USUI INTERNATIONAL CORPORATION

Guide to Employee Benefits

Complete enrollment online via the Paycor enrollment site

Open enrollment window is:
November 7th through November 19th

Contract Year:
January 1, 2019 through December 31, 2019

MICHIGAN PLANNERS
EMPLOYEE BENEFITS · RETIREMENT SERVICES

Group services provided by Michigan Planners

Paycor

Online enrollment powered by Paycor

Introduction

Our employees are our most valuable asset and contributor to our success. That's why we are committed to an employee benefits program that helps our employees stay healthy and feel safe and secure.

This time each year you are able to reassess your current employee benefit selections and determine if any changes need to be made. The purpose of this Guide is to provide you with a summary of the benefit plans available and the basic features of those plans for the January 1, 2019 – December 31, 2019 plan year.

Keep this Guide handy throughout the year as it is an excellent reference source for you and your covered family members.

For specific details of the plans, always consult the actual plan document. Every effort has been made to provide clear and accurate information about these plans. In the event of a discrepancy between this material and the official plan documents, the official plan documents will govern.

Our agent, Michigan Planners, or the insurance company/benefit service provider, is available to answer questions in detail regarding each of the offerings described within this Guide.

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Table of Contents

The benefit summaries found in this Guide have been designed as an easy-to-use reference and are not intended as a contract. Please consult your coverage certificate for complete details. A certificate of coverage and master contract issued by the Insurance Company will always take precedence over any other benefit description.

Getting the Most Benefit From Your Benefits

know. compare. choose.

Save by understanding your care choices

HEALTH CARE HAS BECOME MORE AND MORE COMPLEX.

There's no longer just one place to get care. You can go to your doctor's office, see a doctor online or go to an urgent care center or the emergency room, depending on the seriousness of your condition. You can also call a 24/7 nurse line. Costs differ depending on which option you choose.

Your health plan may also limit you to a local network. So if you go to an urgent care center that's not in your plan's network, you may pay two or three times more for the same service.

CHOICES, CHOICES, CHOICES

Our online tools at **bcbsm.com** can help you make smart health care choices, and save money too. Here's an example:

George injured his ankle playing softball. He can stand and put weight on it, but it's pretty painful and swelling fast. It's 7:30 p.m., and his doctor's office is closed.

- *George hasn't had a lot of medical expenses to date, so he knows that he's still paying his deductible.*
- *He logs in to his member account at **bcbsm.com** and finds that he can use 24/7 online health care when his doctor isn't available. The online doctor will be able to tell him where to go and when.*
- *He sees what care is available in his network using* Find a Doctor*. His results give him some urgent care center and emergency room locations.*
- *Then he checks cost estimates at **bcbsm.com** to better evaluate his choices.**

*For non-Medicare, PPO members only

WHAT GEORGE DISCOVERED DURING HIS 15-MINUTE SEARCH:

1. He's only met $550 of his $2,500 deductible.
2. He has these care options:*

	24-hour nurse line	24/7 online visits	Doctor's office	Urgent care	Emergency room
Cost:	No charge	$49	$130	$150	$350
Location:	Phone	Smartphone	7-minute drive	10-minute drive	20-minute drive
Wait time:	30 seconds	5 minutes	1 hour	1 hour	4 hours
Diagnosis and care advice:	Sprained ankle. Use MICE — motion, ice, compression and elevation — until it feels better. And stay in the dugout for the rest of the season.*				

*Cost, distances and wait times are estimated. Illustrative example, not actual medical advice.

UNDERSTAND YOUR BENEFITS AND OPTIONS

Remember, you're an important player that's paying more and more for your health care. With so much skin in the game, you've got to make the right plays to save money, time and get appropriate care.

SECOND BASE

Ask yourself, what does my plan allow? Use **bcbsm.com** to look at the *My Coverage* page.

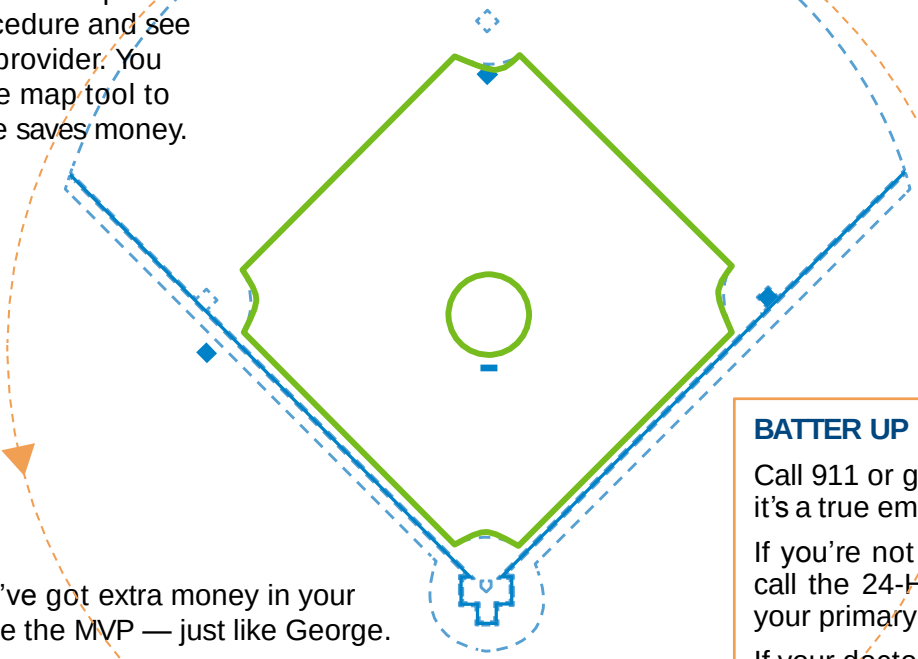
Review what's covered and your plan documents.

THIRD BASE

Use *Find a Doctor* to look up real prices for your procedure and see how they differ by provider. You can also expand the map tool to see if a longer drive saves money.

FIRST BASE

If your doctor orders a specialist, diagnostic test or procedure, log in to **bcbsm.com**.



HOME PLATE

Score! Now you've got extra money in your wallet and you're the MVP — just like George.

BATTER UP

Call 911 or go to a hospital if it's a true emergency.

If you're not sure where to go, call the 24-Hour Nurse Line or your primary doctor for advice.

If your doctor isn't available, use 24/7 online health care or go to an urgent care center.

Visit bcbsm.com/understandcost to learn more about shopping for care using your member account. Plus, download our app at bcbsm.com/app.

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Online Visits℠

Medical and behavioral health

Frequently asked questions

Convenient online care for body and mind.

What is Blue Cross Online Visits℠?

Taking care of yourself and your family's health can be as easy as using your smartphone, tablet or computer to meet with a doctor or therapist face to face. With online visits, you have access to around-the-clock medical care or scheduled behavioral health care, anywhere in the U.S.

How does it work?

Blue Cross Online Visits is fast and convenient. There's no cost to enroll and no monthly fee. Here's how you sign up:

Mobile – Download the BCBSM Online Visits℠ app

Web – Visit **bcbsmonlinevisits.com**

Phone – Call 1-844-606-1608

Add your Blue Cross or Blue Care Network health care plan information.

What medical illnesses can be treated online?

When you can't get to your doctor's office, you can talk to an online doctor about minor illnesses such as:

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

If your life is at risk, please call 911 or go to the nearest emergency room.

What behavioral health concerns does online visits address?

You can speak with a therapist or psychiatrist if you're struggling with challenges such as anxiety, depression and grief. Therapists use talk therapy, while psychiatrists manage medications.

How do I have an online visit?

1. Launch the online visits app or website, and log in to your account.
2. Choose a service: *Medical, Therapy* or *Psychiatry*.
3. Pick a doctor or begin a scheduled visit and enter your payment information.
4. Meet with the doctor or therapist online.
5. Get a prescription, if appropriate, sent to a local pharmacy.
6. Send an optional visit summary to your primary care doctor or other health care provider at the end of your online visit.

How long does an online visit take?

For medical visits, you can see a doctor and get a prescription, if necessary, in usually less than 15 minutes. The average time spent with a doctor is 10 minutes, but a visit may last as long as needed.

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

Do I need to make an appointment?

Medical care is available 24 hours a day, seven days a week without an appointment.

Behavioral health visits are available by appointment only.

- Therapy is available from 7 a.m. to 11 p.m. for adults and children 10 and over.
- Psychiatrists set their own hours and some may also offer evening or weekend appointments. Visits are for adults age 18 and over.

How much does it cost?

Medical visits are $49 or less, based on your cost share. If you have a plan with a copay, it's generally equal to or less than what you pay for a primary care office visit.

Costs for behavioral health visits vary depending on the type of provider and the services you receive. Your cost share is based on your existing outpatient behavioral health benefits.

Will I get a prescription during a visit?

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

Doctors won't prescribe controlled substances.

What kind of doctors and therapists will I see?

They're all specially trained in online visits. You can read their profiles to learn more about them such as languages they speak and other experience.

Doctors have an average of 15 years practicing medicine and are U.S. board-certified. They have experience in areas such as pediatrics, family medicine and emergency care. Psychiatrists are board-certified in psychiatry or neurology.

The masters- and doctoral-level therapists are psychologists, licensed clinical social workers, marriage and family therapists and professional counselors. They're licensed and credentialed in the state where you're having a visit.

Will a doctor provide medical forms or back to school notes?

If appropriate, doctors may provide back-to-work or school notes. You can print these at the end of your visit. Telehealth doctors can't provide federal or state forms that require in-person evaluations (for example, Family Medical Leave Act, disability, handicap parking permits).

Can my children or spouse use online visits?

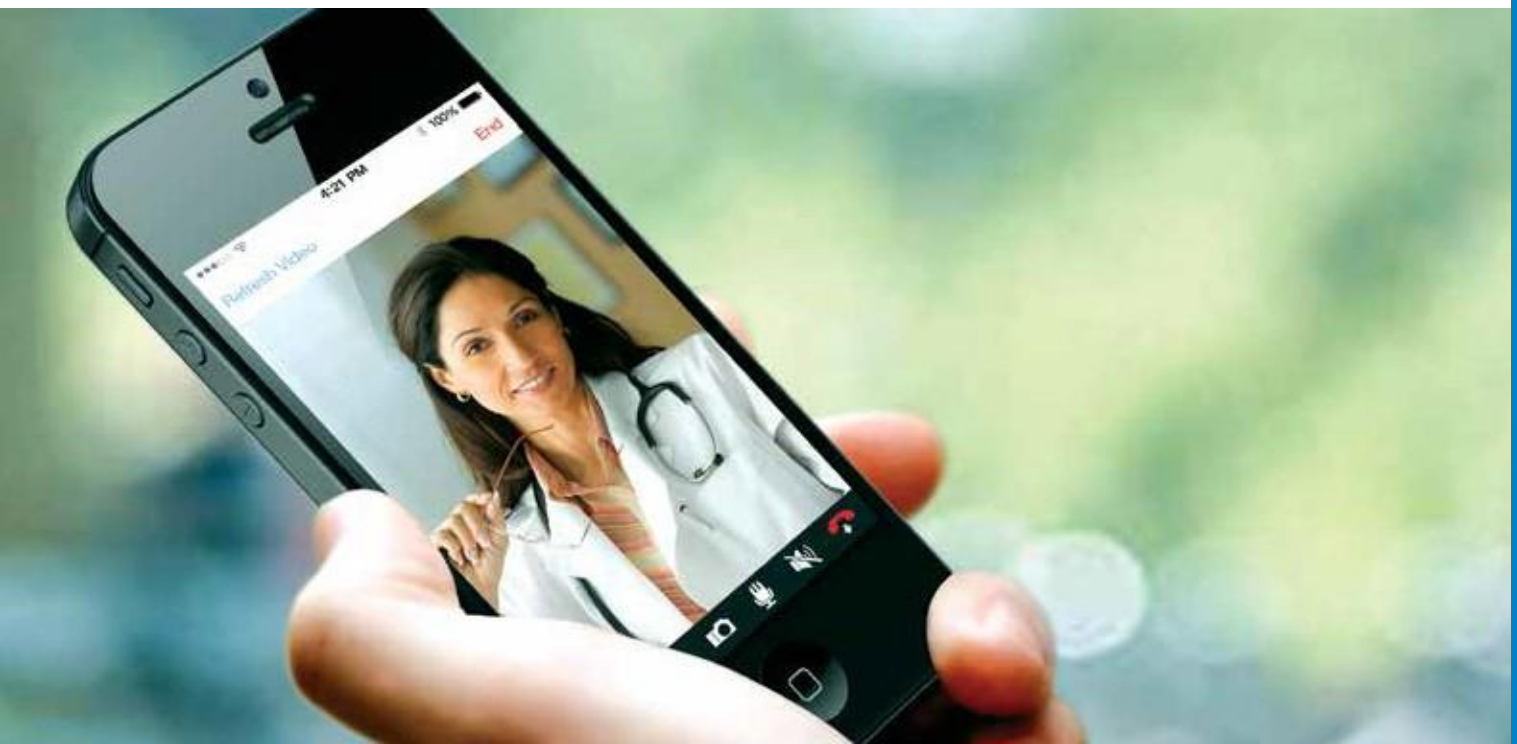
Yes. Parents and guardians can add children younger than age 18 to their account and have medical visits on their behalf.

Spouses and adult children over 18 can create their own account using the BCBSM Online Visits app or going to **bcbsmonlinevisits.com**.

What if I need help with my online visits account or an online visit?

If you have questions or need help with your Blue Cross Online Visits account or an online visit, please call 1-844-606-1608, 24 hours a day, seven days a week.

Remember to coordinate all care with your primary care doctor. Online visits are powered by American Well®, an independent company that provides online visits for Blue Cross and BCN members.



know. compare. choose.

Register for your Blue Cross member account from any device

Your Blue Cross member account keeps your health care information securely in one place. Check your coverage, out-of-pocket balance, claims and more from your computer, smartphone or tablet.

HAVE YOUR BLUE CROSS OR BLUE CARE NETWORK ID CARD AVAILABLE — YOU CAN'T REGISTER WITHOUT IT.

Let's get started.

REGISTER IN ONE OF TWO WAYS:

Go to bcbsm.com/register.

1. Select *Register Now*.
2. Enter your first name, last name, enrollee ID and birth date.
3. Check that your information is entered correctly and select *Continue*.
4. Follow the instructions to verify your eligibility and identity.

Use our app.

1. Download the app on the App Store® or Google Play™ (search for **BCBSM**).
2. Tap the app icon.
3. Tap *Register*.
4. Use the app to snap a photo of your ID card. Your enrollee ID number will be entered for you.
5. Enter your birth date and tap *Continue*. Verify your eligibility and identity.

Register today:

bcbsm.com/register

Get the app.

Download on the App Store

GET IT ON Google Play

Search BCBSM.

Sign up for emails and text messages that tell you when your account has updated plan information.

CREATE YOUR PROFILE AND SET SECURITY.

1. Enter your log-in and contact information:
   - Username
   - Password
   - Phone number
   - Email address
2. Choose a security question from two pull-down menus, and enter the answer.

THAT'S IT. YOU'RE NOW REGISTERED.

THE 5 KEYS TO SECURITY

1. **Think length.** Create a password with at least eight characters.
2. **Be creative.** Include uppercase and lowercase letters, numbers and special characters (!, @, #, &). Consider passphrases (IL1kemYPl@n!). They're easier to remember but tough for someone else to guess.
3. **Mix it up.** Use different passwords for different accounts.
4. **Keep to it yourself.** Don't write down or share your passwords.
5. **Use your options.** Use a numeric PIN code or a fingerprint scanner to lock your screen.

Passwords

Strong: I@mBlue32!
Weak: Abcd1234 ⚠

Source: "Password management and mobile security," Pew Center Research, January 2016.

"Highest Member Satisfaction among Commercial Health Plans in Michigan"

Blue Cross Blue Shield of Michigan received the highest score in Michigan in the J.D. Power 2018 U.S. Member Health Plan Study of customers' satisfaction with their commercial health plan. Visit jdpower.com/awards.

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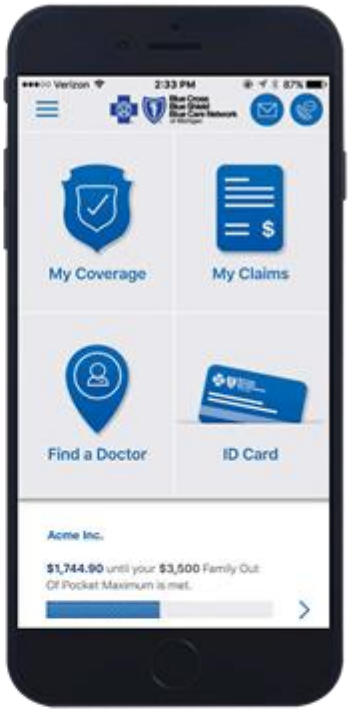
Manage your health care plan anytime, anywhere with our mobile app

know. compare. choose.

SEARCH BCBSM WITHIN THE APPLE® APP STORE OR GOOGLE® PLAY. LEARN MORE TODAY AT BCBSM.COM/APP.



These are just some of the app's features:	
Benefit details	See what your plan covers so you're more informed when you need care.
Deductible and out-of-pocket balances	Know how much you've paid toward your deductible and out-of-pocket maximum balances.
Access to pharmacy and drug information (For members with Blue Cross or Blue Care Network pharmacy coverage)	Look up drug prices, see coverage warnings and find lower cost alternatives.
View claims and EOBs	See what providers charged and why before you pay. Quickly find and search claims by time frame, member, service type or provider.
Find a Doctor	Find a doctor or hospital in your network. Search by location, specialties, quality recognitions and extended office hours. Get GPS-enabled directions to get there fast.
Compare cost estimates	Compare cost information for health care services to keep your health and budget in check.
ID card	Show your ID card to your doctor, so they have the information they need to look up your coverage.
Blue Cross® Health & Wellness, powered by WebMD®3	Take a health assessment, set health goals, track your health measures and find credible health information from WebMD®.

New video tutorials

https://youtu.be/40jraiN--_A

https://youtu.be/8CMh1fp9zzI

Health and Wellness

If your plan has **Blue Cross® Health & Wellness** as one of its benefits, you have a wealth of resources at your fingertips. The Blue Cross Health & Wellness website, powered by WebMD®, gives you some exciting new tools that can help you get healthier, stay well and manage illness.

Blue Cross Blue Shield Blue Care Network of Michigan

Blue Cross Health & Wellness is available 24 hours a day, every day, through your account at bcbsm.com. It gives you the latest information on health and wellness as well as:

- An interactive health assessment
- Digital Health Assistant programs
- Health trackers
- Helpful online tools and resources

Here's how to access the new Blue Cross Health & Wellness site:

- Log in or register for your member account at bcbsm.com.
- Click the Health & Wellness tab at the top to enter the Blue Cross Health & Wellness site. You'll need to register if it's your first time on the site.

WebMD Health Services is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network by providing health and wellness services.

Staying Healthy – There's a lot you can do to stay healthy. Here are some resources to keep you healthy for the long run. Go to bcbsm.com and click on Members/ Health-Wellness and Staying Healthy tab for information on each of the following:

- Flu shots
- Depression screening
- Your Body Mass Index (BMI)
- Early Detection
- Pregnancy
- Understanding your Risks
- Dental health
- Using medications wisely

Case Management – Sometimes, health problems can get complicated. Whether you're dealing with a chronic condition, a serious illness or catastrophic injury, our case management programs can help you.

Our certified case managers focus on

- Making sure patients get the right level of care.
- Finding low-cost alternatives for services.
- Improving patient health.
- Coordinating care and treatment plan.
- Educating patients and their families about treatment options.

24 Hour Nurse Line – The 24/7 service connects you with registered nurses supported by board-certified physician that can:

- Share tips for healthy lifestyle
- Discuss at-home treatments for minor illnesses and injuries
- Answer questions about upcoming surgeries and medical tests
- Provide health education materials about rare or chronic conditions
- Teach you about preventive care like mammograms, immunizations and prostate screenings
- Suggest chronic condition management programs and community resources

Please note: Our 24-hour nurse line should not be used in medical emergencies.

PPO Plans – BCBSM Call 1-800-775-BLUE (2583)

HMO Plans– BCN Call 1-855-624-5214

Prescription Drug Savings

Savings Tip #1

Before You Buy, Check Your Plan's Drug Formulary List; When You Buy, Present Your Medical/R_x Plan Identification Card

The drug formulary list is on your insurance company's website – it contains information to help you get the most from your medications. Filing a claim for these drugs may help you save more, depending upon the insurance company's contract with the pharmacy.

If you use cash and do not use your health plan, these transactions will not apply toward your total out-of-pocket maximum.

Savings Tip #2

Choose Generics over Brand Names and Utilize Mail Order/Retail 90 for Maintenance Drugs (90-Day Supply)

Generic drugs are the bioequivalent of brand name drugs – they have the same active ingredients as the brand name medications and are just as safe but they are more affordable. Some brand name drugs do not yet have an exact generic available; however, there are several alternative generic medications that can treat the condition and lower your copay.

And maintenance medications that are taken for long-term, chronic conditions can be less costly when your physician writes a 90-day prescription.

Savings Tip #3

Resources for High-Cost Specialty Drugs

If you have chronic or difficult health conditions, like multiple sclerosis or rheumatoid arthritis, you may need specialty drugs which typically require special handling, administration and/or monitoring. It's also more likely they'll need special approval to order and you may have to order them through a specialty pharmacy. Drug manufacturers and patient advocacy groups may be able to help with these high-cost drugs.

Here are just a few resources:

- Healthwellfoundation.org
- Copays.org (Patient Advocate Foundation)
- Patientservicesinc.org
- Mygooddays.org
- Astrazeneca.com

70% of generic drugs are available for less than $4 for a 30-day supply!!

Some pharmacies offer generic prescription drugs for no cost at all – at Meijer Pharmacy, for example, amoxicillin (an antibiotic) and atorvastatin (the generic Lipitor) are available at no cost.

Many larger pharmacies, such as those listed below, offer prescription promotions while several independent pharmacies match promotional prices. See individual pharmacy websites for their Prescription Savings Programs and for a specific listing of prescription drugs or contact the pharmacists for additional details.

kmart meijer CVS pharmacy Kroger RITE AID Walgreens WAL*MART Save money. Live better.

Savings Tip #4

Shop Around!

Use these pharmacy search engines for available discounted generic drug programs at pharmacies throughout the USA – visit **www.goodrx.com** or **www.medtipster.com**.

GoodRx medtipster

Many states offer a free statewide prescription drug assistance program – please check your state website (such as **www.michiganrxcard.com** for Michigan residents).

Savings Tip #5

Take Inventory and Talk with Your Doctor

Sample List of Recently Released Generics

Brand Name	*Generic*
Adcirca	tadalafil
Estrace CR	estradiol cream
Namenda XR	memantine ER
Norvir	ritonavir
Reyataz	atazanavir
Sustiva	efavirenz
Syprine	trientine HCl
Treximet	sumatriptan/naproxen
Uceris	budesonide
Viread	tenofovir
Welchol	coleseval

Your physician may use a step-therapy process to try different generic and brand name drugs and dosages to find the one that works best for you.

Check **www.drugs.com/availability/** to find drugs that are available in generic form.

Better Health
Through Prevention

Annual Wellness Visit

NDS will return in early 2019!

NDS provides annual wellness visits administered by a licensed provider, onsite at any organization. Annual preventative visits are often underutilized. We provide easy access to care without being faced with taking a day off to utilize the covered benefit.

Assessment (30 minute appointment) Includes:

- ***Biometrics (BMI, BP, Cholesterol, HDL, LDL, Triglycerides)***
- ***Hemoglobin A1C***
- ***12 Lead EKG – if clinically necessary***
- ***Complete review of Body Systems: Lymphatic, Respiratory, Cardiovascular, Gastrointestinal, Genitourinary, Musculoskeletal, Neurological, Eyes, Ears, Nose and Throat***
- ***Family History, Medications, Social History and Immunizations***
- ***Occupational Health Assessment***
- ***Age-appropriate Screening Education***
- ***Coordination of care with local providers***

CUSTOMIZED DELIVERY

Self contained, custom, mobile testing facility comes on-site

Turnkey Registration & Scheduling

Mail, Email & Print Communication regarding service details to employee

Confidential reports provided to each participant

Aggregate report provided to each corporate or medical host

NDS will contact patients when follow up care is recommended by provider

Educational workshops provided for each event

NDS

Education • Prevention • Health

39595 W. 10 Mile Rd • Ste 102 • Novi, MI 48375 • 888-267-4786 • ***ndswellness.com***

Preventive Care Benefits –

at no cost to you*

Under the Affordable Care Act, you and your family may be eligible for some important preventive services – which can help you avoid illness and improve your health – ***at no additional cost to you or without charging a deductible, co-pay or coinsurance.**** These services are free only when delivered by a doctor or provider in your plan's network. The following pages describe preventive care services for all adults, women, and children.

For example, depending on your age, you may have access – ***at no cost*** – to preventive services such as:

- Blood pressure, diabetes and cholesterol tests
- Many cancer screenings, including mammograms and colonoscopies
- Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression and reducing alcohol use
- Regular well-baby and well-child visits from birth to age 21
- Routine vaccinations against diseases such as measles, polio or meningitis
- Counseling, screening and vaccines to ensure healthy pregnancies
- Flu and pneumonia shots – visit vaccines.gov to learn more

When you take advantage of these preventive services you may be able to prevent illnesses, disease, and other health problems, or detect illness at an early stage when treatment is likely to work best. Getting recommended preventive services and making healthy lifestyle choices are key steps to good health and well-being.

Note: Refer to your medical/prescription drug benefit summary and contact your insurance carrier if you have questions about how, when, and where to obtain no cost preventive care benefits; how to know when a service is coded by the physician as preventive care or diagnostic (a service to monitor, diagnose or treat a condition) which has a cost-share; and, to confirm the service(s) you or your family member is eligible to receive.

Preventive Care Benefits

Free Preventive Health Services

Most health plans must cover a set of preventive services like shots and screening tests at no cost to you. This includes Marketplace private insurance plans.

Preventive Health Services for Adults

All Marketplace health plans and many other plans must cover the following list of preventive services for adults without charging you a copayment or coinsurance. This is true even if you haven't met your yearly deductible. These services are free only when delivered by a doctor or other provider in your plan's network.

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol Misuse screening and counseling
3. Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk
4. Blood Pressure screening
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal Cancer screening for adults 50 to 75
7. Depression screening
8. Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese
9. Diet counseling for adults at higher risk for chronic disease
10. Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting
11. Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence
12. Hepatitis C screening for adults at increased risk, and one time for everyone born 1945-1965
13. HIV screening for everyone ages 15 to 65, and other ages at increased risk
14. Immunization vaccines for adults – doses, recommended ages, and recommended populations vary:

    - Diphtheria
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus (HPV)
    - Influenza (Flu Shot)
    - Measles
    - Meningococcal
    - Mumps
    - Pertussis (Whooping Cough)
    - Pneumococcal
    - Rubella
    - Tetanus
    - Varicella (Chickenpox)

15. Lung cancer screening for adults 55-80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
16. Obesity screening and counseling
17. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
18. Statin preventive medication for adults 40 to 75 at high risk
19. Syphilis screening for adults at higher risk
20. Tobacco Use screening for all adults and cessation interventions for tobacco users
21. Tuberculosis screening for certain adults without symptoms at high risk

Preventive Care Benefits

Preventive Health Services for Pregnant Women or Women Who Become Pregnant

All Marketplace health plans and many other plans must cover the following list of preventive services for women without charging you a copayment or coinsurance. This is true even if you haven't met your yearly deductible. These services are free only when delivered by a doctor or other provider in your plan's network.

1. Anemia screening on a routine basis
2. Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
3. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs); this does not apply to health plans sponsored by certain exempt "religious employers"
4. Folic Acid supplements for women who may become pregnant
5. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
6. Gonorrhea screening for all women at higher risk
7. Hepatitis B screening for pregnant women at their first prenatal visit
8. Preeclampsia prevention and screening for pregnant women with high blood pressure
9. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
10. Syphilis screening
11. Expanded tobacco intervention and counseling for pregnant tobacco users
12. Urinary tract or other infection screening

Other Covered Preventive Health Services for Women

1. Breast Cancer Genetic Test counseling (BRCA) for women at higher risk
2. Breast Cancer mammography screenings every 1 to 2 years for women over 40
3. Breast Cancer chemoprevention counseling for women at higher risk
4. Cervical Cancer screening
    - Pap test (also called a Pap smear) every 3 years for women 21 to 65
    - Human Papillomavirus (HPV) DNA test with the combination of a Pap smear every 5 years for women 30 to 65 who don't want a Pap smear every 3 years
5. Chlamydia Infection screening for younger women and other women at higher risk
6. Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
7. Domestic and interpersonal violence screening and counseling for all women
8. Gonorrhea screening for all women at higher risk
9. HIV screening and counseling for sexually active women
10. Osteoporosis screening for women over age 60 depending on risk factors
11. Rh incompatibility screening and follow-up testing for women at higher risk
12. Sexually Transmitted Infections counseling for sexually active women
13. Syphilis screening for women at increased risk
14. Tobacco Use screening and interventions
15. Urinary incontinence screening for women yearly
16. Well-woman visits to get recommended services for women under 65

Preventive Care Benefits

Preventive Health Services for Children

All Marketplace health plans and many other plans must cover the following list of preventive services for children without charging you a copayment or coinsurance. This is true even if you haven't met your yearly deductible. These services are free only when delivered by a doctor or other provider in your plan's network.

1. Alcohol, tobacco, and drug use assessments for adolescents
2. Autism screening for children at 18 and 24 months
3. Behavioral assessments for children at the following ages: 0-11 mos, 1-4 yrs, 5-10 yrs, 11-14 yrs, 15-17 yrs
4. Bilirubin concentration screening for newborns
5. Blood Pressure screening for children at the following ages: 0-11 mos, 1-4 yrs, 5-10 yrs, 11-14 yrs, 15-17 yrs
6. Blood screening for newborns
7. Cervical Dysplasia screening for sexually active females
8. Depression screening for adolescents beginning routinely at age 12
9. Developmental screening for children under age 3
10. Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders at the following ages: 1-4 yrs, 5-10 yrs, 11-14 yrs, 15-17 yrs
11. Fluoride chemoprevention supplements for children without fluoride in their water source
12. Fluoride varnish for all infants and children as soon as teeth are present
13. Gonorrhea preventive medication for the eyes of all newborns
14. Hearing screening for all newborns; and for children once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years
15. Height, Weight and Body Mass Index (BMI) measurements for children at the following ages: 0-11 mos, 1-4 yrs, 5-10 yrs, 11-14 yrs, 15-17 yrs
16. Hematocrit or Hemoglobin screening for all children
17. Hemoglobinopathies or sickle cell screening for newborns
18. Hepatitis B screening for adolescents at high risk, including adolescents from countries with 2% or more Hepatitis B prevalence, and U.S. – born adolescents not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence: 11-17 years
19. HIV screening for adolescents at higher risk
20. Hypothyroidism screening for newborns
21. Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis (Whooping Cough)
    - Haemophilus influenza type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus (HPV)
    - Inactivated Poliovirus
    - Influenza (Flu Shot)
    - Measles
    - Meningococcal
    - Pneumococcal
    - Rotavirus
    - Varicella (Chickenpox)
22. Iron supplements for children ages 6 to 12 months at risk for anemia
23. Lead screening for children at risk of exposure
24. Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits
25. Medical History for all children throughout development at the following ages: 0-11 mos, 1-4 yrs, 5-10 yrs, 11-14 yrs, 15-17 yrs
26. Obesity screening and counseling
27. Oral health risk assessment for young children ages: 0-11 mos, 1-4 yrs, 5-10 yrs
28. Phenylketonuria (PKU) screening for newborns
29. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
30. Tuberculin testing for children at higher risk of tuberculosis at the following ages: 0-11 mos, 1-4 yrs, 5-10 yrs, 11-14 yrs, 15-17 yrs
31. Vision screening for all children

In-Network Benefit Comparison

Choose only ONE medical plan for yourself and your family members.

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable certificate and riders. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control.

Cost Comparison – Payroll Deductions

2019 Weekly Insurance Cost (Deducted from every paycheck)	**Medical Plan: Basic Deductible: $500 per person $1,000 per family**	**Medical: Premium Deductible: $200 per person $400 per family**
Employee Only:	$9.34	$25.98
Employee + One:	22.43	$62.34
Family:	28.03	$77.93

2019 Bi-Weekly Insurance Cost (Deducted from every paycheck)	**Medical Plan: Basic Deductible: $500 per person $1,000 per family**	**Medical: Premium Deductible: $200 per person $400 per family**
Employee Only:	$18.69	$51.95
Employee + One:	$44.85	$124.68
Family:	$56.06	$155.85

In-Network Benefit Comparison

Blue Cross Blue Shield of Michigan

	Basic Plan	Premium Plan
Deductibles		
One person	$500	$200
Family	$1,000	$400
Coinsurance	80% / 20%	100% / 0%
Annual Coinsurance Maximums		
One person	$1,500	Not Applicable
Family	$3,000	Not Applicable
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 drug cost-sharing amounts.		
Annual Out-of-Pocket Maximums		
One person	$6,600	$5,000
Family	$13,200	$10,000
Applies to deductibles, flat dollar copays and coinsurance amounts for all covered services – including prescription drugs cost-sharing amounts.		
Copays		
PCP office visit	$30	$25
Mobile app visit	$0 **(NO COPAY)**	$0 **(NO COPAY)**
Specialist office visit	$30	$25
Chiropractic	$30, then 20% after deductible	$25
Urgent care	$50	$40
Emergency room	$200 waived if admitted	$200 waived if admitted
Inpatient Admission	$125, then 20% after deductible	$125
The flat dollar copays **do not** apply to your deductible but do apply to your out-of-pocket maximum.		

Prescription Drug Copays				
	30 days	90 days Retail and Mail Order	30 days	90 days Retail and Mail Order
Generic	$10	$10	$10	$10
Preferred brand	$30	$60	$30	$60
Non-preferred brand	$50	$100	$50	$100
Preferred specialty	$30	$60	$30	$60
Non-preferred specialty	$50	$100	$50	$100

PPO Basic Medical Program

Choose only ONE medical plan for yourself and your family members.

New Hire Eligibility Period:
Employees will become eligible for benefits on the first day of the month following 30 days of employment.

Dependent Eligibility:
Dependent children (as defined by the Affordable Care Act, including students and non-students) are eligible to age 26.

Termination of Coverage:
Coverage will end on the date of the status change event.

The Affordable Care Act (ACA) requires that the following documents be provided to plan participants. They were designed to help you understand and evaluate your health insurance choices.

- An easy-to-understand **summary of benefits and coverage (SBC)** which includes specific technical information for simulating coverage examples for three benefit scenarios: having a baby, managing type 2 diabetes, emergency and follow-up treatment for a fracture.

- A **uniform glossary of terms** commonly used in health insurance coverage such as "deductible" and "co-payment“.

Blue Cross Blue Shield of Michigan

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

Usui International Corporation

Group Number: 71505 Effective Date: 01/01/2019

Benefits-at-a-glance

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BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$500 per member $1,000 per family	$1,000 per member $2,000 per family
Copays • Fixed Dollar Copays	$30 copay for : • Office visits • Chiropractic spinal manipulations $50 copay for : • Urgent care services $125 copay for : • Inpatient admissions $200 copay for : • Facility medical emergency	$50 copay for : • Urgent care services $200 copay for : • Facility medical emergency $250 copay for : • Inpatient admissions
Coinsurance • Percent Coinsurance	20% up to a maximum of: $1,500 per member $3,000 per family	40% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$6,600 per member $13,200 per family Includes Deductible, Coinsurance and Copays	$13,200 per member $26,400 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Covered - 60% after deductible
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Covered - 60% after deductible
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Covered - 60% after deductible
Pap Smear Screening - one per calendar year	Covered - 100%	Covered - 60% after deductible
Mammography Screening - one per calendar year	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate specific antigen (PSA) screening - one per calendar year	Covered - 100%	Covered - 60% after deductible
Endoscopic Exams one per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 visits per calendar year, birth through 12 months • 6 visits per calendar year, 13 months through 35 months • 2 visits per calendar year, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Covered - 60% after deductible
Immunizations - pediatric and adult	Covered - 100%	Covered - 60% after deductible

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $30 copay	Covered - 60% after deductible
Online Visits Note: Services are payable when rendered by American Well or BCBS providers	Covered - 100%	Covered - 60% after deductible
Office Consultations	Covered - 80% after deductible	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 80% after deductible	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $200 copay; copay waived if admitted	Covered - 100% after $200 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Covered - 100% after $200 copay	Covered - 100% after $200 copay
Urgent Care Services	Covered - 100% after $50 copay	Covered - 100% after $50 copay
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care excludes dependent children	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - $125 copay then 80% after deductible	Covered - $250 copay then 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 80% after deductible	Covered - 60% after deductible
Home Health Care Limited to a maximum of 50 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible
Skilled Nursing Limited to a maximum of 60 days per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

Behavioral Health Care and Substance Abuse Treatment Services

Benefits	In-Network	Out-of-Network
Inpatient Behavioral Health Care and Substance Abuse Treatment	Covered - $125 copay then 80% after deductible	Covered - $250 copay then 60% after deductible
Outpatient Behavioral Health Care and Substance Abuse Treatment • Online Behavioral Health Visits	Covered - $30 copay then 80% after deductible Covered - $30 copay then 80% after deductible	Covered - 60% after deductible Covered - 60% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 25 visits per calendar year	Covered - $30 copay then 80% after deductible	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 60% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 60% after deductible
Private Duty Nursing Care	Not Covered	Not Covered
Allergy Testing and Therapy	Covered - 80% after deductible	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Note: The following services require preapproval: Inpatient Care, select Radiology and Diagnostic Services, Inpatient Behavioral Health Care and Substance Abuse Treatment, and Skilled Nursing.

Usui International Corporation

Group Number: 71505 Effective Date: 01/01/2019

Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30 day supply	$10 copay - Generic drugs $30 copay - Preferred brand drugs $50 copay - Non-Preferred brand drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Retail and Mail Order - 90 day supply	$10 copay - Generic drugs $60 copay - Preferred brand drugs $100 copay - Non-Preferred brand drugs
Specialty Drugs – 30 day supply	Retail: $10 copay - Generic drugs $30 copay - Preferred brand drugs $50 copay - Non-Preferred brand drugs Mail Order: $10 copay - Generic drugs $60 copay - Preferred brand drugs $100 copay - Non-Preferred brand drugs Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
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	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Not Covered
Diabetic Supplies	Includes: Needles/Syringes - Covered at 100% if an injectable prescription drug was filled within the last 120 days under the BCBSM Rx benefit Retail Test Strips and Lancets: $30 copay Mail Order Test Strips and Lancets: $60 copay

PPO Premium Medical Program

Choose only ONE medical plan for yourself and your family members.

New Hire Eligibility Period:
Employees will become eligible for benefits on the first day of the month following 30 days of employment.

Dependent Eligibility:
Dependent children (as defined by the Affordable Care Act), are eligible to the day on which they turn age 26.

Termination of Coverage:
Coverage will end on the date of the status change event.

The Affordable Care Act (ACA) requires that the following documents be provided to plan participants. They were designed to help you understand and evaluate your health insurance choices.

- An easy-to-understand **summary of benefits and coverage (SBC)** which includes specific technical information for simulating coverage examples for three benefit scenarios: having a baby, managing type 2 diabetes, emergency and follow-up treatment for a fracture.

- A **uniform glossary of terms** commonly used in health insurance coverage such as "deductible" and "co-payment“.

Blue Cross Blue Shield of Michigan

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

Usui International Corporation
Group Number: 71505

Effective Date: 01/01/2019
Benefits-at-a-glance

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

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$200 per member $400 per family	$500 per member $1,000 per family
Copays • Fixed Dollar Copays	$25 copay for : • Office visits • Chiropractic spinal manipulations $40 copay for : • Urgent care services $125 copay for : • Inpatient admissions $200 copay for : • Facility medical emergency	$40 copay for : • Urgent care services $200 copay for : • Facility medical emergency $250 copay for : • Inpatient admissions
Coinsurance • Percent Coinsurance	0%	30% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$5,000 per member $10,000 per family Includes Deductible, Coinsurance and Copays	$13,200 per member $26,400 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Covered - 70% after deductible
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Covered - 70% after deductible
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Covered - 70% after deductible
Pap Smear Screening - one per calendar year	Covered - 100%	Covered - 70% after deductible
Mammography Screening - one per calendar year	Covered - 100%	Covered - 70% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Not Covered
Prostate specific antigen (PSA) screening - one per calendar year	Covered - 100%	Covered - 70% after deductible
Endoscopic Exams one per calendar year	Covered - 100%	Covered - 70% after deductible
Well Child Care • 8 visits per calendar year, birth through 12 months • 6 visits per calendar year, 13 months through 35 months • 2 visits per calendar year, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Covered - 70% after deductible
Immunizations - pediatric and adult	Covered - 100%	Covered - 70% after deductible

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $25 copay	Covered - 70% after deductible
Online Visits Note: Services are payable when rendered by American Well or BCBS providers	Covered - 100%	Covered - 70% after deductible
Office Consultations	Covered - 100% after deductible	Covered - 70% after deductible
Pre-Surgical Consultations	Covered - 100% after deductible	Covered - 70% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $200 copay; copay waived if admitted	Covered - 100% after $200 copay; copay waived if admitted
Non-Emergency use of the Emergency Room	Covered - 100% after $200 copay	Covered - 100% after $200 copay
Urgent Care Services	Covered - 100% after $40 copay	Covered - 100% after $40 copay
Ambulance Services - Medically Necessary Transport	Covered - 100% after deductible	Covered - 100% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 100% after deductible	Covered - 70% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 100% after deductible	Covered - 70% after deductible
Radiation Therapy and Chemotherapy	Covered - 100% after deductible	Covered - 70% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 70% after deductible
Delivery and Nursery Care excludes dependent children	Covered - 100%	Covered - 70% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 100% after $125 copay	Covered - $250 copay then 70% after deductible
Inpatient Medical Care	Covered - 100% after deductible	Covered - 70% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100% after deductible	Covered - 70% after deductible
Home Health Care Limited to a maximum of 50 visits per calendar year	Covered - 100% after deductible	Covered - 70% after deductible
Skilled Nursing Limited to a maximum of 60 days per calendar year	Covered - 100% after deductible	Covered - 70% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 100% after deductible	Covered - 70% after deductible
Bariatric Surgery	Covered - 100% after deductible	Covered - 70% after deductible
Sterilization - males only excludes reversal sterilization	Covered - 100% after deductible	Covered - 70% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 70% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 100% after deductible	Covered - 70% after deductible

Behavioral Health Care and Substance Abuse Treatment Services

Benefits	In-Network	Out-of-Network
Inpatient Behavioral Health Care and Substance Abuse Treatment	Covered - 100% after $125 copay	Covered - $250 copay then 70% after deductible
Outpatient Behavioral Health Care and Substance Abuse Treatment • Online Behavioral Health Visits	Covered - 100% after $25 copay Covered - 100% after $25 copay	Covered - 70% after deductible Covered - 70% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 100% after deductible	Covered - 70% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 25 visits per calendar year	Covered - 100% after $25 copay	Covered - 70% after deductible
Durable Medical Equipment	Covered - 100% after deductible	Covered - 70% after deductible
Prosthetic and Orthotic Devices	Covered - 100% after deductible	Covered - 70% after deductible
Private Duty Nursing Care	Not Covered	Not Covered
Allergy Testing and Therapy	Covered - 100% after deductible	Covered - 70% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 100% after deductible	Covered - 70% after deductible

Note: The following services require preapproval: Inpatient Care, select Radiology and Diagnostic Services, Inpatient Behavioral Health Care and Substance Abuse Treatment, and Skilled Nursing.

Usui International Corporation
Group Number: 71505

Effective Date: 01/01/2019
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30 day supply	$10 copay - Generic drugs $30 copay - Preferred brand drugs $50 copay - Non-Preferred brand drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Retail and Mail Order - 90 day supply	$10 copay - Generic drugs $60 copay - Preferred brand drugs $100 copay - Non-Preferred brand drugs
Specialty Drugs – 30 day supply	Retail: $10 copay - Generic drugs $30 copay - Preferred brand drugs $50 copay - Non-Preferred brand drugs Mail Order: $10 copay - Generic drugs $60 copay - Preferred brand drugs $100 copay - Non-Preferred brand drugs Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
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	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Not Covered
Diabetic Supplies	Includes: Needles/Syringes - Covered at 100% if an injectable prescription drug was filled within the last 120 days under the BCBSM Rx benefit Retail Test Strips and Lancets: $30 copay Mail Order Test Strips and Lancets: $60 copay

Dental Program

New Hire Eligibility Period:
Employees will become eligible for benefits on the first day of the month following 30 days of employment.

Dependent Eligibility:
Dependent children (as defined by the Affordable Care Act), are eligible to the day on which they turn age 26.

Termination of Coverage:
Coverage will end on the date of the status change event.

Most of us go to the dentist more often than our regular doctors. Routine dental exams can identify the signs of many serious health conditions. Catching these conditions in the early stages reduces medical costs for everyone.

A visit to your dentist can help you keep a great smile and prevent many health issues. But dental care can be costly and you can be faced with unforeseen expenses. Did you know, a crown can cost as much as $1,400?* BCBSM dental insurance will help you pay for it. You can go to any licensed dentist anywhere. You are covered whether you see in-network or out-of-network dentists. But, when you see dentists in the PPO network, you save up to 25 percent off what dentists usually charge. If you see a dentist who's outside the PPO network, you can still save money by choosing Blue Par Select dentists.

*http://health.costhelper.com/dental-crown.html

2019 Weekly Insurance Cost (Deducted from every paycheck)	Dental
Employee Only: Employee + One: Family:	$1.89 $3.77 $6.60

2019 Bi-Weekly Insurance Cost (Deducted from every paycheck)	Dental
Employee Only: Employee + One: Family:	$3.78 $7.55 $13.21

Usui International Corporation
Group Number: 71505
Dental Coverage - Blue Dental PPO Plus
Effective Date: 01/01/2019
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Network access information - With Blue Dental PPO Plus, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.

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 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**.
Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.
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.

Blue Par Select℠ 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 non-participating dentists are responsible for any difference between our approved amount and the dentist's charge.

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

Benefits	Coverage
Benefit Period	Calendar Year
Deductible	$50 Individual - Applies to Class II & Class III
Class I services	0%
Class II services	20%
Class III services	50%
Class IV services	50%
Dollar Maximums - Annual Maximum	$1,500 per member Class I, II & III services
Lifetime Orthodontic Maximum	$1,500 per member

Class I services

Benefits	Coverage
Periodic Oral Exams	Covered - 100%, twice per calendar year
Prophylaxis (Teeth Cleaning)	Covered - 100%, twice per calendar year
Bitewing X-Rays	Covered - 100%, twice per calendar year
Full-mouth or Panoramic X-Rays	Covered - 100%, once every 36 months
Fluoride Treatment	Covered - 100%, twice per calendar year
Space Maintainers	Covered - 100%, once per quadrant per lifetime, up to and including age 18
Sealants	Not Covered

Class II services

Benefits	Coverage
Fillings - permanent teeth	Covered - 80% after deductible, once per tooth per surface every 24 months
Fillings - primary teeth	Covered - 80% after deductible, once per tooth per surface every 12 months
Recementing of Inlays, Onlays, Crowns and Bridges	Covered - 80% after deductible, unlimited
Root Canal Therapy	Covered - 80% after deductible, once every 12 months for teeth with one or more canals
Periodontal Scaling and Root Planing	Covered - 80% after deductible, once per quadrant every 24 months
Occlusal Adjustment	Covered - 80% after deductible, up to five times in a 60 month period
Occlusal Biteguards	Covered - 80% after deductible, once every 12 months
General Anesthesia or IV Sedation with oral surgery	Covered - 80% after deductible
Oral Surgery including extractions	Covered - 80% after deductible, unlimited
Palliative Emergency Treatment	Covered - 80% after deductible, unlimited

Class III services

Benefits	Coverage
Removable Dentures - Complete and Partials	Covered - 50% after deductible, once per arch every 60 months
Fixed Bridges	Covered - 50% after deductible, once every 60 months
Implants	Not Covered
Inlays, Onlays and Crowns - permanent teeth	Covered - 50% after deductible, unlimited
Relining or Rebasing of Partials or Dentures	Covered - 50% after deductible, unlimited
Repair to Existing Partials or Dentures	Covered - 50% after deductible, unlimited
Tissue Conditioning	Covered - 50% after deductible, unlimited

Class IV services - Orthodontic services for dependents up to and including age 18

Benefits	Coverage
Orthodontic Services	Covered - 50%
Cephalometric Films and Oral Facial Photos	Covered - 50%

Vision Program

New Hire Eligibility Period:
Employees will become eligible for benefits on the first day of the month following 30 days of employment.

Dependent Eligibility:
Dependent children (as defined by the Affordable Care Act), are eligible to the day on which they turn age 26.

Termination of Coverage:
Coverage will end on the date of the status change event.

Eye care is a vital component of a healthy lifestyle. Routine eye exams can identify the signs of many serious health conditions. Catching these conditions in the early stages reduces medical costs for everyone. With vision insurance, having regular exams and purchasing contacts or glasses is simple and affordable.

2019 Weekly Insurance Cost (Deducted from every paycheck)	Vision
Employee Only: Employee + One: Family:	$2.00 $4.00 $6.64

2019 Bi-Weekly Insurance Cost (Deducted from every paycheck)	Vision
Employee Only: Employee + One: Family:	$4.00 $8.00 $13.28

Blue Cross Blue Shield of Michigan

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

Usui International Corporation
Group Number: 71505

Vision Coverage - Blue Vision
Effective Date: 01/01/2019
Benefits-at-a-glance

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. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. There are more than 3,000 VSP provider locations in Michigan and 53,000 locations nationwide. To find a VSP provider, call **1-800-877-7195** or visit VSP's Web site at **www.vsp.com**.

Member's responsibility (copayments)

Benefits	VSP Provider	Out-of-Network Provider
Eye Exam	100%	100%
Frames and/or lenses or medically necessary contact lenses	No copay	Member responsible for difference between approved amount and provider's charge, after no copay
Benefit Maximum Maximum benefit for all eligible expenses	$400 per member	

Eye exams

Benefits	VSP Provider	Out-of-Network Provider
Covers a 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.	Covered - 100% Once every 12 months	Covered - 100%

Lenses and frames

Benefits	VSP Provider	Out-of-Network Provider
Covers standard eyeglass frames. A wide selection of quality frames is fully covered by VSP up to the frame allowance. Members should ask their doctor which frames are covered in full. Members may select a more expensive frame and pay a cost controlled price difference.	Covered - 100% Once every 12 months	Covered - 100%
Single vision, bifocal, trifocal or lenticular lenses in glass or plastic. **Note:** Additional pairs of prescription glasses and non-covered lens options are discounted when purchased from a VSP provider.	Covered - 100% (one copay applies to both lenses and frames) Once every 12 months	Covered - 100%

Contact Lenses: Members may obtain either eyeglasses or contact lenses, but not both

Benefits	VSP Provider	Out-of-Network Provider
Elective contact lenses (prescribed, but not medically necessary) may be chosen instead of spectacle lenses and a frame.	Once every 12 months	
Therapeutic contact lenses (medically necessary)	Covered - no copay	
	Once every 12 months	

Safety Eye Care Benefit:
Safety eye wear are prescription lenses and frames used for the purpose of safety glasses. Safety eye wear provides prescription glasses certified according to the requirements of the American National Standards Institute (ANSI).
This benefit is in addition to regular frames/lenses.
This coverage is provided for prescription coverage safety lenses and frames that are obtained from an in-network provider. Safety lenses/frames are NOT payable if provided by an out-of-network provider.
The maximum allowance for the frames is limited to $65, and there is no maximum allowance for the lenses.
The frequency/copayment for the safety glasses remains the same as the regular prescription lenses and frames.
This benefit is ONLY available for the SUBSCRIBER, not any dependents listed on the contract, including the spouse.

Employee Group Term Life and AD&D Insurance and Voluntary Term Life Insurance

Please input beneficiary information into the Paycor enrollment system!

New Hire Eligibility Period:
Employees will become eligible for benefits on the first day of the month following 30 days of employment.

Dependent Eligibility:
Dependent, unmarried children are eligible until the day in which they turn 26 years.

Termination of Coverage:
Coverage will end on the date of the status change event.

Group Term Life insurance helps to provide financial protection for the unexpected. Life insurance can help ensure financial security for your family and loved ones upon your death. Your employer paid term life insurance coverage also includes an accidental death and dismemberment (AD&D) benefit. AD&D pays an additional benefit to your beneficiary if you die in an accident, or it pays you if, as the result of an accident, you suffer certain losses.

Keep your beneficiary designations up-to-date.

When was the last time you checked your designations of beneficiary? Your Life Insurance benefits are payable to the beneficiary(ies) you name. An out-of-date designation results in giving the money to someone that you no longer wish to give it to. A review of your beneficiary(ies) should be done any time you experience a major life event, such as marriage, divorce, new baby, home ownership, a health scare, etc. Beneficiary designations may be updated at any time. Contact your HR Department to update your beneficiary designation.

Life Insurance

HELP PROTECT WHAT MATTERS – YOU, YOUR FAMILY & YOUR FUTURE

Life insurance is a simple answer to a very difficult question: How will my loved ones manage financially when I die? It's a subject no one really wants to think about. But, if someone depends on you financially, it's one question you cannot avoid.

PROTECTION FOR EVERY STAGE OF YOUR LIFE

Whether you're single, married, have children or are close to retirement, having life insurance is a must. Life insurance pays benefits to your loved ones after you die, replacing your income and allowing the financial plans you put in place to continue uninterrupted.

When determining how much life insurance you need, think about the expenses you may encounter through every stage of your life. Consider:

FINAL EXPENSES & OTHER DEBT

- Funeral costs and final medical expenses
- Mortgage and credit card debt
- Taxes and estate settlement costs

ONGOING EXPENSES

- Food and clothing
- Housing and utilities
- Transportation
- Health care
- Insurance

FUTURE EXPENSES

- College
- Retirement

HOW MUCH IS ENOUGH?

The toughest part of buying life insurance is determining how much you need. The amount of life insurance you need depends on your personal situation and financial goals. No matter what your current life stage, life insurance is there to help protect your family financially – *even if you can't.*

INCOME REPLACEMENT & ASSETS	
Annual income your loved ones need now and in the future	$_____
(Current income multiplied by number years needed – for example: $50k x 5 years = $250,000)	
Subtotal (Income) =	$_____
FINAL EXPENSES & OTHER DEBT	
Funeral Expenses ($15,000 is a reasonable estimate)	$_____
Mortgage	$_____
Credit Card and other debt (Balance, car loans, etc...)	$_____
Subtotal (Debt) =	$_____
EDUCATIONAL FUNDS	
College costs per person (4 years at Private $118,000/ Public $48,000 institution)	$_____
Subtotal (Education) =	$_____
TOTAL LIFE INSURANCE NEEDED	
Income + Debt + Education =	
Total Need For Life Insurance	$_____

*As of 10/15

Life insurance is underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, 1-800-769-7159. Policy form number 7000GM-U-EZ 2010 or state equivalent (7000GM-U-EZ 2010 NC). United of Omaha is licensed nationwide, except in New York. Some exclusions, limitations and reductions may apply.

Term Life Insurance

FOR EMPLOYEES OF USUI INTERNATIONAL CORPORATION

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 130 hours per month to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.

BENEFITS	
Life Insurance Benefit Amount	For You: $20,000 In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
Accidental Death & Dismemberment (AD&D) Benefit Amount	For You: The Principal Sum amount is equal to the amount of your life insurance benefit.

FEATURES	
Living Care/ Accelerated Death Benefit	80% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $16,000.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Additional AD&D Benefits	In addition to basic AD&D benefits, you are protected by the following benefits: - Child Education - Seat Belt - Airbag - Common Carrier
Portability	Allows you to continue this insurance program should you leave your employer for any reason, without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
Conversion	If your employment ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.

SERVICES	
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep	We work with Willing® to offer employees discounted online will preparation tools. In just a few clicks you can complete a customized plan to protect your family and property (valid in all 50 states). To get started visit www.willing.com/mutualofomaha

AGE REDUCTIONS AND EXCLUSIONS

Insurance benefits and guarantee issue amounts are subject to age reductions:

- At age 65, amounts reduce to 65%
- At age 70, amounts reduce to 40%
- At age 75, amounts reduce to 25%

Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

Please contact your employer if you have questions prior to enrolling.

› Voluntary Term Life Insurance

Help Protect What Matters – You, Your Family & Your Future

We understand you've worked hard to get where you are today. Ensuring your loved ones can maintain financial stability if an unexpected death should occur is something to consider when planning for the future.

We've Got You Covered

As an active employee of USUI International Corporation, you have access to a life insurance policy from United of Omaha Life Insurance Company.

It replaces the income you would have provided, and helps pay funeral costs, manage debt and cover ongoing expenses.

How much insurance is enough?

When determining how much life insurance you need, think about the expenses you may encounter now and through every stage of your life.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 130 hours per month to be eligible for coverage.
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are paid in full by you.

COVERAGE GUIDELINES	Minimum	Guarantee Issue	Maximum
For You	$20,000	5 times annual salary, up to $100,000	$300,000, in increments of $10,000, but no more than 5 times annual salary
Spouse	$5,000	100% of employee's benefit, up to $25,000	50% of employee's benefit, up to $50,000
Children	$5,000	100% of employee's benefit	50% of employee's benefit, up to $10,000

Subject to any reductions shown below. Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability.

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BENEFITS	
Life Insurance Benefit Amount	Within the coverage guidelines defined above, you select the amount of life insurance coverage you want. This plan includes the option to select coverage for your spouse and dependent children. Children include those, up to age 26. In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
FEATURES	
Living Care/ Accelerated Death Benefit	80% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $240,000.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Annual Benefit Amount Increase	If you enroll for even the minimum amount of coverage during your initial enrollment, you have the ability to enroll for additional coverage at your next enrollment by up to $10,000, provided the total amount of insurance does not exceed your maximum benefit amount. This feature allows you to secure additional life insurance protection in the event your needs change (ex. you get married or have a child). Amounts over the Guarantee Issue will require evidence of insurability (information about your health).
Portability	Allows you to continue this insurance program for yourself and your dependents should you leave your employer for any reason, without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
Conversion	If your employment ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep	We work with Willing® to offer employees discounted online will preparation tools. In just a few clicks you can complete a customized plan to protect your family and property (valid in all 50 states). To get started visit www.willing.com/mutualofomaha

AGE REDUCTIONS AND EXCLUSIONS

Insurance benefits and guarantee issue amounts are subject to age reductions:

- At age 65, amounts reduce to 65%
- At age 70, amounts reduce to 40%
- At age 75, amounts reduce to 25%

Spouse coverage terminates when you reach age 70.

Life insurance benefits will not be paid if the insured's death is the result of suicide within two years from the date coverage begins. If this occurs, the sum of the premiums paid will be returned to the beneficiary. The same applies for any future increases in coverage under this plan.

Please contact your employer if you have questions prior to enrolling.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 130 hours per month.

What is Guarantee Issue?

The amount of insurance applied for without answering any health questions (or which does not require evidence of insurability). Coverage amounts over the Guarantee Issue Amount will require evidence of insurability.

What is Evidence of Insurability?

Evidence of Insurability or proof of good health – may be required if you are a late entrant and/or you request any additional coverage above your guarantee issue amount.

Can I take this insurance with me if I change jobs/am no longer a member of this group?

In the event this insurance ends due to a change in your employment/membership status with the group, or for certain other reasons, you may have the right to continue this insurance under the Portability or Conversion provision, subject to certain conditions.

Are there any limitations, reductions or exclusions?

The benefits payable are based on the following:

- Insurance benefits and guarantee issue amounts are subject to age reductions:
  - At age 65, amounts reduce to 65%
  - At age 70, amounts reduce to 40%
  - At age 75, amounts reduce to 25%
- Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

Voluntary Term Life Coverage Selection and Premium Calculation

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.

To select your benefit amount and calculate your premium, do the following:

1) Locate the benefit amount you want from the top row of the employee premium table. Your benefit amount must be in an increment of $10,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
2) Find your age bracket in the far left column.
3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
4) Enter the benefit and premium amounts into their respective areas in the Voluntary Life section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want. For example, if you want $150,000 in coverage, you obtain your premium amount by multiplying the rate for $50,000 times 3.

EMPLOYEE PREMIUM TABLE (52 PAYROLL DEDUCTIONS PER YEAR)

Age	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000	$110,000
0 - 24	$0.32	$0.48	$0.65	$0.81	$0.97	$1.13	$1.29	$1.45	$1.62	$1.78
25 - 29	$0.28	$0.42	$0.55	$0.69	$0.83	$0.97	$1.11	$1.25	$1.38	$1.52
30 - 34	$0.37	$0.55	$0.74	$0.92	$1.11	$1.29	$1.48	$1.66	$1.85	$2.03
35 - 39	$0.46	$0.69	$0.92	$1.15	$1.38	$1.62	$1.85	$2.08	$2.31	$2.54
40 - 44	$0.55	$0.83	$1.11	$1.38	$1.66	$1.94	$2.22	$2.49	$2.77	$3.05
45 - 49	$0.92	$1.38	$1.85	$2.31	$2.77	$3.23	$3.69	$4.15	$4.62	$5.08
50 - 54	$1.48	$2.22	$2.95	$3.69	$4.43	$5.17	$5.91	$6.65	$7.38	$8.12
55 - 59	$2.45	$3.67	$4.89	$6.12	$7.34	$8.56	$9.78	$11.01	$12.23	$13.45
60 - 64	$3.97	$5.95	$7.94	$9.92	$11.91	$13.89	$15.88	$17.86	$19.85	$21.83
65 - 69	$6.42	$9.62	$12.83	$16.04	$19.25	$22.45	$25.66	$28.87	$32.08	$35.28
70 - 74	$12.28	$18.42	$24.55	$30.69	$36.83	$42.97	$49.11	$55.25	$61.38	$67.52
75 - 79	$22.94	$34.41	$45.88	$57.35	$68.82	$80.28	$91.75	$103.22	$114.69	$126.16
80+	$38.91	$58.36	$77.82	$97.27	$116.72	$136.18	$155.63	$175.08	$194.54	$213.99

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse and/or child(ren) coverage. **Your spouse's rate is based on your age,** so find your age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

SPOUSE PREMIUM TABLE (52 PAYROLL DEDUCTIONS PER YEAR)

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0 - 24	$0.08	$0.16	$0.24	$0.32	$0.40	$0.48	$0.57	$0.65	$0.73	$0.81
25 - 29	$0.07	$0.14	$0.21	$0.28	$0.35	$0.42	$0.48	$0.55	$0.62	$0.69
30 - 34	$0.09	$0.18	$0.28	$0.37	$0.46	$0.55	$0.65	$0.74	$0.83	$0.92
35 - 39	$0.12	$0.23	$0.35	$0.46	$0.58	$0.69	$0.81	$0.92	$1.04	$1.15
40 - 44	$0.14	$0.28	$0.42	$0.55	$0.69	$0.83	$0.97	$1.11	$1.25	$1.38
45 - 49	$0.23	$0.46	$0.69	$0.92	$1.15	$1.38	$1.62	$1.85	$2.08	$2.31
50 - 54	$0.37	$0.74	$1.11	$1.48	$1.85	$2.22	$2.58	$2.95	$3.32	$3.69
55 - 59	$0.61	$1.22	$1.83	$2.45	$3.06	$3.67	$4.28	$4.89	$5.50	$6.12
60 - 64	$0.99	$1.98	$2.98	$3.97	$4.96	$5.95	$6.95	$7.94	$8.93	$9.92
65 - 69	$1.60	$3.21	$4.81	$6.42	$8.02	$9.62	$11.23	$12.83	$14.43	$16.04

ALL CHILDREN PREMIUM TABLE (52 PAYROLL DEDUCTIONS PER YEAR)*

$5,000	$10,000
$0.21	$0.42

*Regardless of how many children you have, they are included in the "All Children" premium amounts listed in the table above.

Voluntary Term Life Coverage Selection and Premium Calculation

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.

To select your benefit amount and calculate your premium, do the following:

1) Locate the benefit amount you want from the top row of the employee premium table. Your benefit amount must be in an increment of $10,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
2) Find your age bracket in the far left column.
3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
4) Enter the benefit and premium amounts into their respective areas in the Voluntary Life section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want. For example, if you want $150,000 in coverage, you obtain your premium amount by multiplying the rate for $50,000 times 3.

EMPLOYEE PREMIUM TABLE (26 PAYROLL DEDUCTIONS PER YEAR)

Age	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000	$110,000
0 - 24	$0.65	$0.97	$1.29	$1.62	$1.94	$2.26	$2.58	$2.91	$3.23	$3.55
25 - 29	$0.55	$0.83	$1.11	$1.38	$1.66	$1.94	$2.22	$2.49	$2.77	$3.05
30 - 34	$0.74	$1.11	$1.48	$1.85	$2.22	$2.58	$2.95	$3.32	$3.69	$4.06
35 - 39	$0.92	$1.38	$1.85	$2.31	$2.77	$3.23	$3.69	$4.15	$4.62	$5.08
40 - 44	$1.11	$1.66	$2.22	$2.77	$3.32	$3.88	$4.43	$4.98	$5.54	$6.09
45 - 49	$1.85	$2.77	$3.69	$4.62	$5.54	$6.46	$7.38	$8.31	$9.23	$10.15
50 - 54	$2.95	$4.43	$5.91	$7.38	$8.86	$10.34	$11.82	$13.29	$14.77	$16.25
55 - 59	$4.89	$7.34	$9.78	$12.23	$14.68	$17.12	$19.57	$22.02	$24.46	$26.91
60 - 64	$7.94	$11.91	$15.88	$19.85	$23.82	$27.78	$31.75	$35.72	$39.69	$43.66
65 - 69	$12.83	$19.25	$25.66	$32.08	$38.49	$44.91	$51.32	$57.74	$64.15	$70.57
70 - 74	$24.55	$36.83	$49.11	$61.38	$73.66	$85.94	$98.22	$110.49	$122.77	$135.05
75 - 79	$45.88	$68.82	$91.75	$114.69	$137.63	$160.57	$183.51	$206.45	$229.38	$252.32
80+	$77.82	$116.72	$155.63	$194.54	$233.45	$272.35	$311.26	$350.17	$389.08	$427.98

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse and/or child(ren) coverage. **Your spouse's rate is based on your age,** so find your age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

SPOUSE PREMIUM TABLE (26 PAYROLL DEDUCTIONS PER YEAR)

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0 - 24	$0.16	$0.32	$0.48	$0.65	$0.81	$0.97	$1.13	$1.29	$1.45	$1.62
25 - 29	$0.14	$0.28	$0.42	$0.55	$0.69	$0.83	$0.97	$1.11	$1.25	$1.38
30 - 34	$0.18	$0.37	$0.55	$0.74	$0.92	$1.11	$1.29	$1.48	$1.66	$1.85
35 - 39	$0.23	$0.46	$0.69	$0.92	$1.15	$1.38	$1.62	$1.85	$2.08	$2.31
40 - 44	$0.28	$0.55	$0.83	$1.11	$1.38	$1.66	$1.94	$2.22	$2.49	$2.77
45 - 49	$0.46	$0.92	$1.38	$1.85	$2.31	$2.77	$3.23	$3.69	$4.15	$4.62
50 - 54	$0.74	$1.48	$2.22	$2.95	$3.69	$4.43	$5.17	$5.91	$6.65	$7.38
55 - 59	$1.22	$2.45	$3.67	$4.89	$6.12	$7.34	$8.56	$9.78	$11.01	$12.23
60 - 64	$1.98	$3.97	$5.95	$7.94	$9.92	$11.91	$13.89	$15.88	$17.86	$19.85
65 - 69	$3.21	$6.42	$9.62	$12.83	$16.04	$19.25	$22.45	$25.66	$28.87	$32.08

ALL CHILDREN PREMIUM TABLE (26 PAYROLL DEDUCTIONS PER YEAR)*

$5,000	$10,000
$0.42	$0.83

*Regardless of how many children you have, they are included in the "All Children" premium amounts listed in the table above.

Short Term and Long Term Disability Insurance

New hire Eligibility Period:
Employees will become eligible for benefits on the first day of the month following 30 days of employment.

Termination of Coverage:
Coverage will end on the date of the status change event.

You probably have insurance for your car or home, but what about the source of income that pays for it? You rely on your paycheck for so many things, but what if you were suddenly unable to work due to an accident or illness or pregnancy? How will you put food on the table, pay your mortgage or heat your home? Disability insurance can help replace lost income and make a difficult time a little easier. Protect your most valuable asset – your paycheck.

Disability Insurance

YOUR ABILITY TO EARN AN INCOME MAY BE YOUR MOST IMPORTANT ASSET

YOUR ABILITY TO EARN AN INCOME MAY BE YOUR MOST IMPORTANT ASSET

Most people don't think twice about insuring their home, automobile or health. However, many people don't realize just how important it is to insure their income.

HOW MUCH DISABILITY INSURANCE DO YOU NEED?

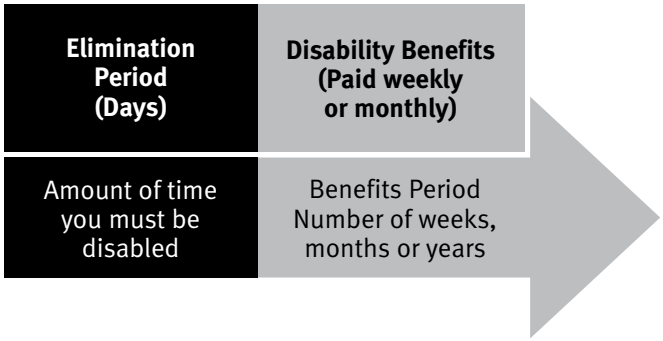
A lengthy disability can be devastating and is more common than you might think. It can result in a loss of income, independence and financial security.

Disability insurance can help provide security when you need it most. It pays you cash benefits when you're sick or hurt and can't work. Consider how long your savings would last to pay for:

- Mortgage or rent
- Child or senior care
- Credit cards and other debts
- Health care
- Groceries
- Utilities
- Car payments
- Clothing

EASY-TO-UNDERSTAND PROTECTION

- **Elimination Period** – The amount of time you must be disabled before benefits begin
- **Benefit Amount** – The amount paid directly to you for as long as you're disabled, or until you've reached the insurance plan's Maximum Benefit Period
- **Maximum Benefit Period** – The longest time period benefits are payable to you
- **Continuation of Benefits** – Allows your disability insurance policy to continue at no cost while you're receiving benefits



Disability insurance underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, 1-800-769-7159. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Policy form: 7000GM-U-EZ 2010 or state equivalent (7000GM-U-EZ 2010 NC). Some exclusions, limitations and reductions may apply.

Short-Term Disability Insurance

FOR EMPLOYEES OF USUI INTERNATIONAL CORPORATION

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 130 hours per month to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Elimination Period	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin: • On the day of your disabling injury. • On the 8th day of your disabling illness.
Weekly Benefit	Your benefit is equivalent to 60% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount less other income sources.
Maximum Benefit Period	Up to 13 weeks
Maximum Weekly Benefit	$750
Minimum Weekly Benefit	$10
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
DEFINITIONS	
Definition of Disability	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings which exceed 99% of your weekly earnings from your regular job. You can be totally or partially disabled during the elimination period.
Definition of Weekly Earnings	Weekly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 52. Weekly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked per week during the 12 month period immediately prior to the date disability begins. If employed for part of the prior 12 month period, weekly earnings is the hourly rate of pay multiplied by the average number of hours worked.
FEATURES	
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 10%.
Survivor Benefit	If you pass away while receiving disability benefits, a lump sum equal to the total weekly benefit payable for the remainder of the maximum benefit period will be paid to your eligible survivor.
SERVICES	
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 130 hours per month.

How long will my benefits be paid?

Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.

Will my benefits be reduced by other sources of income?

Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, other group disability plans, paid family leave, salary continuance/sick leave, settlements on payments received and no-fault benefits.

Does this plan cover me if I become disabled due to an injury at work?

No, your STD insurance only provides benefits for off-the-job coverage for disabilities due to injury or sickness.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

- Benefits are not payable for any disability or loss that:
  - Results from an act of declared or undeclared war or armed aggression
  - Results from participation in a riot or commission of or attempt to commit a felony
  - Arises out of or in the course of employment with the policyholder for benefits under any workers' compensation or occupational disease law, or receives any settlement from the workers' compensation carrier
  - Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, suicide, or attempted suicide
  - Occurs while incarcerated or imprisoned for any period exceeding 31 days
  - Is solely a result of a loss of a professional license, occupation license or certification

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this summary, the certificate booklet will prevail. Benefits availability is subject to final acceptance and approval of the group application by the underwriting company. Disability income insurance is underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, 1-800-769-7159. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Policy form number 7000GM-U-EZ-2010.

Long-Term Disability Insurance

FOR EMPLOYEES OF USUI INTERNATIONAL CORPORATION

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 130 hours per month to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Elimination Period	Your benefits begin on the later of 90 calendar days after the onset of your disabling injury or illness or the date your short term disability ends.
Monthly Benefit	Your benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount less other income sources. The premium for your long-term disability coverage is waived while you are receiving benefits.
Maximum Monthly Benefit	$5,000
Minimum Monthly Benefit	$100
Maximum Benefit Period	If you become disabled prior to age 62, benefits are payable to age 65, your Social Security Normal Retirement Age or 3.5 years, whichever is longest. At age 62 (and older), the benefit period will be based on a reduced duration schedule.
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits.
DEFINITIONS	
Own Occupation	2 Years
Own Occupation Earnings Test	99% during the Own Occ period,then 85% there after
Definition of Monthly Earnings	Monthly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 12. Monthly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked during the 12 month period immediately prior to the date disability begins. If employed for part of the prior 12 month period, monthly earnings is the hourly rate of pay multiplied by the average number of hours worked.
FEATURES	
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 10%.
Survivor Benefit	If you pass away while receiving disability benefits, a lump sum equal to 3 times your monthly benefit will be paid to your eligible survivor.
SERVICES	
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Employee Assistance Program (EAP)	The EAP program provides you and your loved ones access to trained professionals and resources for assistance with personal and workplace issues.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 130 hours per month.

How long will my benefits be paid?

Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.

Will my benefits be reduced by other sources of income?

Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, other group disability plans, salary continuance/sick leave, settlements on payments received and no-fault benefits.

Does this plan cover me if I become disabled due to an injury at work?

Yes, your LTD insurance provides benefits for both on-the-job and off-the-job coverage for disabilities due to injury or sickness.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

- Disabilities related to alcohol and drug abuse are only payable for up to 24 months while insured under the policy.
- Disabilities related to mental disorders are only payable for up to 24 months while insured under the policy.
- Your plan is subject to a pre-existing condition limitation. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 3/12 which means any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.
- Benefits are not payable for any disability or loss that:
  - Results from an act of declared or undeclared war or armed aggression
  - Results from participation in a riot or commission of or attempt to commit a felony
  - Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, suicide, or attempted suicide
  - Results from alcohol and drug abuse and/or substance abuse, except as noted above
  - Results from a mental disorder, except as noted above
  - Is caused by alcohol and drug abuse and/or substance abuse, while not being actively supervised by and receiving continuing treatment from a rehabilitation center or designated institution approved for such treatment by an appropriate body in the governing jurisdiction
  - Occurs while incarcerated or imprisoned for any period exceeding 31 days
  - Is solely a result of a loss of a professional license, occupation license or certification

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

Employee Assistance Program

New Hire Eligibility Period:

Employees will become eligible for benefits on the first day of the month following 30 days of employment. Employees insured through the Long Term Disability Insurance have access to the EAP program for themselves and immediate family members.

Work-life Balance Employee Assistance Program helps you find balance between work and home life. This confidential EAP provides guidance for personal issues that you might be facing and information about other concerns that affect your life, whether it's a life event or on a day-to-day basis.

The Work-life Balance Employee Assistance Program, is provided by Ceridian HCM. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. This information is for illustrative purposes only. It is not a contract. Insurance products are underwritten by the subsidiaries of UNUM Group.

Basic Employee Assistance Program

Life's not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life. Your Employee Assistance Program (EAP) can be the answer for you and your family.

WE'RE HERE TO HELP

Mutual of Omaha's EAP assists employees and their eligible dependents with personal or job-related concerns, including:

- Emotional well-being
- Family and relationships
- Legal and financial
- Healthy lifestyles
- Work and life transitions

EAP BENEFITS

- Unlimited telephone access to EAP professionals 24 hours a day, seven days a week
- Telephone assistance and referral
- Service for employees and eligible dependents
- Legal assistance and financial services
  - Online will preparation
  - Legal library & online forms
  - Telephonic financial consultation
- Resources for:
  - Financial tools and resources
  - Substance abuse and other addictions
  - Dependent and elder care assistance & referral services
- Access to a library of educational articles, handouts and resources via *mutualofomaha.com/eap*

WHAT TO EXPECT

You can trust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solutions that are responsive to your needs.

Your EAP benefits are provided through your employer. If additional services are needed, your EAP will help locate appropriate resources in your area.

Don't delay if you need help. Visit *mutualofomaha.com/eap* or call 800-316-2796 for confidential consultation and resource services.

Benefits that work℠

10088

Flexible Spending Account

Plan Year: January 1, 2019 – December 31, 2019

New Hire Eligibility Period:
Employees will become eligible to participate on the first day of the month following 30 days of employment. Enrollment on the company's medical, dental, or vision plans is not required.

Termination of Coverage:
Coverage will end on the date of the status change event.

Flexible spending accounts, or FSAs, allow you to pay for eligible expenses on a pre-tax basis. You determine an amount to be deducted from your paycheck before taxes are calculated and placed in an FSA. You pay for eligible expenses from the account and save on taxes since you have lower taxable income.

Health Care Flexible Spending Account
(HCFSA) allows you to set aside a portion of your paycheck on a pre-tax basis to help you pay deductibles, copays and coinsurance, and out-of-pocket healthcare (medical, dental, vision, hearing, prescription drug, and other expenses) not covered by insurance.

Dependent Care Flexible Spending Account
(DCFSA) allows you to set aside a portion of your paychecks on a pretax basis to pay for eligible daycare expenses provided during working hours for an eligible dependent. An eligible dependent could be your child(ren) under age 13, an incapacitated spouse, or an elderly parent who is your tax dependent. Eligible expenses are those that provide care so that you and your spouse (if you are married) can work outside the home or so your spouse can attend school full time. **THIS ACCOUNT IS NOT FOR REIMBURSEMENT OF MEDICAL EXPENSES.**

Flexible Spending Account

Health Care Flexible Spending Account
Example of tax savings in a year

Flexible spending accounts provide you with an important tax advantage that can help you pay for health care expenses on a pretax basis. As a result of the personal tax savings you incur, your spendable income will increase. The example that follows illustrates how an FSA can save money.

Bob and Jane's combined gross income is $30,000. They are married and file their income taxes jointly. Since Bob and Jane expect to spend $3,000 in medical expenses in the next plan year, they decide to direct a total of $2,700 into their FSAs. (See table)

	Without FSA	With FSA
Gross income	**$30,000**	**$30,000**
FSA contributions	$0	-$2,700
Gross income	$30,000	$27,300
Estimated taxes		
Federal	-$2,550*	-$1,773*
State	-$900**	-$749**
FICA	-$2,295	-$1,910
After-tax earnings	**$24,255**	**$22,868**
Eligible out-of-pocket medical expenses	-$3,000	$300
Remaining spendable income	**$21,255**	**$22,568**
Spendable income increase	**--**	**$1,313**

** Assumes standard deductions and four exemptions*
*** Varies, assumes 3 percent*
This example is for illustrative purposes only. Every situation varies and it is recommended you consult a tax advisor for all tax advice.

Flexible Spending Account

Health Care Flexible Spending Account

- You will have the opportunity to elect to receive income tax-free reimbursement for some or all of your unreimbursed health care expenses under the Health Care Flexible Spending Account (Health Care FSA). Under the Health Care FSA, you purchase a specific level of health care reimbursement benefits, paying for coverage with pre-tax contributions.

  If you elect benefits under this portion of the plan, a non-interest bearing health care account will be set up to keep a record of the reimbursements you are entitled to, as well as the contributions you have made for such benefits during the plan year.

  The maximum annual health care reimbursement that you may elect is $2,700 per plan year.

You have 90 days after the close of the Plan Year to submit claims for reimbursement. You can carry over up to $500 of unused funds from one year to the next. Any health care reimbursement benefit payments that are unclaimed by the close of the plan year following the plan year in which the eligible medical expense was incurred shall be forfeited.

Debit Card: With the debit card, there is no need for you to pay copays or other expenses out-of-pocket. Also, there will be no need to submit manual claim forms for reimbursement. The card provides you with access to the money in your FSA. When you pick up an eligible prescription or need to pay for other qualified health care expenses, you simply present the card to an eligible provider. A dedicated web site allows you to quickly and easily view account balances and information and access a sample list of covered expenses online.

SAVE YOUR RECEIPTS! You may be asked to substantiate a claim at any time.

OVER-THE-COUNTER DRUGS

The cost of an over-the-counter (OTC) medicine or drug cannot be reimbursed through your FSA unless a prescription or letter of medical necessity is obtained. This does not affect insulin, even if purchased without a prescription, or other health care expenses such as medical devices, eye glasses, contact lenses, copays and deductibles.

Dependent Care Flexible Spending Account

You may elect to receive income tax-free reimbursement for some or all of your work-related dependent care expenses under the Dependent Care Flexible Spending Account (Dependent Care FSA). Under these provisions, you provide a source of pre-tax funds to reimburse yourself for your eligible employment related expenses by entering into a salary reduction agreement with your employer in lieu of a corresponding amount of your regular pay. This arrangement helps you because the coverage you elect is non-taxable and you save social security and income taxes on the amount of your salary conversion. If you elect benefits under this portion of the plan, a non-interest bearing dependent care account will be set up to keep a record of the reimbursements you are entitled to.

The maximum annual dependent care reimbursement that you may elect is $5,000 (or $2,500 for married filing separate returns) per plan year.

Any dependent care reimbursement payments that are unclaimed by the close of the plan year following the plan year in which the eligible employment related expense was incurred shall be forfeited.

To receive reimbursement you will have to submit a claim form along with a written statement/bill.

FSA Reimbursement:
Fax claims to: 800-391-6562 or 269-327-0716
Secure online submission: https://claims.basiconline.com/Portal.aspx
Mail claims to: BASIC, 9246 Portage Industrial Drive, Portage, MI 49024
Claim status/questions: 800-444-1922 ext. 1 or 269-327-1922 ext. 1

Important Notices

Qualifying Life Events
COBRA Continuation Coverage
HIPAA Privacy Overview
Social Security Number Privacy Act
Women's Health and Cancer Rights Act
Children's Health Insurance Program (CHIP)

The Important Notices found in this Guide have been designed as an easy-to-use reference and are not intended to be an official notice. Please consult your Summary Plan Description (SPD) and/or contact your Human Resource Department for official notices.

Administrative Service

Contacting the Carrier

Qualifying Life Events

Should you experience any of the following life events, you must request to have your coverage changed within **30 days** of the event.
You must upload your birth certificates to the Paycor portal for all dependents!

- **Birth of a child**
- **Adoption or legal guardianship of a child**
- **Marriage**
- **Dependent stepchild due to marriage**
- **Divorce or legal separation**
- **Loss of child's dependent status due to age or eligible for other coverage**
- **Death of a dependent**
- **Dependents' loss of coverage through spouse's plan**
- **Medicare eligible – if you or your dependents become eligible for Medicare**
- **Any other life event not listed**

Unless otherwise indicated, changes not reported within 30 days of an event can only be made at the annual open enrollment.

COBRA Continuation Coverage

What is COBRA continuation health coverage?*
Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.

What does COBRA do?*
COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available when coverage is lost due to certain specific events. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves.

Which employers are required to offer COBRA coverage?*
Employers with 20 or more employees are usually required to offer COBRA coverage and to notify their employees of the availability of such coverage. COBRA applies to plans maintained by private-sector employers and sponsored by most state and local governments.

Under COBRA, what benefits must be covered?*
Qualified beneficiaries must be offered coverage identical to that available to similarly situated beneficiaries who are not receiving COBRA coverage under the plan (generally, the same coverage that the qualified beneficiary had immediately before qualifying for continuation coverage). A change in the benefits under the plan for the active employees will also apply to qualified beneficiaries. Qualified beneficiaries must be allowed to make the same choices given to non-COBRA beneficiaries under the plan, such as during periods of open enrollment by the plan.

Who can answer other COBRA questions?*
COBRA administration is shared by three federal agencies. The U.S. Department of Labor handles questions about notification rights under COBRA for private-sector employees. The Department of Health and Human Services handles questions relating to state and local government workers. The Internal Revenue Service, Department of the Treasury, has other COBRA jurisdiction.

*The above information was taken from “Frequently Asked Questions about COBRA Continuation Health Coverage” on the Department of Labor website (dol.gov).

Important Note: The preceding is intended to provide a simplified overview of the COBRA law and is to be used for informational purposes only.

HIPAA Privacy Overview

Health Insurance Portability and Accountability Act (HIPAA)
To administer your benefits, information requested for enrollment must be collected and shared with your group insurance carriers. This information on you as well as your eligible enrolled dependents includes personal information including name, social security number, birthdate, employee salary, address, telephone number, and possibly health history information, proof of dependent status, or other requested information specific to insurance plan provisions. In addition to the applicable insurance companies receiving your information, business partners including Michigan Planners, Inc., also receive necessary information to assist in processing and administering your benefits in compliance with policy service and law regulations.

What information is protected by HIPAA privacy rules?
Information is protected if it relates to an individual's past, present or future physical or mental condition, or to the provision or payment of health care. Under HIPAA, any electronic, paper or oral communication transmitted by a covered entity is considered protected health information, or PHI. Covered entities subject to privacy rules include: hospitals, physicians and other health care providers, health plans and claim clearinghouses.

Rights of individuals
The privacy rules are intended to protect the rights of individual health care consumers. Individuals have the right to:

* Confidential communication of their PHI
* Inspect and copy their PHI
* Receive written notice of health plans' privacy practices
* Request restrictions on certain uses and disclosures of their PHI
* Request amendments to their PHI
* Receive an accounting of certain disclosures of their PHI

Social Security Number Privacy Act

The State of Michigan Public Act 454 took effect March 1, 2005. The Act contains a number of protective measures applicable to all business entities, including schools and libraries, to ensure the security of social security numbers, including those of its employees and if applicable, its patrons or students. Generally, the Social Security Number Privacy Act places restrictions on the use, display, and disclosure of social security numbers that are obtained in the ordinary course of business.

Women's Health and Cancer Rights Act of 1998

Pursuant to federal law, the plan will pay for the following benefits for any participant who is receiving insured benefits under the plan covering a mastectomy and who elects breast reconstruction, subject to applicable annual and lifetime plan limits, copayments and deductibles:

(1) reconstruction of the breast on which the mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses and physical complications of all stages of mastectomy, including lymphedemas.

These benefits will be provided in a manner as determined in consultation with the attending physician and the patient. The plan may not deny an eligible employee or an eligible dependent eligibility or continued eligibility to enroll or to renew coverage solely to avoid providing these benefits.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your Human Resource Dept. for contact information (state listing) for more information on eligibility.

Alabama	Indiana	Massachusetts	New Hampshire	Oregon	Utah
Alaska	Iowa	Minnesota	New Jersey	Pennsylvania	Vermont
Arkansas	Kansas	Missouri	New York	Rhode Island	Virginia
Colorado	Kentucky	Montana	North Carolina	South Carolina	Washington
Florida	Louisiana	Nebraska	North Dakota	South Dakota	West Virginia
Georgia	Maine	Nevada	Oklahoma	Texas	Wisconsin
					Wyoming

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Administrative Service

If you have any benefit questions or claim issues, please contact our claims department at 1-800-674-9235 or claims@miplanners.com.

In compliance with HIPAA law, we are required to obtain a signed authorization for each claim in question. Please sign and fax the authorization prior to giving us personal information.

When faxing claims, please use our secure fax number: 1-586-263-0690.

MICHIGAN PLANNERS
EMPLOYEE BENEFITS · RETIREMENT SERVICES

We are here to service your benefit programs and help in any way we can.

Contacting the Carrier

Blue Cross Blue Shield of MI
For customer service, call the number on the back of your member ID card or 1-313-225-9000
www.bcbsm.com

Mutual of Omaha
Life: 1-800-775-8805
Disability: 1-800-877-5176
EAP: 1-800-316-2796
www.mutualofomaha.com

BASIC
1-800-444-1922
www.basiconline.com

NOTES

Group services provided by:

MICHIGAN PLANNERS
EMPLOYEE BENEFITS · RETIREMENT SERVICES

59259 Van Dyke
Washington, MI 48094

417 South Union Street
Traverse City, MI 49684

586-263-9000 or 800-674-9235

Main Fax: 586-263-0690
Claims Fax: 586-263-5961
www.miplanners.com