreferred brand-name specialty drugs	1 to 30-day period	You pay 25% of approved amount, but no more than $300	You pay 25% of approved amount, but no more than $300	You pay 25% of approved amount, but no more than $300	You pay 25% of the approved amount, but no more than $300 plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	No coverage	No coverage	No coverage
	61 to 83-day period	No coverage	No coverage	No coverage	No coverage
	84 to 90-day period	No coverage	No coverage	No coverage	No coverage

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA.	100% of approved amount	No coverage	100% of approved amount	75% of approved amount
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy.	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers

Features of your prescription drug plan

BCBSM Custom Select Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Select Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay for these drugs. • **Tier 4 (generic and preferred brand-name specialty)** - Tier 4 includes covered specialty drugs listed as generic drugs (Tier 1) or preferred brand-name drugs (Tier 2) from the Custom Select Drug List. These drugs have a proven record for safety and effectiveness, and offer the best value to our members. They have the lowest specialty drug copay. • **Tier 5 (nonpreferred brand-name specialty)** - Tier 5 includes covered specialty drugs listed as nonpreferred brand name (Tier 3). These drugs may not have a proven record for safety or their clinical value may not be as high as the specialty drugs in Tier 4. They have the highest specialty drug copay.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Exclusions	The following drugs are not covered: • Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service • State-controlled drugs • Brand-name drugs that have a generic equivalent available • Drugs to treat erectile dysfunction and weight loss • Prenatal vitamins (prescribed and over-the-counter) • Brand-name drugs used to treat heartburn • Compounded drugs, with some exceptions • Cosmetic drugs

Blue Cross Blue Shield of Michigan

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

Vision Coverage (Pediatric)
Benefits-at-a-glance
Effective for groups on their plan year

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

Note: Vision benefits are only available to members up to age 19. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

Member's responsibility (copays)

Benefits	In-network	Out-of-network
Eye exam	None	None
Prescription glasses (lenses and/or frames)	None	None
Medically necessary contact lenses	None	None

Eye exam

Benefits	In-network	Out-of-network
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	100% of approved amount	Reimbursement up to $34 (member responsible for any difference)
	One eye exam per calendar year	

Lenses and Frames

Benefits	In-network	Out-of-network
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
	One pair of lenses, with or without frames, per calendar year	
Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.		
Standard frames from a "select" collection	100% of approved amount	Reimbursement up to $38.25 (member responsible for any difference)
	One frame per calendar year	

Contact Lenses

Benefits	In-network	Out-of-network
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	100% of approved amount	Reimbursement up to $210 (member responsible for any difference)
	Covered - annual supply	
Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply)	100% of approved amount	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Covered according to quantities outlined in your certificate, per calendar year	

Blue Cross Blue Shield of Michigan

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Blue Traditional Medicare Supplemental Coverage SG
Supplemental Care Coverage
Effective Date: On or after January 2021
Benefits-at-a-glance

This is not a Medicare document. It is intended as an easy-to-read summary of many important features of Blue Cross Blue Shield Supplemental health care benefits. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield certificates and riders. For more detailed information on Medicare benefits, please call or visit you local Social Security office or consult the Medicare handbook (available on the Medicare Web site at **medicare.gov** or at any Social Security office)

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

Note: Medicare deductible and coinsurance amounts are effective January 1, 2021 and are subject to change yearly.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Deductible amounts	• **Medicare Part A** $1,484 (for days 1-60) each benefit period • **Medicare Part B** $203 per calendar year	None
Coinsurance/fixed dollar copays	• **Hospital stay** $371 per day (for days 61-90) and $742 per each "lifetime reserve day" after day 90 (up to 60 days over your lifetime) • **Skilled nursing facility stay** (a limit of 100 days each benefit period) $185.50 per day (for days 21-100)	None
Coinsurance/percent copay amounts	• 20% of Medicare approved amount for most general services • 20% of Medicare approved amount for outpatient mental health care	None

Preventive care services

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Health maintenance exam (yearly "Wellness" visit)	Covered at 100% of Medicare approved amount*, once every 12 months **Note:** Your first yearly "Wellness" visit can't take place within 12 months of your enrollment in Part B or your "Welcome to Medicare" preventive visit.	Covered in full by Medicare; no additional coverage by BCBSM

Gynecological exam	Covered at 100% of Medicare approved amount*, once every 24 months	When **not** covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Pap smear screening - laboratory services only	Covered at 100% of Medicare approved amount*, once every 24 months (more frequently if at high risk)	When **not** covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year
Voluntary sterilizations for females	Not covered **Note:** Medicare covers voluntary sterilization if it's necessary for the treatment of an illness or injury.	Covered at 100% of BCBSM approved amount
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	Not covered	Covered at 100% of BCBSM approved amount
Contraceptive injections - includes cost of medication when provided by the physician	Not covered	Covered at 100% of BCBSM approved amount
Screening fecal occult blood test	Covered at 100% of Medicare approved amount*, once every 12 months, if age 50 and older	When **not** covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening flexible sigmoidoscopy	Covered at 100% of Medicare approved amount*, once every 48 months, if age 50 and older, or every 120 months after a previous screening colonoscopy for those not at high risk	When **not** covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Prostate specific antigen (PSA) test	Covered at 100% of Medicare approved amount*, once every 12 months, if over age 50 **Note:** A digital rectal exam is covered at 80% of Medicare approved amount less Part B deductible	When **not** covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Flu shots	Covered at 100% of Medicare approved amount*, one flu shot per flu season	Covered in full by Medicare; no additional coverage by BCBSM
Hepatitis B shots - for those at medium or high risk for Hepatitis B	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Pneumococcal shot	Covered at 100% of Medicare approved amount*	Covered in full by Medicare; no additional coverage by BCBSM
Mammography screening	Covered at 100% of Medicare approved amount*, once every 12 months at age 40 and older (one baseline mammogram for women between ages 35 and 39)	When **not** covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year, no age restrictions
Screening colonoscopy	Covered at 100% of Medicare approved amount*, once every 120 months (high risk every 24 months) or every 48 months after a previous flexible sigmoidoscopy	When **not** covered by Medicare - covered at 100% of BCBSM approved amount, one per member per calendar year

Well-baby and child care visits	One health maintenance exam covered at 100% of Medicare approved amount* every 12 months, subsequent well-baby and child care visits not covered	Covered at 100% of BCBSM approved amount • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act and not covered by Medicare	Not covered	Covered at 100% of BCBSM approved amount

* Under Medicare coverage, you pay nothing for these services if the doctor or other qualified health care provider accepts assignment. You may be required to pay 20 percent of the Medicare approved amount for the doctor's visit.

Physician office services

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Office visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Outpatient and home visits	Covered at 80% of Medicare approved amount less Part B deductible	Not covered
Office consultations	Covered at 80% of Medicare approved amount less Part B deductible	Not covered

Emergency medical care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital emergency room (facility services) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Ambulance services - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

Clinical laboratory services

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Laboratory and pathology tests - used in the diagnosis and treatment of an illness or injury	Covered at 100% of Medicare approved amount for most diagnostic laboratory and pathology services (covered at 80% of approved amount for certain laboratory services)	Covered in full by Medicare

Hospital care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies - **does not** include private duty nursing • Days 1-60 of each benefit period	Covered at 100% of Medicare approved amount less Part A deductible (also includes inpatient mental health and residential substance use disorder)	Covers Medicare deductible
• Days 61-90 of each benefit period	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
• Lifetime reserve days after day 90 of each benefit period (up to 60 days over your lifetime)	Covered at 100% of Medicare approved amount less Part A daily coinsurance	Covers Medicare daily coinsurance
• Additional days	Not covered	Covered at BCBSM approved amount, up to an additional 275 days
Chemotherapy	Covered at 80% of Medicare approved amount for administration and drugs, must meet Medicare criteria	Covers Medicare deductible and coinsurance

Alternatives to hospital care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Skilled nursing facility care - subject to medical criteria • Days 1-20 of each benefit period	Covered at 100% of Medicare approved amount	Covered in full by Medicare
• Days 21-100 of each benefit period	Covered at 100% of Medicare approved amount less daily coinsurance	Covers Medicare coinsurance
• Days 101 and after	Not covered	Not covered
Hospice care	Covered at Medicare approved amount less small copayment for outpatient prescription drugs and less small coinsurance for inpatient respite care	Covers limited costs not covered by Medicare
Home health care services - must be medically necessary and must be provided by a **Medicare-certified** home health agency	Covered at 100% of Medicare approved amount	Covered in full by Medicare

Surgical services provided by a physician

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Surgery - includes related surgical services	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance

Human organ transplants

Note: Payment is based on medical necessity and must be rendered in an approved facility.

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Heart and liver transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance

Lung and heart-lung transplants	Covered at 80% of Medicare approved amount less deductible	Covers Medicare deductible and coinsurance
Pancreas transplants	Not covered **Note:** Pancreas transplants are covered under certain conditions. Please call Medicare for more information.	Not covered **Note:** Covers Medicare deductible and coinsurance when covered by Medicare
Bone marrow transplants - under certain conditions	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance
Kidney, cornea and skin transplants	Covered at 80% of Medicare approved amount less deductible (Please call Medicare for more information.)	Covers Medicare deductible and coinsurance

Mental health care

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Inpatient mental health care in psychiatric facility • Days 1-190 **lifetime**	See "Hospital care" benefits (Medicare pays the claim as part of your regular Part A hospital coverage, subject to Part A deductible and coinsurance) **Note:** In most cases, psychiatric care in general (as opposed to psychiatric) hospitals is not subject to the 190-day limit.	Covers Medicare deductible and daily coinsurance
• Additional days after 190 lifetime days are used	Not covered	Not covered
Outpatient mental health care	Covered at 80% of Medicare approved amount less Part B deductible **Note:** If you get your services in a hospital outpatient clinic, or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital.	Covers Medicare deductible and coinsurance

Other covered services

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Allergy testing and therapy - with approved diagnosis	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance for testing. Injections are not covered.
Chiropractic services (limited coverage) - must be medically necessary	Covered at 80% of Medicare approved amount less Part B deductible **Note:** You pay all costs for noncovered services or tests ordered by a chiropractor (including x-rays and massage therapy).	Not covered

Outpatient physical, speech and occupational therapy	Covered at 80% of Medicare approved amount less Part B deductible **Note:** There may be a limit on the amount Medicare will pay for these services in a single year and there may be certain exceptions to these limits.	Covers Medicare deductible and coinsurance or set copayment
Durable medical equipment - must be obtained from a Medicare-approved supplier	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Prosthetic appliances	Covered at 80% of Medicare approved amount less Part B deductible	Covers Medicare deductible and coinsurance
Private duty nursing	Not covered	Not covered
Oral cancer drugs	Approved drugs are covered	Covered in full by Medicare

Foreign travel

Benefits	Original Medicare coverage	Medicare Supplemental coverage
Hospital services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount, up to 30 days for covered services
Physician services	Not covered, except as specified in the Medicare handbook	Covered at BCBSM approved amount

Blue Traditional Medicare Supplemental Coverage SG
Supplemental Care Coverage
Effective Date: On or after January 2021
Benefits-at-a-glance

Prescription Drug Discount Program - Prescription drug manufacturers provide coupon programs for certain medications. Your benefit plan allows you to take advantage of BCBSM-approved coupon programs for select medications. This benefit may lower the cost-sharing typically required for these drugs. Your out-of-pocket expense will be no more than your benefit cost-sharing. When a manufacturer coupon is used, only the amount you paid for the prescription will apply towards your annual out-of-pocket maximum.

NOTE: Adjustments may be required to accurately reflect your annual out-of-pocket maximum to reflect your true out-of-pocket cost.

This program may be discontinued at any time if it is no longer supported by the vendor.

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is AllianceRx Walgreens Prime, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. AllianceRx Walgreens Prime will handle mail order prescriptions only for specialty drugs. You may obtain specialty drugs through a Walgreens retail pharmacy as well as long as the drug is available at that location. You may want to call ahead to confirm availability at the location. ***If you go to a non-AllianceRx Walgreens Prime, you may be responsible for 100% of the cost of the specialty drug.*** Other mail order prescriptions for non-specialty medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call AllianceRx Walgreens Prime customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a **90-Day Retail Network provider or** mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the initial quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply. The controlled substances affected by this prescription drug requirement are available online at **bcbsm.com/pharmacy**.

Member's responsibility (copays and coinsurance amounts)

Note: The 25% member liability for covered drugs obtained from an out-of-network pharmacy will **not** contribute to your annual out-of-pocket maximum.

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Out-of-pocket maximum	$7,150 per member, $14,300 family (two or more members), per calendar year for all covered prescription drugs obtained from in-network retail pharmacies and BCBSM's approved mail order provider			

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic drugs	1 to 30-day period	You pay $10 copay	You pay $10 copay	You pay $10 copay	You pay $10 copay plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $20 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $20 copay	No coverage	No coverage
	84 to 90-day period	You pay $20 copay	You pay $20 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay $40 copay	You pay $40 copay	You pay $40 copay	You pay $40 copay plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $80 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $110 copay	No coverage	No coverage
	84 to 90-day period	You pay $110 copay	You pay $110 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay $80 copay	You pay $80 copay	You pay $80 copay	You pay $80 copay plus an additional 25% of the BCBSM approved amount for the drug
	31 to 60-day period	No coverage	You pay $160 copay	No coverage	No coverage
	61 to 83-day period	No coverage	You pay $230 copay	No coverage	No coverage
	84 to 90-day period	You pay $230 copay	You pay $230 copay	No coverage	No coverage

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved **generic** and **select brand name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA.	100% of approved amount	No coverage	100% of approved amount	75% of approved amount
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs and devices are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
Select diabetic supplies and devices (test strips, lancets and glucometers) For a list of diabetic supplies available under the pharmacy benefit refer to your BCBSM drug list at BCBSM.com/pharmacy.	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers

Features of your prescription drug plan

BCBSM Custom Select Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Select Drug List. Preferred brand-name drugs are also safe and effective, but require a higher copay. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay for these drugs.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. **Step Therapy**, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at **bcbsm.com/pharmacy**.

Features of your prescription drug plan

Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.
Exclusions	The following drugs are not covered: • Over-the-counter drugs and drugs with comparable OTC counterparts (e.g., antihistamines, cough/cold and acne treatment) unless deemed an Essential Health Benefit or not considered a covered service • State-controlled drugs • Brand-name drugs that have a generic equivalent available • Drugs to treat erectile dysfunction and weight loss • Prenatal vitamins (prescribed and over-the-counter) • Brand-name drugs used to treat heartburn • Compounded drugs, with some exceptions • Cosmetic drugs

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Blue Traditional Medicare Supplemental Coverage SG
Supplemental Care Coverage
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Benefits-at-a-glance

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com**.

Note: Vision benefits are only available to members up to age 19. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

Member's responsibility (copays)

Benefits	In-network	Out-of-network
Eye exam	None	None
Prescription glasses (lenses and/or frames)	None	None
Medically necessary contact lenses	None	None

Eye exam

Benefits	In-network	Out-of-network
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	100% of approved amount	Reimbursement up to $34 (member responsible for any difference)
	One eye exam per calendar year	

Lenses and Frames

Benefits	In-network	Out-of-network
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary	100% of approved amount	Reimbursement up to approved amount based on lens type (member responsible for any difference)
	One pair of lenses, with or without frames, per calendar year	

Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.

104080RX90MO3XS;ADM MOS816 RX;ADM MOS816 VIS;BC-COMP;BS 65 OPTION 1;BV-PEDS;CMS SG;GCP-D;GPC-SAT 2;GPC-SAT-MHP-2;HCR MS PCB;HCR-MS-WCB-ECS;PDRX SG;RX-MC-ESN SG;RX-MC-VCP SG

Standard frames from a "select" collection	100% of approved amount	Reimbursement up to $38.25 (member responsible for any difference)
	One frame per calendar year	

Contact Lenses

Benefits	In-network	Out-of-network
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	100% of approved amount	Reimbursement up to $210 (member responsible for any difference)
	Covered - annual supply	
Standard (one pair annually) • Monthly (six-month supply) • Bi-weekly (three-month supply) • Dailies (three-month supply)	100% of approved amount	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Covered according to quantities outlined in your certificate, per calendar year	

Blue Cross Blue Shield of Michigan

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Company Name: Howell Area Parks & Recreation

Blue Dental[SM] PPO 100/80/50 (80/50/50) SG Non-voluntary $1,250 ($800) annual maximum

Benefits-at-a-Glance

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Network access information
With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll have the greatest coverage and savings when they choose a dentist who is a member of the Blue Dental PPO network.[1]

Blue Dental PPO network – Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations[2] nationwide. PPO dentists agree to accept our approved amount as full payment for covered services – members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on noncovered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **mibluedentist.com** or call **1-888-826-8152.**

[1] *Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.*
[2] *A dentist location is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two offices would be two dentist locations.*

Members who go to non-PPO dentists can still save money through our Blue Par Select arrangement.

Blue Par Select[SM] arrangement – Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services – members pay only applicable coinsurance and deductibles. To find a dentist who may participate with BCBSM, please visit **mibluedentist.com.**

Note: Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

Member's responsibility (deductible, copays and dollar maximums)

Benefits	In-network	Out-of-network
Deductibles Applies to Class II and Class III services only	$25 per member, $50 for two members, $75 per family per calendar year	$50 per member, $100 for two members, $150 per family per calendar year
Coinsurance (percentage of BCBSM's approved amount for covered services)		
Class I services	None (covered at 100%)	20%
Class II services	20%	50%
Class III services	50%	50%
Class IV services	Not Covered	Not Covered
Dollar Maximums		

Blue Cross Blue Shield of Michigan

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Company Name: Howell Area Parks & Recreation

Member's responsibility (deductible, copays and dollar maximums)

Benefits	In-network	Out-of-network
Annual maximum for Class I, II and III services	Combined $1,250 per non-pediatric member Per calendar year (no more than $800 of this amount can be used for services rendered by non-PPO dentists). The annual benefit maximum does not apply to pediatric members.	Combined $1,250 per non-pediatric member Per calendar year (no more than $800 of this amount can be used for services rendered by non-PPO dentists). The annual benefit maximum does not apply to pediatric members.
Lifetime maximum for Class IV services	Not covered For members up to their 19th birthday if ortho selected.	Not covered For members up to their 19th birthday if ortho selected.
Out-of-pocket maximum The maximum out-of-pocket expense pediatric members will pay in a calendar year for deductible and coinsurance amounts applied to most covered in-network dental services. The out-of-pocket maximum does not apply to charges that exceed our approved PPO fee, services provided by non-PPO dentists, non-covered services, or orthodontic services.	$350 for one pediatric member or $700 for two or more pediatric members per calendar year. There is no out-of-pocket maximum for non-pediatric members. **Note**: This out-of-pocket maximum is separate from the annual out-of-pocket maximum that applies under your hospital and medical coverage (if any).	Not Applicable

Plan's responsibility

The plan’s responsibility is subject to a review of the reported diagnosis, dental necessity verification and the availability of dental benefits at the time the claim is processed, as well as the conditions, exclusions and limitations, and deductible and coinsurance requirements under the applicable BCBSM certificates and riders.

Class I services

Benefits	In-network	Out-of-network
Most Diagnostic and preventive services:		
Routine oral examinations/evaluations – twice per calendar year	100% of approved amount	80% of approved amount
Routine prophylaxes (cleanings) – three times per calendar year for pediatric members; two times per calendar year for all other members	100% of approved amount	80% of approved amount
Fluoride treatment or topical application of fluoride - twice every calendar year for members to the end of the month of their 19th birthday	100% of approved amount	80% of approved amount

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Company Name: Howell Area Parks & Recreation

Class I services

Benefits	In-network	Out-of-network
Sealants - once per first permanent molar every 36 months for members to the end of the month of their ninth birthday; once per second permanent molar every 36 months for members to the end of the month of their 14th birthday	100% of approved amount	80% of approved amount
Bitewing X-rays One set (up to four films) per calendar year	100% of approved amount	80% of approved amount
Oral brush biopsy sample collection Twice per calendar year	100% of approved amount	80% of approved amount

Class II services

Benefits	In-network	Out-of-network
Other diagnostic and preventive services:		
Diagnostic tests and laboratory examinations	80% of approved amount after deductible	50% of approved amount after deductible
Space maintainers - for missing posterior primary teeth for members to the end of the month of their 15th birthday	80% of approved amount after deductible	50% of approved amount after deductible
Panoramic or full-mouth X-rays Once per 60 months	80% of approved amount after deductible	50% of approved amount after deductible
Emergency palliative treatment	80% of approved amount after deductible	50% of approved amount after deductible
Minor restorative services:		
Amalgam and resin-based composite fillings and fillings of similar materials – once per tooth and surface per 48 months for permanent teeth; once per tooth and surface per 24 months for primary teeth	80% of approved amount after deductible	50% of approved amount after deductible
Recementation or repair of posts, crowns, veneers, inlays and onlays – three times per tooth per calendar year	80% of approved amount after deductible	50% of approved amount after deductible
Extractions and surgical removal of non-impacted teeth	80% of approved amount after deductible	50% of approved amount after deductible
Non-surgical endodontic services:		
Root canal treatments – once per tooth per lifetime (retreatment of a root canal 12 or more months after the initial root canal treatment is payable once per tooth per lifetime)	80% of approved amount after deductible	50% of approved amount after deductible
Therapeutic pulpotomies or pulpal debridement	80% of approved amount after deductible	50% of approved amount after deductible
Vital pulpotomies on primary teeth	80% of approved amount after deductible	50% of approved amount after deductible
Apexification	80% of approved amount after deductible	50% of approved amount after deductible
Non-surgical periodontic services:		
Periodontal maintenance – three times per calendar year in place of routine dental prophylaxis for pediatric members; two times per calendar year in place of routine dental prophylaxis for all other members	80% of approved amount after deductible	50% of approved amount after deductible

Company Name: Howell Area Parks & Recreation

Class II services

Benefits	In-network	Out-of-network
Periodontal scaling and root planing – once per quadrant per 24 months for pediatric members; once per quadrant per 36 months for all other members	80% of approved amount after deductible	50% of approved amount after deductible
Localized delivery of antimicrobial agents – one surface per tooth and three teeth per quadrant with a maximum of 12 teeth per year for non-pediatric members only	80% of approved amount after deductible	50% of approved amount after deductible
Limited occlusal adjustments – up to five times per 60 months for non-pediatric members only	80% of approved amount after deductible	50% of approved amount after deductible
Occlusal biteguards (and relines and repairs to occlusal biteguards) – once per 60 months for non-pediatric members only	80% of approved amount after deductible	50% of approved amount after deductible
Adjustments, repairs, relines, rebases and tissue conditioning for removable prosthetic appliances:		
Relines or rebases of partial dentures or complete dentures – once per 36 months per arch	80% of approved amount after deductible	50% of approved amount after deductible
Tissue conditioning – once per 36 months per arch	80% of approved amount after deductible	50% of approved amount after deductible
Adjunctive general services:		
General anesthesia or IV sedation	80% of approved amount after deductible	50% of approved amount after deductible
Office visits for observation (during regularly scheduled hours) for non-pediatric members only	80% of approved amount after deductible	50% of approved amount after deductible
Office visits after regularly scheduled hours	80% of approved amount after deductible	50% of approved amount after deductible
House and hospital calls for non-pediatric members only	80% of approved amount after deductible	50% of approved amount after deductible
Antibiotic injections for non-pediatric members only	80% of approved amount after deductible	50% of approved amount after deductible

Class III services

Benefits	In-network	Out-of-network
Major restorative services:		
Onlays, crowns and veneers – once per permanent tooth per 60 months for members age 12 and older only	50% of approved amount after deductible	50% of approved amount after deductible
Substructures, including cores and posts	50% of approved amount after deductible	50% of approved amount after deductible
Oral surgery services other than extractions of non-impacted teeth:		
Surgical exposure and facilitation of eruption of unerupted teeth	50% of approved amount after deductible	50% of approved amount after deductible
Incision and drainage of cellulitis or fascial space abscesses of intraoral soft tissue	50% of approved amount after deductible	50% of approved amount after deductible
Removal of exostoses (excess bony growths of the upper and lower jaw)	50% of approved amount after deductible	50% of approved amount after deductible

Company Name: Howell Area Parks & Recreation

Class III services

Benefits	In-network	Out-of-network
Excision of hyperplastic tissue per arch	50% of approved amount after deductible	50% of approved amount after deductible
Soft tissue biopsies for pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Frenulectomies	50% of approved amount after deductible	50% of approved amount after deductible
Surgical endodontic services:		
Apical surgeries on permanent teeth	50% of approved amount after deductible	50% of approved amount after deductible
Surgical periodontic services:		
Gingivectomies and gingivoplasties	50% of approved amount after deductible	50% of approved amount after deductible
Osseous surgeries for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Gingival flap procedures	50% of approved amount after deductible	50% of approved amount after deductible
Soft tissue grafts	50% of approved amount after deductible	50% of approved amount after deductible
Bone replacement grafts for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible
Prosthodontic services:		
Complete dentures – once per 84 months	50% of approved amount after deductible	50% of approved amount after deductible
Removable partial dentures and fixed partial dentures (bridges), including abutment crowns and pontics – once per 84 months for members age 16 and older only	50% of approved amount after deductible	50% of approved amount after deductible
Recementation and repairs of bridges	50% of approved amount after deductible	50% of approved amount after deductible
Stayplates to replace recently extracted permanent anterior (front) teeth	50% of approved amount after deductible	50% of approved amount after deductible
Endosteal implants and implant-related services – once per tooth per lifetime for teeth numbered 2 through 15 and 18 through 31 for non-pediatric members only	50% of approved amount after deductible	50% of approved amount after deductible

Class IV services – Orthodontic services for dependents under age 19

Benefits	In-network	Out-of-network
Orthodontics and related services	Not Covered	Not Covered

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Blue Vision℠ SG, VSP Choice Network 12/12/12 $5/$10 Copay
Vision Coverage
Benefits-at-a-glance
Effective for groups on their plan year

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Note: Vision benefits are only available to covered members (subscribers, spouses and dependent children) age 19 and older. Members may choose between prescription glasses (lenses and frame) **or** contact lenses, but not both.

Member's responsibility (copays)

Benefits	In-network	Out-of-network
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay
Medically necessary contact lenses	$10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay

Eye exam

Benefits	In-network	Out-of-network
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $34 less $5 copay (member responsible for any difference)
	One eye exam every calendar year	

Lenses and Frames

Benefits	In-network	Out-of-network
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note:** Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	$10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $10 copay (member responsible for any difference)
	One pair of lenses, with or without frames, once every calendar year	

Benefits	In-network	Out-of-network
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to $38.25 less $10 copay (member responsible for any difference)
	One frame every calendar year	

Contact Lenses

Benefits	In-network	Out-of-network
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$10 copay	Reimbursement up to $210 less $10 copay (member responsible for any difference)
	One pair of contact lenses once every calendar year	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Contact lenses are covered up to allowance once every calendar year	

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Member's responsibility (copays)

Benefits	In-network	Out-of-network
Eye exam	$5 copay	$5 copay applies to charge
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Eye exam

Benefits	In-network	Out-of-network
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $34 less $5 copay (member responsible for any difference)
	One eye exam every calendar year	

Lenses and Frames

Benefits	In-network	Out-of-network
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note:** Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	$10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $10 copay (member responsible for any difference)
	One pair of lenses, with or without frames, every calendar year	

Benefits	In-network	Out-of-network
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to $38.25 less $10 copay (member responsible for any difference)
	One frame every 2 calendar years	

Contact Lenses

Benefits	In-network	Out-of-network
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$10 copay	Reimbursement up to $210 less $10 copay (member responsible for any difference)
	One pair of contact lenses every calendar year	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Contact lenses are covered up to allowance every calendar year	

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Member's responsibility (copays)

Benefits	In-network	Out-of-network
Eye exam	$5 copay	$5 copay applies to charge
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Medically necessary contact lenses	$10 copay	Member responsible for difference between approved amount and provider's charge, after $10 copay

Eye exam

Benefits	In-network	Out-of-network
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $34 less $5 copay (member responsible for any difference)
	One eye exam every 2 calendar years	

Lenses and Frames

Benefits	In-network	Out-of-network
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. **Note:** Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	$10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $10 copay (member responsible for any difference)
	One pair of lenses, with or without frames, every 2 calendar years	

Benefits	In-network	Out-of-network
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $10 copay (one copay applies to **both** lenses and frames)	Reimbursement up to $38.25 less $10 copay (member responsible for any difference)
	One frame every 2 calendar years	

Contact Lenses

Benefits	In-network	Out-of-network
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$10 copay	Reimbursement up to $210 less $10 copay (member responsible for any difference)
	One pair of contact lenses every 2 calendar years	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
	Contact lenses are covered up to allowance every 2 calendar years	

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Howell Area Parks & Recreation

Simply Blue HRA PPO Gold $1500 w/ EA

Coverage for: Individual/Family | **Plan Type:** PPO

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

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

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall deductible?	$1,500 Individual/ $3,000 Family	$3,000 Individual/ $6,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at (https://www.healthcare.gov/coverage/preventive-care-benefits/).
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan? (May include a coinsurance maximum)	$6,350 Individual/ $12,700 Family	$12,700 Individual/ $25,400 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, any pharmacy penalty and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See (http://www.bcbsm.com) or call the number on the back of your BCBSM ID card for a list of network providers.		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.		You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/office visit; deductible does not apply	40% coinsurance	None
	Specialist visit	$50 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/ screening/ immunization	No Charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	May require preauthorization

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com/druglists	Generic drugs	$15 copay/prescription for retail 30-day supply; $35 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% coinsurance of the approved amount for the drug; deductible does not apply	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network. Select diabetic supplies and devices may be covered under the prescription drug program.
	Preferred brand-name drugs	$50 copay/prescription for retail 30-day supply; $140 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% coinsurance of the approved amount for the drug; deductible does not apply	
	Nonpreferred brand-name drugs	$70 copay/prescription or 50% coinsurance of the approved amount (whichever is greater), but no more than $100 for retail 30-day supply; $200 copay/prescription or 50% coinsurance of the approved amount (whichever is greater), but no more than $290 copay/prescription for retail or mail order 90-day supply; deductible does not apply	In-Network copay plus an additional 25% coinsurance of the approved amount for the drug; deductible does not apply	
	Generic and preferred brand-name specialty drugs	20% coinsurance of the approved amount, but no more than $200 copay/prescription for retail or mail order 30-day supply; deductible does not apply	In-Network copay plus an additional 25% coinsurance of the approved amount for the drug. Generics excluded from deductible.	Preauthorization is required. Specialty drugs limited to a 15 or 30-day supply. Pharmacy Specialty drugs obtained from other than an Exclusive Specialty Pharmacy Network provider will not be covered.
	Nonpreferred brand-name specialty drugs	25% coinsurance of the approved amount, but no more than $300 copay/prescription for retail or mail order 30-day supply; deductible does not apply	In-Network copay plus an additional 25% coinsurance of the approved amount for the drug; deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay/visit; deductible does not apply	$150 copay/visit; deductible does not apply	Copay waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	Mileage limits apply
	Urgent care	$60 copay/visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required
	Physician/surgeon fee	20% coinsurance	40% coinsurance	50% coinsurance after deductible for bariatric surgery
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	20% coinsurance	20% coinsurance for mental health; 40% coinsurance for substance use disorder	Your cost share may be different for services performed in an office setting
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	Prenatal: No Charge; deductible does not apply Postnatal: 20% coinsurance	Prenatal: 40% coinsurance Postnatal: 40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services cost share may apply. Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Physician certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical and Occupational Therapy is limited to a combined maximum of 30 visits per member, per calendar year; Speech Therapy is limited to a maximum of 30 visits per member, per calendar year.
	Habilitation services	20% coinsurance for Applied Behavioral Analysis; 20% coinsurance for Physical, Speech and Occupational Therapy	20% coinsurance for Applied Behavioral Analysis; 40% coinsurance for Physical, Speech and Occupational Therapy	Applied behavioral analysis (ABA) treatment for Autism - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization. 30 visits/year, Includes physical therapy and occupational therapy. 30 visits/year, Includes speech therapy.
	Skilled nursing care	20% coinsurance	20% coinsurance	Preauthorization is required. Limited to 120 days per member per calendar year
	Durable medical equipment	20% coinsurance	40% coinsurance	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
	Hospice services	No Charge; deductible does not apply	No Charge; deductible does not apply	Physician certification required. Visit limits apply.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	Children's eye exam	No Charge; deductible does not apply	You are responsible for the difference between the BCBSM approved amount and the amount charged by the provider.	Limited to once in a calendar year for members up to the age of 19
	Children's glasses	No Charge; deductible does not apply	You are responsible for the difference between the BCBSM approved amount and the amount charged by the provider.	Frames (chosen from a select collection) and lenses are covered once in a calendar year for members up to the age of 19.
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

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

- Acupuncture treatment
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See http://provider.bcbs.com
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov or by calling the number on the back of your BCBSM ID card. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross® and Blue Shield® of Michigan by calling the number on the back of your BCBSM ID card.

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

Does this plan provide Minimum Essential Coverage? **Yes**

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

Does this plan meet Minimum Value Standards? **Yes**

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

Language Access Services: **See Addendum**

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

About these Coverage Examples:

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

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

The plan's overall deductible	$1,500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,270**

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

The plan's overall deductible	$1,500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

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

The plan's overall deductible	$1,500
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$300
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,870**

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

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

ADDENDUM – LANGUAGE ACCESS SERVICES and NON-DISCRIMINATION

We speak your language

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

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

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

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

ܐܢ ܐܢܬܘܢ، ܝܢ ܚܕ ܦܪܨܘܦܐ ܕܡܥܘܕܪܝܬܘܢ ، ܡܣܢܩܝܢ ܠܗܘܢ ܠܥܘܕܪܢܐ، ܐܝܬܠܘܢ ܙܕܩܘܬܐ ܠܡܩܒܠܬܐ ܕܥܘܕܪܢܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟܘܢ ܡܢ ܓܘ ܕܡܐ. ܠܡܡܠܠܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܕܫܡܫܬܐ ܕܥܡܝܠܐ ܥܠ ܣܛܪܐ ܕܟܪܛܝܣܟܘܢ ܝܢ 877-469-2583 TTY:711 ܐܢ ܠܐ ܗܘܝܬܘܢ ܗܕܡܐ.

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

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

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

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

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

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

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

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

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

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

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

Important disclosure

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

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

Quote Census

Name	Birth Date	Dependents Enrolling?	Relationship to Employee	Member Type	Status
Christopher Techentin	03/10/1991	Yes	Employee	Regular	Enrolling
Kimberly Techentin	03/19/1991	No	Spouse	Regular	Enrolling
Kyle Tokan	07/30/1993	No	Employee	Regular	Enrolling
Kevin Troshak	04/07/1987	No	Employee	Regular	Enrolling

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Medical Loss Ratio Reporting & Enrollment Attestation

Federal Tax Id ☐☐ - ☐☐☐☐☐☐☐

Customer name	Customer contact email	Renewal date	Effective date

Common control

Do you have multiple employer groups or common control? ☐ Yes ☐ No

If yes, please provide a letter from your group's CPA or tax attorney (on his or her letterhead) certifying that your companies meet the Internal Revenue Service definition of a controlled group, the relationship between the companies along with percentage of ownership for each company.

Where the rebate should be mailed, if applicable:

☐ Current company mailing address ☐ Other mailing address

Street address

City State Zip

Sole proprietor status: Please check one of the following:

- ☐ I am not a sole proprietor or a sole shareholder.
- ☐ I am a partnership with no employees.
- ☐ I am a sole proprietor or a sole shareholder **AND:**

Must check one of the following if a sole proprietor or sole shareholder

- ☐ My employees **are** enrolled in medical health care coverage that I sponsor.
- ☐ My employees **are not** enrolled in medical health care coverage that I sponsor.

Group Health Plan Type. Your group health plan status will fall into one of the following three options. Please check the appropriate option. If you are an ERISA-exempt church plan (as described below) you must also choose one of the rebate distribution options:

- ☐ My group health plan is an employee benefit plan established or maintained by an employer or an employee organization (such as a union). I am not a sole
- ☐ My group's health plan is a nonfederal government plan. (i.e. states, municipalities, special districts, such as: school districts, park districts, and airport districts.)
- ☐ My group's health plan is an ERISA-exempt church plan (i.e. church plan, a convention or an association of churches) **AND:**

Must check one of the following if ERISA-exempt

- ☐ Rebate will be sent to the group. The plan agrees to use any rebate issued for the benefit of the group health plan subscribers.
- ☐ Rebate will be sent to the plan subscribers. The plan does not agree to use any rebate issued for the benefit of the group health plan subscribers.

Note:

If an option is not selected from the rebate distribution options above, any rebates will be sent directly to the enrollees of the group health plan covered by the policy during the Medical Loss Ratio reporting year. Each enrollee will receive an equal share without regard to how much each enrollee actually paid towards premiums.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Medical Loss Ratio Reporting & Enrollment Attestation(continued)

Federal Tax Id ☐☐ - ☐☐☐☐☐☐☐

Most recently completed calendar year ☐☐☐☐

Employee count information

FTE employee count	☐☐☐	Number of ineligible part-time employees	☐☐☐	Number of ineligible seasonal employees	☐☐☐	Number of eligible employees in Michigan	☐☐☐	Number of eligible employees outside of Michigan	☐☐☐		
MLR employee count[1]	☐☐☐	Number of employees chosing no coverage	☐☐☐	Number of employees not offered coverage	☐☐☐	Number of employees covered by an individual health plan	☐☐☐	Number of employees covered by another group health plan through a spouse, another employer, or retirement plan	☐☐☐		

[1] Provide the average number of active (nonretiree) employees in your company on business days during the most recently completed calendar year.

Current Health Carriers offered to employees

List all health carriers that are offered to your employees and the number of medical contracts enrolled in each.

Carrier	Number of active medical enrolling	Number of active dental enrolling	Number of active vision enrolling	Number of retirees enrolling	Number of cobra enrolling
Blue Cross Blue Shield of MI	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐
Blue Care Network of MI	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐
	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐

- BCBSM/BCN will distribute any applicable rebates in good faith based on this attestation. Blue Cross and BCN will be held harmless for any losses that result from action taken based on this group attestation.
- I certify that the group does not provide any contribution or reimbursement of premiums for employees enrolled in an individual plan through Blue Cross, BCN, Health Insurance Marketplace, or other carrier.
- I certify that the employees indicated above who are waiving coverage are not enrolled in other coverage that the group offers to its employees.
- I attest that the employee counts provided above and the group health plan information are complete and accurate and maintain records to support this and will be able to provide the documentation at the request of Blue Cross or BCN Underwriting.
- I am authorized by _____ sponsor of the group health plan described above. I attest that the employee counts provided above and the group health plan information are complete and accurate.

Submitted by	Signature	Title	Date
_____	_____	_____	_____

Summary of Accounts

@XXXXXXXXXXX@936	Money Market Public Funds	49,605.53
@XXXXXXXXXXX@138	Public Funds HY DDA	205,258.95
@XXXXXXXXXXX@204	Savings Non-Consumer	22,641.31
Total		277,505.79

Checking Accounts

Public Funds HY DDA

Account Number	@XXXXXXXXXXX@138	Statement Dates	1/01/22 thru 1/31/22
Beginning Balance	115,931.84	Days in the statement period	31
116 Deposits/Credits	201,385.57	Average Balance	144,031.86
65 Checks/Debits	112,076.69	Average Collected	143,107.12
Service Charge	.00	Interest Earned	18.23
Interest Paid	18.23	Annual Percentage Yield Earned	0.15%
Current Balance	205,258.95	2022 Interest Paid	18.23

	Total For This Period	Total Year-to-Date
Total Overdraft Fees	$.00	$.00
Total Returned Item Fees	$.00	$.00

Activity in Date Order

Date	Description	Amount
1/03	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	1,875.00
1/03	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	1,055.00
1/03	12312021 C TIVITY HEALTH PPD 25746678 25746678	801.00
1/03	GLOBAL DEP GLOBAL PAYMENTS CCD	610.00

Public Funds HY DDA @XXXXXXXXXXX@138 (Continued)

Activity in Date Order

Date	Description	Amount
	8788240022289	
1/03	GLOBAL DEP GLOBAL PAYMENTS	552.00
	CCD	
	8788240022289	
1/03	GLOBAL DEP GLOBAL PAYMENTS	230.00
	CCD	
	8788240022289	
1/03	GLOBAL DEP GLOBAL PAYMENTS	216.00
	CCD	
	8788240022289	
1/03	GLOBAL DEP GLOBAL PAYMENTS	185.00
	CCD	
	8788240022289	
1/03	GLOBAL STL GLOBAL PAYMENTS	712.07-
	CCD	
	8788240022289	
1/04	GLOBAL DEP GLOBAL PAYMENTS	479.00
	CCD	
	8788240022289	
1/04	GLOBAL DEP GLOBAL PAYMENTS	112.00
	CCD	
	8788240022289	
1/04	GLOBAL DEP GLOBAL PAYMENTS	95.00
	CCD	
	8788240022289	
1/05	GLOBAL DEP GLOBAL PAYMENTS	2,092.00
	CCD	
	8788240022289	
1/05	GLOBAL DEP GLOBAL PAYMENTS	475.00
	CCD	
	8788240022289	
1/05	GLOBAL DEP GLOBAL PAYMENTS	32.00
	CCD	
	8788240022289	
1/05	INVOICE PAYCHEX EIB	24,741.49-
	CCD	
	X95554200000182	
1/06	INVOICE PAYCHEX EIB	2,671.83
	CCD	
	X95573000002038	
1/06	GLOBAL DEP GLOBAL PAYMENTS	570.00
	CCD	

Public Funds HY DDA @XXXXXXXXXXX@138 (Continued)

Activity in Date Order

Date	Description	Amount
	8788240022289	
1/06	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	174.00
1/06	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	112.00
1/06	Deposit	490.00
1/06	Deposit	485.00
1/06	Deposit	343.00
1/06	Deposit	315.00
1/06	Deposit	210.00
1/06	Deposit	69.00
1/06	GLOBAL CBK GLOBAL PAYMENTS CCD 8788240022289	90.00-
1/07	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	780.00
1/07	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	146.00
1/07	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	144.00
1/10	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	1,435.00
1/10	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	1,165.00
1/10	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	610.00
1/10	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	278.00
1/10	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	224.00
1/10	GLOBAL DEP GLOBAL PAYMENTS CCD	214.00

Public Funds HY DDA @XXXXXXXXXXX@138 (Continued)

Activity in Date Order

Date	Description	Amount
	8788240022289	
1/10	GLOBAL DEP GLOBAL PAYMENTS	112.00
	CCD	
	8788240022289	
1/10	GLOBAL DEP GLOBAL PAYMENTS	96.00
	CCD	
	8788240022289	
1/10	GLOBAL DEP GLOBAL PAYMENTS	32.00
	CCD	
	8788240022289	
1/11	GLOBAL DEP GLOBAL PAYMENTS	922.00
	CCD	
	8788240022289	
1/11	GLOBAL DEP GLOBAL PAYMENTS	155.00
	CCD	
	8788240022289	
1/11	GLOBAL DEP GLOBAL PAYMENTS	64.00
	CCD	
	8788240022289	
1/12	GLOBAL DEP GLOBAL PAYMENTS	995.00
	CCD	
	8788240022289	
1/12	GLOBAL DEP GLOBAL PAYMENTS	196.00
	CCD	
	8788240022289	
1/12	GLOBAL DEP GLOBAL PAYMENTS	133.00
	CCD	
	8788240022289	
1/12	PAYOUT RunSignUp	65.00
	CCD	
	TX11345390700XT	
	TRN*1*TX11345390700XT**47A8TF5	
	TIY770I16	
	RMR*IK*TX11345390700XT RunSign	
	up 365429	
1/13	GLOBAL DEP GLOBAL PAYMENTS	910.00
	CCD	
	8788240022289	
1/13	GLOBAL DEP GLOBAL PAYMENTS	348.00
	CCD	
	8788240022289	
1/13	GLOBAL DEP GLOBAL PAYMENTS	176.00
	CCD	

Public Funds HY DDA @XXXXXXXXXXX@138 (Continued)

Activity in Date Order

Date	Description	Amount
	8788240022289	
1/13	Deposit	28,579.00
1/13	Deposit	411.00
1/13	Deposit	271.00
1/13	Deposit	235.00
1/13	Deposit	132.00
1/13	Deposit	20.00
1/14	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	372.00
1/14	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	330.00
1/14	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	32.00
1/18	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	1,131.50
1/18	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	1,041.00
1/18	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	626.00
1/18	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	340.00
1/18	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	326.00
1/18	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	310.00
1/18	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	254.00
1/18	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	112.00
1/18	GLOBAL DEP GLOBAL PAYMENTS CCD	96.00

Public Funds HY DDA @XXXXXXXXXXX@138 (Continued)

Activity in Date Order

Date	Description	Amount
	8788240022289	
1/18	GLOBAL CBK GLOBAL PAYMENTS	90.00
	CCD	
	8788240022289	
1/18	GLOBAL DEP GLOBAL PAYMENTS	32.00
	CCD	
	8788240022289	
1/18	GLOBAL DEP GLOBAL PAYMENTS	32.00
	CCD	
	8788240022289	
1/18	GLOBAL DEP GLOBAL PAYMENTS	30.00
	CCD	
	8788240022289	
1/18	Deposit	85,900.74
1/18	Deposit	245.00
1/18	Deposit	210.00
1/18	Deposit	170.00
1/19	GLOBAL DEP GLOBAL PAYMENTS	1,517.00
	CCD	
	8788240022289	
1/19	GLOBAL DEP GLOBAL PAYMENTS	438.00
	CCD	
	8788240022289	
1/19	GLOBAL DEP GLOBAL PAYMENTS	196.00
	CCD	
	8788240022289	
1/19	INVOICE PAYCHEX EIB	23,461.02-
	CCD	
	X95723400001159	
1/20	GLOBAL DEP GLOBAL PAYMENTS	654.00
	CCD	
	8788240022289	
1/20	GLOBAL DEP GLOBAL PAYMENTS	237.00
	CCD	
	8788240022289	
1/20	INVOICE PAYCHEX-OAB	133.50-
	CCD	
	95724300027725X	
1/20	GLOBAL DEP GLOBAL PAYMENTS	50.00-
	CCD	
	8788240022289	
1/21	GLOBAL DEP GLOBAL PAYMENTS	384.00
	CCD	

Public Funds HY DDA @XXXXXXXXXXX@138 (Continued)

Activity in Date Order

Date	Description	Amount
	8788240022289	
1/21	GLOBAL DEP GLOBAL PAYMENTS CCD	339.00
	8788240022289	
1/21	GLOBAL DEP GLOBAL PAYMENTS CCD	112.00
	8788240022289	
1/24	GLOBAL DEP GLOBAL PAYMENTS CCD	5,409.00
	8788240022289	
1/24	GLOBAL DEP GLOBAL PAYMENTS CCD	2,438.00
	8788240022289	
1/24	GLOBAL DEP GLOBAL PAYMENTS CCD	451.00
	8788240022289	
1/24	GLOBAL DEP GLOBAL PAYMENTS CCD	335.00
	8788240022289	
1/24	GLOBAL DEP GLOBAL PAYMENTS CCD	288.00
	8788240022289	
1/24	GLOBAL DEP GLOBAL PAYMENTS CCD	96.00
	8788240022289	
1/24	GLOBAL DEP GLOBAL PAYMENTS CCD	60.00
	8788240022289	
1/24	GLOBAL DEP GLOBAL PAYMENTS CCD	48.00
	8788240022289	
1/25	GLOBAL DEP GLOBAL PAYMENTS CCD	749.00
	8788240022289	
1/25	GLOBAL DEP GLOBAL PAYMENTS CCD	135.00
	8788240022289	
1/25	GLOBAL DEP GLOBAL PAYMENTS CCD	106.00
	8788240022289	
1/26	GLOBAL DEP GLOBAL PAYMENTS CCD	1,717.00

Public Funds HY DDA @XXXXXXXXXXX@138 (Continued)

Activity in Date Order

Date	Description	Amount
	8788240022289	
1/26	GLOBAL DEP GLOBAL PAYMENTS	476.00
	CCD	
	8788240022289	
1/26	GLOBAL DEP GLOBAL PAYMENTS	76.00
	CCD	
	8788240022289	
1/26	PAYOUT RunSignUp	75.00
	CCD	
	TX11898674900XT	
	TRN*1*TX11898674900XT**3S5U1V5	
	TOI5CATOE	
	RMR*IK*TX11898674900XT RunSign	
	up 368491	
1/26	Deposit	28,461.50
1/26	Deposit	282.00
1/26	Deposit	218.00
1/26	Deposit	214.00
1/26	Deposit	120.00
1/26	Deposit	102.00
1/26	Deposit	78.00
1/27	GLOBAL DEP GLOBAL PAYMENTS	3,094.00
	CCD	
	8788240022289	
1/27	GLOBAL DEP GLOBAL PAYMENTS	329.00
	CCD	
	8788240022289	
1/27	GLOBAL DEP GLOBAL PAYMENTS	230.00
	CCD	
	8788240022289	
1/28	GLOBAL DEP GLOBAL PAYMENTS	3,023.00
	CCD	
	8788240022289	
1/28	GLOBAL DEP GLOBAL PAYMENTS	627.00
	CCD	
	8788240022289	
1/28	GLOBAL DEP GLOBAL PAYMENTS	468.00
	CCD	
	8788240022289	
1/31	GLOBAL DEP GLOBAL PAYMENTS	675.00
	CCD	
	8788240022289	

Public Funds HY DDA @XXXXXXXXXXX@138 (Continued)

Activity in Date Order

Date	Description	Amount
1/31	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	620.00
1/31	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	488.00
1/31	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	370.00
1/31	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	247.00
1/31	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	224.00
1/31	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	206.00
1/31	GLOBAL DEP GLOBAL PAYMENTS CCD 8788240022289	196.00
1/31	Interest Deposit	18.23

--- CHECKS IN NUMBER ORDER ---

Date	Check No	Amount	Date	Check No	Amount
1/11	13682	120.00	1/10	13742	405.00
1/10	13707*	337.07	1/10	13743	107.50
1/11	13709*	3,436.60	1/11	13744	724.00
1/19	13711*	100.00	1/13	13745	3,553.42
1/10	13716*	140.00	1/28	13746	5,000.00
1/10	13719*	711.00	1/19	13747	1,270.00
1/03	13727*	1,145.00	1/20	13748	160.00
1/11	13731*	64.00	1/24	13749	140.00
1/10	13732	2,708.69	1/20	13750	45.00
1/12	13733	3,677.79	1/21	13751	15.35
1/28	13734	14.50	1/20	13752	60.00
1/11	13735	195.67	1/21	13754*	347.18
1/11	13736	2,000.00	1/20	13755	94.50
1/10	13737	216.00	1/21	13757*	1,145.00
1/12	13738	5,275.00	1/31	13758	120.58
1/12	13740*	2,916.00	1/21	13759	2,775.13
1/12	13741	5,202.00	1/20	13761*	536.28

* Denotes missing check numbers

Public Funds HY DDA @XXXXXXXXXXX@138 (Continued)

--- CHECKS IN NUMBER ORDER ---

Date	Check No	Amount	Date	Check No	Amount
1/24	13762	695.00	1/28	13778	1,657.17
1/19	13763	368.40	1/24	13779	352.97
1/20	13764	4,054.50	1/28	13780	2,158.32
1/31	13766*	80.00	1/25	13781	293.87
1/19	13767	1,909.98	1/25	13782	222.77
1/21	13768	104.00	1/26	13783	541.23
1/21	13770*	450.00	1/25	13787*	44.94
1/20	13772*	120.00	1/25	13788	965.34
1/24	13773	711.00	1/25	13789	264.84
1/19	13774	120.00	1/25	13790	276.97
1/20	13775	379.20	1/31	13793*	1,824.00
1/19	13776	320.56	1/26	13797*	87.00
1/20	13777	128.29			

* Denotes missing check numbers

Daily Balance Information

Date	Balance	Date	Balance	Date	Balance
1/01	115,931.84	1/11	98,703.58	1/21	167,959.72
1/03	119,598.77	1/12	83,021.79	1/24	175,185.75
1/04	120,284.77	1/13	110,550.37	1/25	174,107.02
1/05	98,142.28	1/14	111,284.37	1/26	205,298.29
1/06	103,492.11	1/18	202,230.61	1/27	208,951.29
1/07	104,562.11	1/19	176,831.65	1/28	204,239.30
1/10	104,102.85	1/20	171,961.38	1/31	205,258.95

Interest Rate Summary

Date	Rate
12/31	0.150000%

Money Market Public Funds

Account Number	@XXXXXXXXXXX@936	Statement Dates	1/01/22 thru 1/31/22
Beginning Balance	49,603.43	Days in the statement period	31
Deposits/Credits	.00	Average Balance	49,603.43
Checks/Debits	.00	Average Collected	49,603.43
Service Charge	.00	Interest Earned	2.10
Interest Paid	2.10	Annual Percentage Yield Earned	0.05%
Current Balance	49,605.53	2022 Interest Paid	2.10

	Total For This Period	Total Year-to-Date
Total Overdraft Fees	$.00	$.00
Total Returned Item Fees	$.00	$.00

Activity in Date Order

Date	Description	Amount
1/31	Interest Deposit	2.10

Daily Balance Information

Date	Balance	Date	Balance
1/01	49,603.43	1/31	49,605.53

Interest Rate Summary

Date	Rate
12/31	0.050000%

Savings Accounts

Savings Non-Consumer

Account Number	@XXXXXXXXXXX@204	Statement Dates	1/01/22 thru 1/31/22
Beginning Balance	22,641.11	Days in the statement period	31
Deposits/Credits	.00	Average Ledger	22,641.11
Checks/Debits	.00	Average Collected	22,641.11
Service Charge	.00	Interest Earned	.20
Interest Paid	.20	Annual Percentage Yield Earned	0.01%
Ending Balance	22,641.31	2022 Interest Paid	.20

Activity in Date Order

Date	Description	Amount
1/31	Interest Deposit	.20

Daily Balance Information

Date	Balance	Date	Balance
1/01	22,641.11	1/31	22,641.31

Savings Non-Consumer @XXXXXXXXXXX@204 (Continued)

Interest Rate Summary

Date	Rate
12/31	0.010000%

LAKE TRUST

4605 S Old US Highway 23
Brighton, MI 48114-7521
888.267.7200 laketrust.org

HOWELL AREA PARKS & RECREATION
AUTHORITY
1661 N LATSON RD
HOWELL MI 48843-9007

Account Statement

Member ID: 110099341
Statement Period: Jan 01, 2022 to Jan 31, 2022

Account Balances at a Glance

Total Savings	$5,083.32
Total Checking	$0.00
Total Loans	$0.00

Commercial Membership Savings - 10006221590

Post Date	Amount	Balance	Description
01/01		$5,083.10	**Beginning Balance**
01/31	$0.22	$5,083.32	Credit Interest/Dividend
01/31		$5,083.32	**Ending Balance**

The average daily balance during this period was $5,083.10.
The Annual Percentage Yield Earned for this account is 0.05%.
The Amount of interest / dividend earned year to date is $0.22.

02/11/2022 REVENUE AND EXPENDITURE REPORT FOR HAPRA
PERIOD ENDING 01/31/2022

GL NUMBER	DESCRIPTION	2022 ORIGINAL BUDGET	2022 AMENDED BUDGET	YTD BALANCE 01/31/2022	ACTIVITY FOR MONTH 01/31/22	AVAILABLE BALANCE	% BDGT USED
Fund 208 - PARKS & REC AUTHORITY							
Revenues							
Dept 751 - RECREATION / PARKS DEPARTMENT							
208-751-587.001	PK/RC MARION TWP PARTICIPATION	0.00	0.00	28,375.00	28,375.00	(28,375.00)	100.00
208-751-587.002	PK/RC GENOA TWP PARTICIPATION	0.00	0.00	28,375.00	28,375.00	(28,375.00)	100.00
208-751-587.003	PK/RC OCEOLA TWP PARTICIPATION	0.00	0.00	28,375.00	28,375.00	(28,375.00)	100.00
208-751-587.005	PK/RC HOWELL CITY PARTICIPATION	0.00	0.00	28,375.00	28,375.00	(28,375.00)	100.00
208-751-587.006	PK/RC HOWELL TWP PARTICIPATION	0.00	0.00	28,375.00	28,375.00	(28,375.00)	100.00
208-751-650.106	FACILITY MEMBERSHIPS	0.00	0.00	7,230.00	7,230.00	(7,230.00)	100.00
208-751-651.020	BENNETT BLDG RENTAL FEES	0.00	0.00	640.00	640.00	(640.00)	100.00
208-751-651.022	OCEOLA BLDG RENTAL FEES	0.00	0.00	3,612.50	3,612.50	(3,612.50)	100.00
208-751-651.026	GYMANASIUM RENTALS	0.00	0.00	2,447.50	2,447.50	(2,447.50)	100.00
208-751-665.000	INVESTMENT INTEREST	0.00	0.00	20.75	20.75	(20.75)	100.00
208-751-671.002	MISC REVENUES	0.00	0.00	100.00	100.00	(100.00)	100.00
208-751-675.026	GIFT CERTIFICATE	0.00	0.00	10.00	10.00	(10.00)	100.00
Total Dept 751 - RECREATION / PARKS DEPARTMENT		0.00	0.00	155,935.75	155,935.75	(155,935.75)	100.00
TOTAL REVENUES		0.00	0.00	155,935.75	155,935.75	(155,935.75)	100.00
Expenditures							
Dept 751 - RECREATION / PARKS DEPARTMENT							
208-751-702.001	SAL & WAGES DIRECTOR	0.00	0.00	5,076.92	5,076.92	(5,076.92)	100.00
208-751-702.003	SAL & WAGES - BUSINESS MANAGER	0.00	0.00	3,160.82	3,160.82	(3,160.82)	100.00
208-751-702.004	SAL & WAGES - OPERATIONS MGR	0.00	0.00	3,584.00	3,584.00	(3,584.00)	100.00
208-751-702.024	SAL & WAGES -MARKETING	0.00	0.00	2,960.00	2,960.00	(2,960.00)	100.00
208-751-702.030	SAL & WAGES FRONT OFFICE	0.00	0.00	5,248.13	5,248.13	(5,248.13)	100.00
208-751-702.034	SAL & WAGE FACILITIES MAINT/COORD	0.00	0.00	3,878.00	3,878.00	(3,878.00)	100.00
208-751-713.000	EMPLOYER SHARE FICA	0.00	0.00	1,783.65	1,783.65	(1,783.65)	100.00
208-751-714.000	EMPLOYEE MEDICAL INSURANCE	0.00	0.00	863.52	863.52	(863.52)	100.00
208-751-714.002	EMP DISABILITY /LIFE INSURANCE	0.00	0.00	198.06	198.06	(198.06)	100.00
208-751-714.004	ICMA RETIREMENT	0.00	0.00	250.00	250.00	(250.00)	100.00
208-751-727.000	OFFICE SUPPLIES	0.00	0.00	222.62	222.62	(222.62)	100.00
208-751-740.000	OPERATING SUPPLIES - GENL	0.00	0.00	48.09	48.09	(48.09)	100.00
208-751-801.000	PROFESSIONAL SERVICES	0.00	0.00	2,541.72	2,541.72	(2,541.72)	100.00
208-751-840.000	DUES, SUBSCRIPTIONS & MEMBERSHIPS	0.00	0.00	1,650.00	1,650.00	(1,650.00)	100.00
208-751-850.000	COMMUNICATION - TELEPHONES	0.00	0.00	1,047.86	1,047.86	(1,047.86)	100.00
208-751-850.008	COMMUNICATION - INTERNET & CABLE	0.00	0.00	1,492.30	1,492.30	(1,492.30)	100.00
208-751-860.000	TRAVEL	0.00	0.00	2,319.00	2,319.00	(2,319.00)	100.00
208-751-900.000	MARKETING, PRINTING & PUBLISHING	0.00	0.00	47.90	47.90	(47.90)	100.00
208-751-910.000	INSURANCE	0.00	0.00	3,553.42	3,553.42	(3,553.42)	100.00
208-751-920.000	UTILITIES - ELECTRICITY	0.00	0.00	490.68	490.68	(490.68)	100.00
208-751-920.001	UTILITIES - GAS	0.00	0.00	1,137.83	1,137.83	(1,137.83)	100.00
208-751-920.002	UTILITIES - WAT / SEW	0.00	0.00	233.65	233.65	(233.65)	100.00
208-751-920.003	UTILITIES - RUBBISH	0.00	0.00	73.34	73.34	(73.34)	100.00
208-751-920.015	UTILTIES - RUBBISH/OCEOLA	0.00	0.00	54.95	54.95	(54.95)	100.00
208-751-930.014	OCEOLA BLDG EXPENSE	0.00	0.00	8,448.01	8,448.01	(8,448.01)	100.00
208-751-931.000	BLDG R & M AND SUPPLIES	0.00	0.00	61.17	61.17	(61.17)	100.00
208-751-931.014	BLDG R &M OCEOLA	0.00	0.00	1,106.36	1,106.36	(1,106.36)	100.00
208-751-940.000	EQUIPMENT RENTAL	0.00	0.00	2,875.32	2,875.32	(2,875.32)	100.00
208-751-940.040	FACILITY RENT	0.00	0.00	4,000.00	4,000.00	(4,000.00)	100.00
208-751-956.003	BANK CHARGES & FEES	0.00	0.00	845.57	845.57	(845.57)	100.00
208-751-970.000	CAPITAL OUTLAY / EQUIPMENT	0.00	0.00	1,832.00	1,832.00	(1,832.00)	100.00
208-751-980.005	EQUIPMENT/COMPUTER SOFTWARE	0.00	0.00	4,054.50	4,054.50	(4,054.50)	100.00
Total Dept 751 - RECREATION / PARKS DEPARTMENT		0.00	0.00	65,139.39	65,139.39	(65,139.39)	100.00
TOTAL EXPENDITURES		0.00	0.00	65,139.39	65,139.39	(65,139.39)	100.00
Fund 208 - PARKS & REC AUTHORITY:							
TOTAL REVENUES		0.00	0.00	155,935.75	155,935.75	(155,935.75)	100.00
TOTAL EXPENDITURES		0.00	0.00	65,139.39	65,139.39	(65,139.39)	100.00
NET OF REVENUES & EXPENDITURES		0.00	0.00	90,796.36	90,796.36	(90,796.36)	100.00

02/11/2022 REVENUE AND EXPENDITURE REPORT FOR HAPRA
PERIOD ENDING 01/31/2022

GL NUMBER	DESCRIPTION	2022 ORIGINAL BUDGET	2022 AMENDED BUDGET	YTD BALANCE 01/31/2022	ACTIVITY FOR MONTH 01/31/22	AVAILABLE BALANCE	% BDGT USED
Fund 214 - YOUTH SPORTS							
Revenues							
Dept 751 - RECREATION / PARKS DEPARTMENT							
214-751-650.050	PROGRAM FEES - VOLLEYBALL	0.00	0.00	2,005.00	2,005.00	(2,005.00)	100.00
214-751-650.051	PROGRAM FEES - ENRICHMENT	0.00	0.00	740.00	740.00	(740.00)	100.00
214-751-650.054	PROGRAM FEES - BASKETBALL	0.00	0.00	310.00	310.00	(310.00)	100.00
214-751-650.102	DROP IN SPORTS	0.00	0.00	1,001.25	1,001.25	(1,001.25)	100.00
Total Dept 751 - RECREATION / PARKS DEPARTMENT		0.00	0.00	4,056.25	4,056.25	(4,056.25)	100.00
TOTAL REVENUES		0.00	0.00	4,056.25	4,056.25	(4,056.25)	100.00
Expenditures							
Dept 751 - RECREATION / PARKS DEPARTMENT							
214-751-702.080	SAL & WAGES YOUTH SPORTS MGR	0.00	0.00	2,880.00	2,880.00	(2,880.00)	100.00
214-751-702.081	SAL & WAGES YOUTH SPORTS COORDINATORS	0.00	0.00	618.50	618.50	(618.50)	100.00
214-751-713.000	EMPLOYER SHARE FICA	0.00	0.00	287.22	287.22	(287.22)	100.00
214-751-740.000	OPERATING SUPPLIES	0.00	0.00	139.00	139.00	(139.00)	100.00
214-751-740.080	OPER SUPPLIES/VOLLEYBALL	0.00	0.00	70.00	70.00	(70.00)	100.00
214-751-740.086	OPERATING SUPPLIES - BASKETBALL	0.00	0.00	2,591.50	2,591.50	(2,591.50)	100.00
214-751-801.017	BACKGROUND CHECKS	0.00	0.00	314.50	314.50	(314.50)	100.00
214-751-804.009	CONTRACT SERV - OFFCL /COACHES	0.00	0.00	180.00	180.00	(180.00)	100.00
214-751-860.000	CONFERENCE /TRANSPORTATION	0.00	0.00	485.00	485.00	(485.00)	100.00
Total Dept 751 - RECREATION / PARKS DEPARTMENT		0.00	0.00	7,565.72	7,565.72	(7,565.72)	100.00
TOTAL EXPENDITURES		0.00	0.00	7,565.72	7,565.72	(7,565.72)	100.00
Fund 214 - YOUTH SPORTS:							
TOTAL REVENUES		0.00	0.00	4,056.25	4,056.25	(4,056.25)	100.00
TOTAL EXPENDITURES		0.00	0.00	7,565.72	7,565.72	(7,565.72)	100.00
NET OF REVENUES & EXPENDITURES		0.00	0.00	(3,509.47)	(3,509.47)	3,509.47	100.00

02/11/2022 REVENUE AND EXPENDITURE REPORT FOR HAPRA
PERIOD ENDING 01/31/2022

GL NUMBER	DESCRIPTION	2022 ORIGINAL BUDGET	2022 AMENDED BUDGET	YTD BALANCE 01/31/2022	ACTIVITY FOR MONTH 01/31/22	AVAILABLE BALANCE	% BDGT USED
Fund 216 - FESTIVALS							
Revenues							
Dept 751 - RECREATION / PARKS DEPARTMENT							
216-751-650.003	PROGRAM FEES SPECIAL EVENTS	0.00	0.00	10,322.00	10,322.00	(10,322.00)	100.00
216-751-678.048	PROGRAM FEES MELON RUN	0.00	0.00	140.00	140.00	(140.00)	100.00
Total Dept 751 - RECREATION / PARKS DEPARTMENT		0.00	0.00	10,462.00	10,462.00	(10,462.00)	100.00
TOTAL REVENUES		0.00	0.00	10,462.00	10,462.00	(10,462.00)	100.00
Expenditures							
Dept 751 - RECREATION / PARKS DEPARTMENT							
216-751-702.001	SAL & WAGES FESTIVAL DIRECTOR	0.00	0.00	2,800.00	2,800.00	(2,800.00)	100.00
216-751-713.000	EMPLOYER SHARE FICA	0.00	0.00	214.20	214.20	(214.20)	100.00
216-751-727.000	OFFICE SUPPLIES	0.00	0.00	81.96	81.96	(81.96)	100.00
216-751-740.035	OPER SUPPLIES - SPECIAL EVENTS	0.00	0.00	7,681.79	7,681.79	(7,681.79)	100.00
216-751-740.102	OPER SUPP MELON FESTIVAL	0.00	0.00	5,625.00	5,625.00	(5,625.00)	100.00
216-751-860.000	CONFERENCE /TRANSPORTATION	0.00	0.00	485.00	485.00	(485.00)	100.00
216-751-900.000	PRINTING & PUBLISHING	0.00	0.00	202.95	202.95	(202.95)	100.00
Total Dept 751 - RECREATION / PARKS DEPARTMENT		0.00	0.00	17,090.90	17,090.90	(17,090.90)	100.00
TOTAL EXPENDITURES		0.00	0.00	17,090.90	17,090.90	(17,090.90)	100.00
Fund 216 - FESTIVALS:							
TOTAL REVENUES		0.00	0.00	10,462.00	10,462.00	(10,462.00)	100.00
TOTAL EXPENDITURES		0.00	0.00	17,090.90	17,090.90	(17,090.90)	100.00
NET OF REVENUES & EXPENDITURES		0.00	0.00	(6,628.90)	(6,628.90)	6,628.90	100.00

02/11/2022 REVENUE AND EXPENDITURE REPORT FOR HAPRA
PERIOD ENDING 01/31/2022

GL NUMBER	DESCRIPTION	2022 ORIGINAL BUDGET	2022 AMENDED BUDGET	YTD BALANCE 01/31/2022	ACTIVITY FOR MONTH 01/31/22	AVAILABLE BALANCE	% BDGT USED
Fund 217 - PRESCHOOL							
Revenues							
Dept 751 - RECREATION / PARKS DEPARTMENT							
217-751-651.007	REC FEE/PRESCHOOL TUITION	0.00	0.00	4,875.00	4,875.00	(4,875.00)	100.00
Total Dept 751 - RECREATION / PARKS DEPARTMENT		0.00	0.00	4,875.00	4,875.00	(4,875.00)	100.00
TOTAL REVENUES		0.00	0.00	4,875.00	4,875.00	(4,875.00)	100.00
Expenditures							
Dept 751 - RECREATION / PARKS DEPARTMENT							
217-751-702.023	SAL & WAGES PRESCHOOL	0.00	0.00	3,527.75	3,527.75	(3,527.75)	100.00
217-751-713.000	EMPLOYER SHARE FICA	0.00	0.00	283.34	283.34	(283.34)	100.00
Total Dept 751 - RECREATION / PARKS DEPARTMENT		0.00	0.00	3,811.09	3,811.09	(3,811.09)	100.00
TOTAL EXPENDITURES		0.00	0.00	3,811.09	3,811.09	(3,811.09)	100.00
Fund 217 - PRESCHOOL:							
TOTAL REVENUES		0.00	0.00	4,875.00	4,875.00	(4,875.00)	100.00
TOTAL EXPENDITURES		0.00	0.00	3,811.09	3,811.09	(3,811.09)	100.00
NET OF REVENUES & EXPENDITURES		0.00	0.00	1,063.91	1,063.91	(1,063.91)	100.00

02/11/2022 REVENUE AND EXPENDITURE REPORT FOR HAPRA
PERIOD ENDING 01/31/2022

GL NUMBER	DESCRIPTION	2022 ORIGINAL BUDGET	2022 AMENDED BUDGET	YTD BALANCE 01/31/2022	ACTIVITY FOR MONTH 01/31/22	AVAILABLE BALANCE	% BDGT USED
Fund 218 - SENIOR CENTER							
Revenues							
Dept 751 - RECREATION / PARKS DEPARTMENT							
218-751-650.030	PROGRAM FEES - ENRICHMENT	0.00	0.00	1,426.00	1,426.00	(1,426.00)	100.00
218-751-650.098	PROGRAM FEES - FITNESS	0.00	0.00	3,437.50	3,437.50	(3,437.50)	100.00
218-751-678.012	MEMBERSHIP FEES	0.00	0.00	5,578.75	5,578.75	(5,578.75)	100.00
Total Dept 751 - RECREATION / PARKS DEPARTMENT		0.00	0.00	10,442.25	10,442.25	(10,442.25)	100.00
TOTAL REVENUES		0.00	0.00	10,442.25	10,442.25	(10,442.25)	100.00
Expenditures							
Dept 751 - RECREATION / PARKS DEPARTMENT							
218-751-702.027	SAL & WAGES SENIORS	0.00	0.00	2,776.00	2,776.00	(2,776.00)	100.00
218-751-713.000	EMPLOYER SHARE FICA	0.00	0.00	212.38	212.38	(212.38)	100.00
218-751-740.032	OPER SUPP/SENIORS	0.00	0.00	29.95	29.95	(29.95)	100.00
218-751-740.061	OPER SUPP/FITNESS	0.00	0.00	41.97	41.97	(41.97)	100.00
218-751-740.070	OPER SUPP/ TRAVEL	0.00	0.00	525.00	525.00	(525.00)	100.00
218-751-804.008	CONTRACT SERV - INSTRUCTORS	0.00	0.00	1,480.00	1,480.00	(1,480.00)	100.00
218-751-860.000	CONFERENCE /TRANSPORTATION	0.00	0.00	485.00	485.00	(485.00)	100.00
Total Dept 751 - RECREATION / PARKS DEPARTMENT		0.00	0.00	5,550.30	5,550.30	(5,550.30)	100.00
TOTAL EXPENDITURES		0.00	0.00	5,550.30	5,550.30	(5,550.30)	100.00
Fund 218 - SENIOR CENTER:							
TOTAL REVENUES		0.00	0.00	10,442.25	10,442.25	(10,442.25)	100.00
TOTAL EXPENDITURES		0.00	0.00	5,550.30	5,550.30	(5,550.30)	100.00
NET OF REVENUES & EXPENDITURES		0.00	0.00	4,891.95	4,891.95	(4,891.95)	100.00

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PERIOD ENDING 01/31/2022

GL NUMBER	DESCRIPTION	2022 ORIGINAL BUDGET	2022 AMENDED BUDGET	YTD BALANCE 01/31/2022	ACTIVITY FOR MONTH 01/31/22	AVAILABLE BALANCE	% BDGT USED
Fund 219 - SUMMER DAY CAMP							
Revenues							
Dept 751 - RECREATION / PARKS DEPARTMENT							
219-751-651.003	SUMMER CAMP	0.00	0.00	10,515.00	10,515.00	(10,515.00)	100.00
219-751-651.025	SPECIALTY CAMPS	0.00	0.00	500.00	500.00	(500.00)	100.00
Total Dept 751 - RECREATION / PARKS DEPARTMENT		0.00	0.00	11,015.00	11,015.00	(11,015.00)	100.00
TOTAL REVENUES		0.00	0.00	11,015.00	11,015.00	(11,015.00)	100.00
Expenditures							
Dept 751 - RECREATION / PARKS DEPARTMENT							
219-751-702.037	SAL & WAGES SUMMER CAMP COUNSELOR	0.00	0.00	1,100.00	1,100.00	(1,100.00)	100.00
Total Dept 751 - RECREATION / PARKS DEPARTMENT		0.00	0.00	1,100.00	1,100.00	(1,100.00)	100.00
TOTAL EXPENDITURES		0.00	0.00	1,100.00	1,100.00	(1,100.00)	100.00
Fund 219 - SUMMER DAY CAMP:							
TOTAL REVENUES		0.00	0.00	11,015.00	11,015.00	(11,015.00)	100.00
TOTAL EXPENDITURES		0.00	0.00	1,100.00	1,100.00	(1,100.00)	100.00
NET OF REVENUES & EXPENDITURES		0.00	0.00	9,915.00	9,915.00	(9,915.00)	100.00

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PERIOD ENDING 01/31/2022

GL NUMBER	DESCRIPTION	2022 ORIGINAL BUDGET	2022 AMENDED BUDGET	YTD BALANCE 01/31/2022	ACTIVITY FOR MONTH 01/31/22	AVAILABLE BALANCE	% BDGT USED
Fund 221 - TEEN CENTER							
Revenues							
Dept 751 - RECREATION / PARKS DEPARTMENT							
221-751-649.000	CONCESSION SALES TEEN	0.00	0.00	298.25	298.25	(298.25)	100.00
221-751-650.005	PROGRAM FEES TEENS	0.00	0.00	1,395.00	1,395.00	(1,395.00)	100.00
Total Dept 751 - RECREATION / PARKS DEPARTMENT		0.00	0.00	1,693.25	1,693.25	(1,693.25)	100.00
TOTAL REVENUES		0.00	0.00	1,693.25	1,693.25	(1,693.25)	100.00
Expenditures							
Dept 751 - RECREATION / PARKS DEPARTMENT							
221-751-702.026	SAL & WAGES TEEN MANAGERS	0.00	0.00	3,037.50	3,037.50	(3,037.50)	100.00
221-751-702.041	SAL & WAGES - TEEN SUPERVISOR	0.00	0.00	486.50	486.50	(486.50)	100.00
221-751-713.000	EMPLOYER SHARE FICA	0.00	0.00	337.25	337.25	(337.25)	100.00
221-751-714.000	EMPLOYEE MEDICAL INSURANCE	0.00	0.00	442.36	442.36	(442.36)	100.00
221-751-727.000	OFFICE SUPPLIES	0.00	0.00	43.85	43.85	(43.85)	100.00
221-751-740.015	OPER SUPP/CONCESSIONS	0.00	0.00	156.94	156.94	(156.94)	100.00
221-751-979.100	GRANTS >$1000 EXP	0.00	0.00	5,202.00	5,202.00	(5,202.00)	100.00
Total Dept 751 - RECREATION / PARKS DEPARTMENT		0.00	0.00	9,706.40	9,706.40	(9,706.40)	100.00
TOTAL EXPENDITURES		0.00	0.00	9,706.40	9,706.40	(9,706.40)	100.00
Fund 221 - TEEN CENTER:							
TOTAL REVENUES		0.00	0.00	1,693.25	1,693.25	(1,693.25)	100.00
TOTAL EXPENDITURES		0.00	0.00	9,706.40	9,706.40	(9,706.40)	100.00
NET OF REVENUES & EXPENDITURES		0.00	0.00	(8,013.15)	(8,013.15)	8,013.15	100.00

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PERIOD ENDING 01/31/2022

GL NUMBER	DESCRIPTION	2022 ORIGINAL BUDGET	2022 AMENDED BUDGET	YTD BALANCE 01/31/2022	ACTIVITY FOR MONTH 01/31/22	AVAILABLE BALANCE	% BDGT USED
Fund 223 - DOG PARK							
Revenues							
Dept 751 - RECREATION / PARKS DEPARTMENT							
223-751-675.074	DOG PARK SALES - FOBS	0.00	0.00	540.00	540.00	(540.00)	100.00
Total Dept 751 - RECREATION / PARKS DEPARTMENT		0.00	0.00	540.00	540.00	(540.00)	100.00
TOTAL REVENUES		0.00	0.00	540.00	540.00	(540.00)	100.00
Fund 223 - DOG PARK:							
TOTAL REVENUES		0.00	0.00	540.00	540.00	(540.00)	100.00
TOTAL EXPENDITURES		0.00	0.00	0.00	0.00	0.00	0.00
NET OF REVENUES & EXPENDITURES		0.00	0.00	540.00	540.00	(540.00)	100.00
TOTAL REVENUES - ALL FUNDS		0.00	0.00	199,019.50	199,019.50	(199,019.50)	100.00
TOTAL EXPENDITURES - ALL FUNDS		0.00	0.00	109,963.80	109,963.80	(109,963.80)	100.00
NET OF REVENUES & EXPENDITURES		0.00	0.00	89,055.70	89,055.70	(89,055.70)	100.00