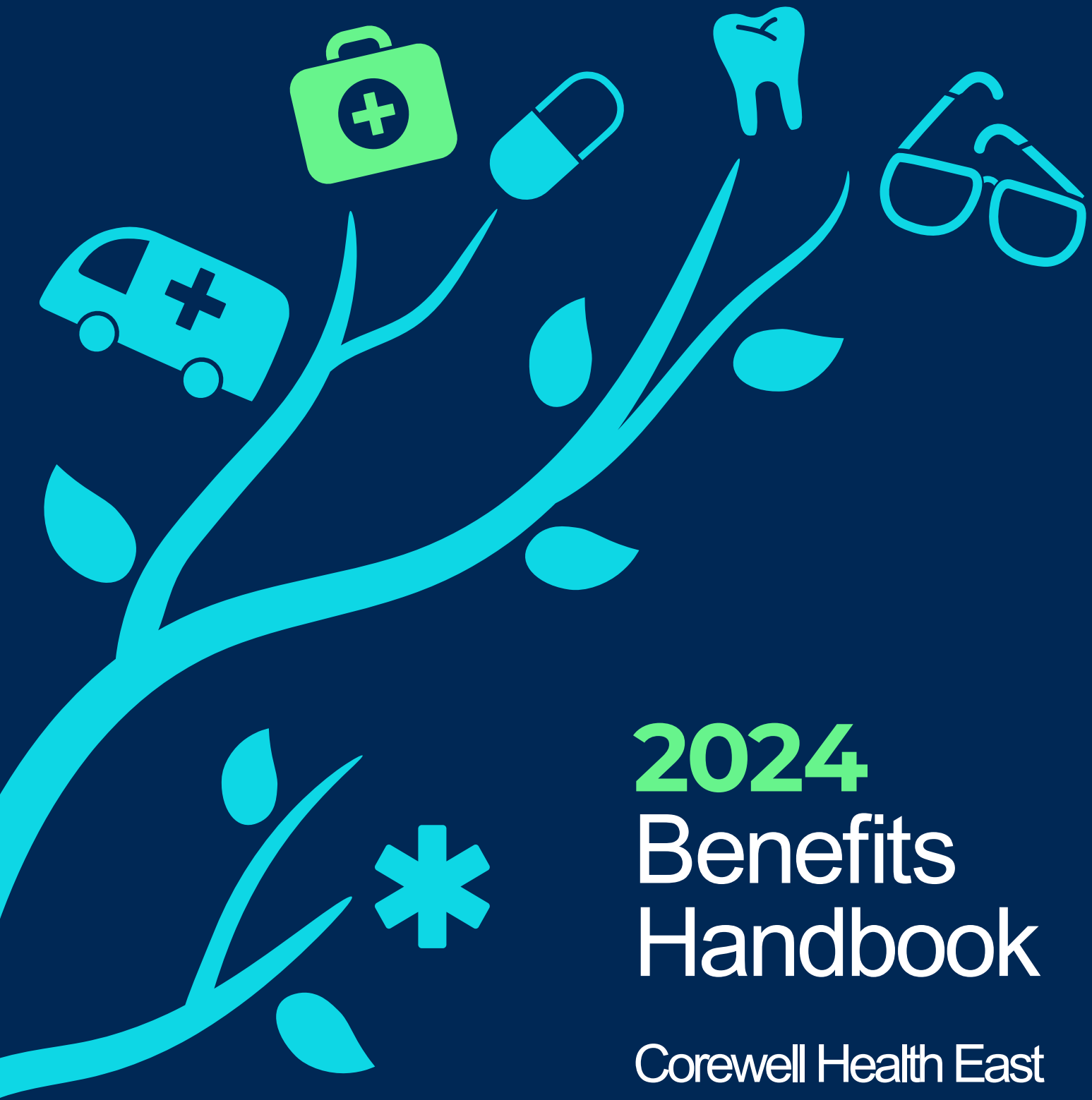
Corewell Health™



2024 Benefits Handbook

Corewell Health East

Benefit program

Let’s bring your 2024 benefits into focus.

Questions? We’re here to help

This book is for Corewell Health. As you read through this material you may find that you have questions about the benefit program. Contact HR Support Center at 877-AskHR11 (877.275.4711) Monday-Friday 7:30 am to 4:30 pm. Access 24/7 assistance through ServiceNow.

Chat with ALEX to help with your decisions

ALEX is an easy-to-use, online resource that helps you find the best benefit plans for you and your family. Talking with ALEX feels like having a conversation with a real person, and because ALEX uses simple language and avoids insurance jargon, its explanations and recommendations are easy to understand. Visit ALEX and find your best-fit plan today.

Corewell Health East:
https://start.myalex.com/corewellhealth/east

HIPAA – notice of privacy practices

The Corewell Health benefit plan maintains a notice of privacy practices that provides information on how protected health information (PHI) is used or maintained by the Plan. If you would like a copy of the plan’s notice of privacy practices, contact the HR Support Center at 877-AskHR11 (877.275.4711). A copy of this notice is also available on ServiceNow.

A word about social security

While the money you spend on a pretax basis is free from federal income tax, it is also free from social security withholding. That means that since you will be paying less into the social security system, it is possible that any future benefits you receive from social security may be somewhat smaller than if you had not paid for benefits with pretax money. Generally speaking, however, any such reduction in social security benefits would be very small, and the advantages gained through participation in the Corewell Health benefit program far outweigh any potential reduction in your social security amounts.

Your Corewell Health benefit program

Introduction

Corewell Health invests in you, your family and the health of our communities by offering a benefits program to give you choices to design a benefits package that includes the best options for you. From medical and dental coverage to life insurance and AD&D, consider the benefit plans that best fit you and your family's needs..

All references to:

- Beaumont Health in this booklet, refers to the Legacy Beaumont Health benefits program, also known as Corewell Health East
- Spectrum Health in this booklet, refers to the Legacy Spectrum Health benefits program, also known as Corewell Health West, Corewell Health South or Priority Health.

In this book, you will find the information you need to enroll in the Corewell Health benefit program. This book contains an overview of how the program works, how to make your benefit selections, and some important things to keep in mind as you make your choices.

To enroll, use the online enrollment system within Workday. If you have any questions or need assistance, contact the HR Support Center at 877-AskHR11 (877.275.4711).

This book provides a summary of the general provisions of your benefit plans. A complete description of each benefit plan can be found in the summary plan descriptions, plan certificates or legal documents. **In case of conflict between the information presented here and the legal documents, the legal documents will govern. Corewell Health retains the right to change the benefit program at any time with or without notice.**

Common law employer

We have made great strides in benefits harmonization for Corewell Health. As we continue benefit program harmonization efforts into 2024 and beyond, there may be variations in benefits until harmonized. Benefits that may still have variations based on the legacy organizations will be offered to you based on your common law employer in Workday, here are some details to note:

Corewell Health East	• Common law employer in Workday is one of the following: • William Beaumont • Oakwood Healthcare, Inc • Botsford General Hospital • Beaumont Health Foundation • Botsford Continuing Care Corporation • Oakwood Health Promotions, Inc. • Beaumont Medical Group – Hospital Based Services • Beaumont Medical Group - Specialty Services • Beaumont Medical Group - Primary Care Services.
Corewell Health West, Corewell Health South and Priority Health	• Common law employer in Workday is one of the following: • Corewell Health Corporate, • Spectrum Health Medical Group • Spectrum Health Visiting Nurse Association – South • Spectrum Health Continuing Care Corporate • Lakeland Hospitals at Niles & St. Joseph, Inc • Southwestern Medical Clinic Physicians, Inc.

Your Corewell Health benefit program

Eligibility

Team members are eligible for benefits if they are either a full-time or part-time team member regularly assigned to work at least 40 hours per two-week pay period and are employed in a benefit eligible position. Corewell Health considers a full-time team member to work between 72-80 hours per pay period and a part-time team member to work between 40-71 hours per pay period.

Enrolling in benefits

Go to your Workday profile.

Benefit enrollment is time sensitive; please make sure you enroll by the deadline. If you are a new hire or newly eligible you will have 31 days to enroll in your benefits from your date of hire, or date of status change for those newly eligible for benefits. You will also be given an annual opportunity to enroll or change your benefits during open enrollment.

There are detailed instructions on how to use the online enrollment tool within Workday or within ServiceNow. If you need assistance, contact the HR Support Center at 877-AskHR11 (877.275.4711).

We recommend having the below items prior to beginning your enrollment:

- Complete information for dependents you would like to cover under your plans including:
  - Name
  - date of birth
  - social security number (SSN) – required you must provide a valid SSN in order to provide coverage for your dependents under the plan. Only exception to this rule is for newborn children who may not yet have a SSN at time of enrollment in which you must update once you have this number available or when your dependents are living in the United States under a Visa. Things to note: there are policies within our program that will not pay benefit to those not living in the United States.
- Electronic copy of marriage certificate if newly adding a legally married spouse*
- Electronic copy of birth or adoption certificate if newly adding any children*
  - *OR if marriage certificate and/or birth certificates are not readily available you may submit a copy of the first page of the previous 2 years' tax returns that list the names, Social Security Number, and relationship of your dependent(s).
- Beneficiary information
- If enrolling in medical benefits, Primary Care Physician (PCP) information for yourself and dependents. You will need to provide the numeric10 digit provider ID found on the Priority Health website.

Paying for your benefits

Your benefit premiums will be deducted from each of your paychecks starting the month in which your plans are effective and through the end of the month in which your benefits are ending. Benefit deductions are taken from all pay periods.

Your Corewell Health benefit program

Benefit program choices

The Corewell Health benefit program includes the following benefits:

- Two medical plan options
- Two dental plan options
- Two vision plan options
- Life insurance for you and your family
- Disability protection
- Health care and daycare/dependent care flexible spending accounts
- Health savings accounts
- Retirement savings accounts
- Voluntary benefits

Core benefits

Corewell Health provides all benefit eligible team members core benefits at no cost to you. You will automatically be enrolled in the following core benefits:

- Core Life insurance & Core Accidental death and dismemberment (AD&D)
- Core Short-term disability (STD)
- Core Long-term disability (LTD)

Coverage levels

Corewell Health offers you four different coverage levels to meet the specific needs of you and your family. You can choose different coverage levels for each benefit plan type.

- Team member only coverage
- Team member and spouse coverage
- Team member and child(ren) coverage
- Team member and family coverage (family coverage includes coverage for team member, spouse and child(ren))

Coverage for dependents

You are able to choose coverage for your eligible dependents. Eligible dependents include:

- Your legally married spouse
- Children up to age 26.
  *Children include natural children, stepchildren, legally adopted children, and children under your legal court appointed guardianship. Coverage continues until the end of the month in which the dependent reaches the age limit of the plan. **Once your child no longer meets the eligibility criteria, coverage will end as of the last day of the month in which the event occurs.**
- Your disabled child of any age, who is unmarried, incapable of self-support and claimed by you as a dependent on your income tax return, provided the disability began before the age limits.

Your Corewell Health benefit program

When coverage begins

When eligible, you will have 31 days to enroll in benefits.

If you are in a benefit eligible position upon hire, you will have 31 days to enroll in benefits, and your benefits begin on the first of the month following your date of hire. For example, if your hire date with Corewell Health is January 17, then your benefits will begin February 1.

If you are newly eligible for benefits because your status changed to 40 or more hours per pay period, you will have 31 days to enroll in benefits, and your benefits will begin the first of the month following the effective date of the change. For example, if your status changed to 40 hours per pay period August 27, your benefits would begin September 1.

When coverage terminates

Life, AD&D, short-term disability and long-term disability terminate on your last day worked or the last day you or your dependent(s) no longer meet eligibility requirements*. All other coverage terminates on the last day of the month in which you or your dependent(s) no longer meet eligibility requirements, or if the benefit plan you are enrolled in terminates.

For example, if your last date worked at Corewell Health is July 15 your life, AD&D, short-term and long-term disability benefits will terminate on July 15. All other benefits will continue until the last date of the month in which you worked so your coverage would end July 31. If your last date worked at Corewell Health was the last day of a month, July 31 for example, your coverage would end at the end of that day.

*Your termination date is your last day worked. Your termination date may not be extended with paid time off (PTO). Refer to the Separation of employment policy on ServiceNow.

Terminated team members and dependents have certain rights to continue coverage under the COBRA continuation provisions. These detailed provisions will be mailed to you and your dependents if you terminate your employment or drop below benefit eligible status. COBRA information from isolved Benefit Solutions will be mailed to your home shortly after coverage terminates.

Terminated team members and dependents have the option to convert life insurance to an individual policy. Voya Financial, the insurance carrier, will notify you of your options. In order to convert your policy, you must do so within 60 days from the date the coverage terminates.

Default coverage

If you **do not enroll** in the Corewell Health benefit program within 31 days of your hire date/status change date, you will receive the following benefits.

- Core life insurance
- Core AD&D Insurance
- Core short-term disability (STD)
- Core long-term disability (LTD)

Key coverage change details

Annual benefit open enrollment

Corewell Health's annual benefit open enrollment is held each year in the fall. This is typically the only time you are allowed to change your benefit elections during the year. Changes made during open enrollment are effective January 1 of the following year.

In most cases, your elections made during open enrollment, or during your first enrollment opportunity of the year, remain in effect until the end of the plan year, December 31. If you fail to enroll, you will not be able to change your enrollment until the next open enrollment, unless you experience a qualifying event, referenced below.

Mid-year benefit enrollment – due to change in employment status

Change employment status	
No benefits (0-39 hours/pp) to benefit eligibility (40 hours/pp or above)	Our plan allows you enroll in benefits as you are now eligible for benefits with this change in hours. you will have 31 days to enroll in benefits, and your benefits begin on the first of the month following your date of change.

Full-time (72-80 hours/pp) to part-time (40-71 hours/pp)	Our plan does not allow you to make changes to your benefit elections if you experience these changes, however, the cost of your benefits may change based on your change in status and hours worked per pay period. These changes in cost will occur automatically the first of the month following the effective date of this change.
Part-time (40-71 hours/pp) to full-time (72-80 hours/pp)	

Mid-year benefit enrollment – due to family status change

You cannot terminate your coverage or change your elections at any time during the year unless you experience a qualified family status change. Plan rules and restrictions apply. **If you experience one of the qualifying events, you have 31 days from the event date to submit a Life Event benefit change in Workday, this is a self-service process.** ServiceNow keyword: how to change benefit elections.

You will be eligible to make a benefit level change with **immediate coverage** if:

- You obtain a new dependent by birth or adoption
- Your spouse or dependent dies
- You become married

You will be eligible to make a benefit level change with coverage **effective on the first of the month following the status change date** if:

- You become divorced, or legally separated
- Your spouse begins* or loses employment
- Your spouse has a significant change in coverage because of a job change (such as change from full-time to part-time or vice versa). This does not apply to the health care FSA.
- You experience a significant change in your or your spouse's health care coverage because of your spouse's employment.
- A child gains or loses dependency status*

Key coverage change details

Needed Documentation for mid-year benefit changes

For most qualifying events you will also need to include documentation that supports the requested change. Your benefit change will remain in a pending status in Workday until the proper documentation has been received. You will have 31 days from the event date to submit and provide proper documentation that supports the benefit change:

Marriage: Marriage Certificate	**Birth:** Birth Certificate, Crib Card, Footprint card	**Adoption:** Adoption Papers	**Divorce:** Divorce Decree
Gain of coverage: Letter of gained coverage with effective date	**Loss of coverage:** Letter of lost coverage with effective date	**Death of Spouse:** Death Certificate	**Death of Child:** Death Certificate

Mid-year benefit enrollment – at anytime

There are some benefit changes that you are able to make at any time during the year.

You will be eligible to make a benefit change with **immediate coverage** for:

- Change to your life insurance beneficiary
- Change your contribution to the Health Savings Account (HSA) bank account

You will be eligible to make a benefit change with coverage **effective on the first of the month following the status change date** for:

- Change to your daycare/dependent care flexible spending account (FSA) due to change in daycare, such as daycare closing, increase in daycare cost, decrease in daycare cost, no longer need care, change in daycare center (must provide documentation from the daycare center describing the change).

*If you opt out of medical coverage, you may not enroll in a medical plan for these qualifying events.

Health & Wellbeing Benefits

Corewell Health provides the following Health & Wellbeing benefits. Explore the details of these benefits in the following pages:

- **Medical benefits**
  - Medical plan riders-perks
  - Tru hearing
  - mystrength
  - BenefitHub
  - Livengo
- **Voluntary benefits - supplemental medical plans**
  - Group accident
  - Group hospital indemnity
  - Group critical illness
- **Health savings account (HSA)**
- **Dental benefits**
- **Vision benefits**
  - Eyeconic online eyewear store
  - Kids Care program
  - Tru hearing
- **Flexible spending accounts (FSA)**
- **Healthy Lifestyles - Wellbeing Program**
  - Medical plan credit
  - Lifestyle spending account (LSA)

Medical benefits

Our partner: Priority Health
phone: PriorityGPS: 866.518.1769
website: priorityhealth.com

Considering a medical plan

Only you can decide what is the right medical option for your needs.

Because so much goes into picking the right medical plan, we recommend using ALEX® to understand your options and help you pick your best-fit plan. ALEX will ask you questions about your family, coverage needs, and expected health care expenses and use your answers to figure out the best plan for your personal needs (everything you say remains confidential, of course*). Also, because ALEX is available from any computer or mobile device with an internet connection, you can use ALEX with your family as you consider your options. *ALEX does not create, receive, maintain, transmit, collect, or store any identifiable end-user information.

Talk to ALEX now at:

Corewell Health East:
https://start.myalex.com/corewellhealth/east

Priority Health claims information

If you are currently covered by Priority Health, refer to your explanation of benefits (EOB) statements which provide a record of your health care expenses. As a Priority Health member, you have full access to all your claims history including prescriptions. To help you in the selection process, be sure to obtain claims information by accessing your Priority Health account.

Virtual Care - Register for MyChart and use the Priority Health app

MyChart is the platform Corewell Health uses to offer you personalized and secure online access to your medical records. It securely enables you to use the internet to help manage and receive information about your health. Visit spectrumhealth.org/spectrumhealthapp.org for more information or to create an account. If you need assistance with your account, please contact MyChart App Support at 877.308.5083 or email appsupport@spectrumhealth.org.

All Corewell Health team members and dependents enrolled with Priority Health will receive video visits and eVisits for low acuity primary care for a $0 copay. To note, the $0 cost under the HSA/POS plan is due to the CARES act extension that has been extended until the end of 2024, there is no guarantee the $0 cost will remain under the HSA/POS plan into the future.

Virtual therapy is now available through the Priority Health App. All Corewell Health team members and dependents (18+) enrolled with Priority Health will receive virtual therapy (for stress, anxiety, and depression, grief, and sadness) for a $0 copayment, including the HSA/POS plan. To note, the $0 cost under the HSA/POS plan is due to the CARES act extension that has been extended until the end of 2024, there is no guarantee the $0 cost will remain under the HSA/POS plan into the future.

Behavioral Health virtual visits can be accessed by logging into your member center at priorityhealth.com or accessing the Priority Health app. Behavioral health virtual visits are supported by MDLive and Priority Health network partners.

To schedule a visit directly with Corewell Health, download the MyChart app, Priority Health app or call 844.322.7374.

Medical benefits

Prescription drugs

If you participate in a medical plan offered by Corewell Health, you can save on your prescription drug costs by filling with Tier 1 medications. If a Tier 1 is available and you purchase a higher tier, you may be charged the difference in cost. When looking at the medical benefit comparison in the following pages, here is a key to what prescriptions are within each tier.

Tier 1:	This tier includes low-cost generic drugs – proven to be as safe as name brand drugs – and, on some formularies, select brand name drugs
Tier 2:	Includes preferred and lower cost brand name drugs, and some higher cost generic drugs. If you must take a brand name drug, we recommend working with your provider to choose one that is covered here, and the most affordable.
Tier 3:	Non-preferred and expensive brand name drugs, as well as higher-cost generic drugs. These drugs may cost you a significant amount out-of-pocket, we recommend asking your provider if a tier 1 or 2 option can be prescribed instead.
Tier 4:	Includes very expensive brand name and generic drugs, and preferred specialty drugs used to treat complex conditions. Specialty drugs often have high costs and may have special handling or storage requirements. They are usually dispensed by trained personnel at specialty pharmacies. If you need to take a specialty drug, we recommend working with your provider to choose one that is covered here.
Tier 5:	Non-preferred specialty drugs, and the most expensive brand name and generic drugs are covered here because they offer limited clinical value. Most have a similar lower-cost option offering the same clinical value on tiers 1 through 4. We recommend asking your provider about alternatives.

Mail-in prescription drug program

You may also lower your prescription drug copayment by using the mail order prescription drug program. The medical plan offers a mail order prescription drug program through Express Scripts. You may get a 3-month supply of your prescription for 2 co-payments (after deductible with the HSA/POS medical plan). For more information on mail order, visit priorityhealth.com, login and access your Priority Health account. You may also contact PriorityGPS at 866.518.1769 or contact Express Scripts directly at 844.586.5349.

Priority Health Specialty Drug Savings Program

If you or one of your covered dependents are taking a specialty medication you may qualify to get that medication through the Priority Health Specialty Drug Savings Program. To help you save at the pharmacy, Priority Health is providing a specialty drug savings program that helps you take advantage of available manufacturer copay assistance and ensures you receive your medications for $0. If you take a specialty medication that’s included on the program drug list, a SaveOnSP representative will reach out directly to you. That's it, no catches, plus it’s completely free for eligible members. This program is just one of the ways Priority Health is working to help make health care more affordable.

Medical benefits

Comparing the medical plans

This graph serves as a side-by-side comparison of the medical plans that Corewell Health offers through Priority Health. Your primary address in Workday drives available medical plan options*.

	HMO medical plan		HSA/POS medical plan*		
	Tier 1** network only	Tier 2** network only	Tier 1** network only	Tier 2** network only	Tier 3 out-of-network
Annual deductible Single Family	 $650 $1,300	 $2,000 $4,000	 $1,600 $3,200	 $2,000 $4,000	 $5,000 $10,000
Annual employer HSA contribution	Not Applicable		Single: up to $500, Family: up to $750***		
Hospital services	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
PCP physician office visit	$25 copayment	$35 copayment	90% after deductible	70% after deductible	60% after deductible
Retail clinics	$25 copayment	$55 copayment	90% after deductible	70% after deductible	60% after deductible
Preventive care	Covered in full. Deductible does not apply.		Covered in full. Deductible does not apply.		
	Refer to Priority Health preventive care guidelines available on priorityhealth.com				
Virtual care (medical and behavioral health)	Covered in full. Deductible does not apply.		Covered in full. Deductible will apply for illness injury virtual care. Due to an extension of the CARES Act behavioral health virtual care will be covered in full prior to deductible, there is no guarantee this will continue into the future.		Not Applicable
Specialist office visit	$40 copayment	$50 copayment	90% after deductible	70% after deductible	60% after deductible
Urgent care	$55 copayment	$65 copayment	90% after deductible	70% after deductible	60% after deductible
Prescriptions	$15 tier 1, $50 tier 2 $100 tier 3, 4 & 5 At a participating pharmacy		$15 tier 1, $50 tier 2 $80 tier 3, 20% max of $150 tier 4 & 20% max of $300 tier 5 At a participating pharmacy, after deductible (Certain RXs for certain chronic conditions may be covered prior to deductible, see summary)		
Emergency department	$150 copayment		$150 copayment, after deductible		
Coinsurance out-of-pocket maximum per year Single Family	 $2,000 $4,000	 $3,000 $6,000	 $5,000 $10,000*	 $5,000 $10,000*	 $10,000 $20,000*
			*no more than $9,100 per person under family		
Out-of-pocket limit per year total Single Family	 $9,100 $18,200		 $5,000 $10,000*	 $5,000 $10,000*	 $10,000 $20,000
			*no more than $9,100 per person under family		
Out of area child dependent coverage	Most services covered at 70% after deductible.		out-of-network benefit level applies.		

The HSA/POS is the only plan available to team members living in the UP of Michigan.

**For details regarding providers and services for your plan, refer to next page.
***Annual Corewell Health employer HSA contribution is deposited into the HSA account each paycheck (approx. $19.23 per pay for single and $28.75 per pay for all other coverage tiers until the maximum has been reached).
Tier 2 services that apply to the deductible, will credit both Tier 1 and Tier 2 deductibles. Only Tier 1 services will credit Tier 1 deductibles. Tier 1 and Tier 2 out-of-pocket maximums track in combination. On the HSA/POS plan Tier 3 does not apply to Tier 1 or Tier 2.

Medical benefits

Medical benefit providers and service areas

The medical benefit plans offer a tiered structure to give you coverage, flexibility and access based on where you work and live, where you choose to receive your care and the provider you select. When accessing care within Corewell Health and other affiliated providers/facilities you are able to save on the out of pocket cost of this care.

Your home address in Workday, will determine the provider tiers and cost you will pay based on the facilities or providers you seek for services.

	HMO medical plan		HSA/POS medical plan*		
	Tier 1** network only	Tier 2** network only	Tier 1** network only	Tier 2** network only	Tier 3 out-of-network
Live in the defined Michigan counties	Corewell Health network	Priority Health network	Corewell Health network	Priority Health & Cigna network	Out-of-Network – any provider
Live in Michigan outside of the defined counties	Corewell Health **& Priority Health** networks	Not Applicable	Corewell Health, **Priority Health** & Cigna networks	Not Applicable	Out-of-Network – any provider
Live out of the state of Michigan	Corewell Health, Priority Health **& Cigna** networks	Not Applicable	Corewell Health, Priority Health **& Cigna** networks	Not Applicable	Out-of-Network – any provider

Here are the details:

Live in the defined Michigan Counties of: Allegan, Barry, Berrien, Cass, Ionia, Kent, Lake, Macomb, Mason, Mecosta, Monroe, Montcalm, Muskegon, Newaygo, Oakland, Oceana, Osceola, Ottawa, Van Buren, Washtenaw or Wayne

You have the option to flex between Tier 1 and Tier 2 to meet your care needs, as long as you're still in the Priority Health network*.

Tier 1: Corewell Health facilities across Michigan including all legacy Beaumont Health, Lakeland and Spectrum Health*** and providers, Answer Health, BACO Holland Hospital facilities and providers and We Are for Children as well as affiliated ancillary facilities such as Mary Free Bed, Pine Rest and Forest View. Copayments and deductibles are lower when you choose Tier 1 services. Everyone is eligible to Tier 1 services, no one is excluded.** Tier 1 providers may refer to Tier 2 facilities/providers. You are encouraged to contact Priority Health Customer Service to benefits prior to engaging in services.

Tier 2: includes all other Priority Health participating facilities and providers.

**To find providers under your plan and tier, visit prioritythealth.com, select the find a doctor tool and under the employer plan section select Corewell Health Employer Group.

Medical benefits

Medical benefit providers and service areas

Live in Michigan outside of the defined counties listed above:

You'll receive Tier 1 coverage no matter where you receive your health care, as long as you're still in the Priority Health network.

Tier 1: includes all Priority Health participating facilities and providers, if enrolled in the HMO plan*. The HSA/POS plan includes Priority Health and Cigna networks (outside the state of Michigan).

Live out of the state of Michigan:

You'll receive Tier 1 coverage no matter where you receive your health care, as long as you're still in the Priority Health or Cigna network.

Tier 1: includes all Priority Health participating facilities and providers.* . If you live outside of Michigan, you will also have access to both the Priority Health and Cigna networks in whatever plan you choose.

*To find providers under your plan, visit priorityhealth.com, select the find a doctor tool and under the plan drop down menu select PriorityHMO (for HMO medical plan) or PriorityPOS A (for the HSA/POS medical plan).

*** For a complete list of Corewell Health facilities, visit corewellhealth.org and scroll to "Our connected network of care." From there, you can select a region. You are able to obtain services from either side of the system at Tier 1 coverage.

How Deductibles work in the Corewell Health medical plans

An insurance plan deductible is a fixed dollar amount you must pay out of your own pocket before the insurance will pay for an eligible covered service. Below is a chart with details on how the deductibles work for each plan. The following page provides further details on specific amounts.

	HMO medical plan		HSA/POS medical plan		
Coverage Tier	Tier 1 network only	Tier 2 network only	Tier 1 network only	Tier 2 network only	Tier 3 out-of-network
Team member only	$650 per person	$2,000 per person	$1,600	$2,000	$5,000
Team member + spouse	$650 per person not to exceed $1,300 per family	$2,000 per person not to exceed $4,000 per family	$3,200	$4,000	$10,000
Team member + child(ren)	$650 per person not to exceed $1,300 per family	$2,000 per person not to exceed $4,000 per family	$3,200	$4,000	$10,000
Team member + family	$650 per person not to exceed $1,300 per family	$2,000 per person not to exceed $4,000 per family	$3,200	$4,000	$10,000

Medical benefits

Overview of how the plans work

There are many educational resources available to you to learn more about how the Corewell Health medical plans through Priority Health work. Here is a list of resources

- Visit ALEX at and find your best-fit plan today. Within Alex you can learn more about each plan and how each plan will work as well as what your worst-case scenario may be based on services you think you may seek in the year.
- Corewell Health East: https://start.myalex.com/corewellhealth/east

Here is a little visual to help get you started, but remember Alex is the best at explaining these benefits, so plan on visiting the Alex website:

HMO medical plan

- When there is a co-payment $ the service is not subject to deductible.
- Deductible applies when there is a co-insurance % for the service, once deductible has been met co-insurance % until the out-of-pocket cost are met.
- There is a true single and family deductible, if one meets the single deductible there would need to be another family member with services to reach the family deductible.
- There is a co-insurance out of pocket max to protect against the large hospitalization bills.

Team member
$60 co-payments

Spouse
$550 co-payments

Child
$650 hospital deductible, $2,000 co-insurance max

$3,260 paid in total between co-payments, deductible and co-insurance.

$650 of the $1,300 deductible was met, and the maximum co-insurance for that hospitalization was $2,000.

This is assuming ALL services were with Tier 1 providers and enrolled in the HMO medical plan.

HSA/POS medical plans

- This is a high deductible health plan in which all services are subject to deductible, including prescriptions.
- If there is one person on the plan you are subject to the single deductible, if there is more than one person on the plan you are subject to the family deductible.
- Once deductible has been met co-insurance % and co-payments $ kick in until the out-of-pocket cost are met.

Team member
$100 in services

Spouse
$300 in services

Child
$2,100 in services

$2,500 of the total $3,200 deductible has been met. If $3,200 deductible was met, then co-insurance % and/or co-payments $ would have kicked in.

This is assuming ALL services were with Tier 1 providers and enrolled in the HSA/POS medical plan.

Medical benefits

Team member contributions for medical benefits

Your benefit premiums will be deducted from each paycheck.

Corewell Health East - Common law employer: William Beaumont, Oakwood Healthcare, Inc, Botsford General Hospital, Beaumont Health Foundation, Botsford Continuing Care Corporation, Oakwood Health Promotions, Inc., Beaumont Medical Group – Hospital Based Services, Beaumont Medical Group - Specialty Services or Beaumont Medical Group - Primary Care Services.

Per pay period		HMO medical plan	HSA/POS medical plan
Full time (72-80 hours per pay period)	Team member	$76.40	$44.89
	Team member+spouse	$138.07	$68.76
	Team member+child(ren)	$132.94	$66.77
	Team member+family	$179.19	$84.66
Part time (40-71 hours per pay period)	Team member	$102.10	$54.78
	Team member+spouse	$194.61	$90.51
	Team member+child(ren)	$186.90	$87.54
	Team member+family	$256.29	$114.34

Save on your medical benefits by participating in Healthy Lifestyles

Participate in Healthy Lifestyles
If you're a Priority Health member through Corewell Health you can choose a medical premium credit of $25 per pay period, up to $650 per year*, for participating in the Corewell Health wellbeing program. Refer to the Healthy Lifestyles program details within this book for more details on this medical premium credit and other rewards within the program.

Team member employed at the time of annual benefits enrollment, enrollment for Healthy Lifestyles is in the fall of each year. **New hires have 90 days from date of hire to enroll.** Visit prioritythealth.com to complete your online health assessment and get started. For more details about the program, including opportunities to engage and earn points, search in ServiceNow using keyword: healthy lifestyles.

*For example, if you are full time and enroll in the HMO plan with team member coverage you will see a deduction of $76.40 for medical AND a ($25.00) medical plan credit resulting in a cost of $51.40. - if there is no reward elected this is the default reward, reward is up to $650 per year.

Medical benefits

Out of area child dependent medical coverage

Child **living within** Corewell Health or Priority Health service area Child **receiving services within** Corewell Health or Priority Health service area Services are covered as Tier 1 or Tier 2 of the plan enrolled in, just as all other family members.	Child **living outside** Corewell Health or Priority Health service area within the United States Child **receiving services within** Priority Health Cigna Network Services are covered as Tier 1 of the plan enrolled in.	Child **living outside** Corewell Health or Priority Health service area within the United States* Child **receiving services outside** Priority Health or Cigna network **Services are covered under the out of area Dependent Child Benefit Rider, illustrated below**	Child **living outside** of the United States Child **receiving services outside** of the United States **Are covered for medical emergencies and urgent care services only,** covered as Tier 1 of the plan enrolled in. All other services are **not covered**

*Contact Priority Health, let them know your child is an out of area dependent.

Out of area dependent child benefit rider

The details highlight below apply to dependents who are living in the United State but outside the Priority Health service area. It applies to all medical plans. To be eligible, the dependent child must be outside the Priority Health or Cigna networks. Coverage details apply only to the dependent child living out of the Priority Health service area.

If you have coverage under the HSA/POS Tier 3 applies to out of area dependents.

HMO medical plan	
Annual deductible Single Family	 $2,000 $4,000
Hospital services	30% coinsurance of reasonable and customary charges after deductible. Prior authorization is required except in medical emergencies or for mother and her newborn. You may be directed into the Priority Health service area if medically appropriate for some non-emergency services.
PCP physician office visit	30% coinsurance of reasonable and customary charges after deductible
Retail clinics	30% coinsurance of reasonable and customary charges after deductible
Preventive care	30% coinsurance of reasonable and customary charges after deductible
	Refer to Priority Health preventive care guidelines available on priorityhealth.com
Virtual care (medical and behavioral health)	Covered in full. Deductible does not apply. .
Specialist office visit	30% coinsurance of reasonable and customary charges after deductible
Urgent care	30% coinsurance of reasonable and customary charges after deductible
Prescriptions	$15 tier 1, $50 tier 2, $100 tier 3, 4 & 5. At a participating pharmacy, after deductible.)
Emergency department	$150 copayment
Coinsurance out-of-pocket maximum per year	Not Applicable
Out-of-pocket limit per year total	Not Applicable

Refer to your Priority Health Certificate of Coverage for more information. **In case of conflict between the information presented here and the certificates of coverage, the certificates of coverage will govern.**

Medical benefits

Coverage summary: Priority Health HMO medical plan

Employed by Corewell Health: plan not available to those living in the UP of Michigan.

The HMO medical plan covers visits to your primary care physician with a copayment. Most inpatient and outpatient services are covered by the plan with a small portion of coinsurance owed. There is a per person deductible not to exceed the per family deductible per contract year. The coinsurance out-of-pocket maximum is per person not to exceed the per family per contract year, provides coverage to limit your out of pocket expense for hospitalization services. The plan also has an out-of-pocket limit which will be the most you would pay for services in a calendar year. The out-of-pocket limit includes any deductible, coinsurance or copayments paid for any covered services and/or prescriptions throughout the year. Once the total limit has been paid the plan will pay 100 percent for covered services and/or prescriptions.

The HMO medical plan covers preventive care, such as yearly physicals, as well as treatment of sickness or injury. To receive benefits, you must use Priority Health's participating physicians and facilities, except in an emergency. You are not required by Priority Health to get a referral from your PCP to see other participating physicians or specialists; however, the specialist may require a referral from your PCP. The plan will not pay benefits if you use a non-participating facility or physician (unless Priority Health has authorized an approved non-participating physician or facility).

Referrals for mental health and substance abuse conditions are coordinated through the Priority Health behavioral health department 800.673.8043. If your PCP refers you to a physician not listed in your provider directory, be sure you have written approval from Priority Health to see that physician.

Prior approval is required before you may obtain certain services. If you seek services that require prior approval without receiving prior approval from Priority Health, you will receive a reduction in benefit coverage for those services. You will also be responsible for those services that are beyond those approved, beyond the benefit maximums or excluded from coverage. For questions around authorizations, contact PriorityGPS at 866.518.1769. Priority Health must be notified of emergency admissions as soon as reasonably possible.

You are required to select a PCP for yourself and each covered member of your family. If a PCP is not chosen, Priority Health will assign one for each member of your family covered under your plan. **Your deductible and level of coverage is dependent on where you live and provider/facilities chosen, see medical benefit providers and service areas section of this book for details**

Covered services included in the HMO medical plan:

- **Hospitals:** 80/70 percent coverage, deductible applies, coinsurance up to annual coinsurance maximum.
- **Preventive care:** 100 percent covered, no copayment or deductible required
- **Primary Care Physician:** $25/$35 copayment per visit. Copayments are due upon receipt of the service—be prepared to pay that amount each time you visit your physician.
- **Virtual care (medical and behavioral health):** 100 percent coverage, no copayment required.
- **Specialist office visit:** $40/$50 copayment per visit
- **Urgent care:** $55/$65 copayment per visit
- **Prescriptions:** $15 tier 1/$50 tier 2/$100 tier 3, 4 & 5 copayment
- **ER:** $150 copayment per visit (waived if admitted)
- **Mental health and substance abuse services:** copayment or coinsurance apply depending on type of service.
- **Ancillary services:** 80/70 percent coverage, deductible applies, coinsurance up to annual coinsurance maximum.

Priority Health HMO medical plan

Annual deductible	Tier 1 network only	Tier 2 network only
Individual	$650	$2,000
Family	$1,300	$4,000
A deductible is the amount of covered expenses you must incur during the contract year before benefits will be paid. Deductible amounts are included in the out-of-pocket limit. The deductible is applicable where indicated.		
Coinsurance maximum		
Individual	$2,000 coinsurance maximum per plan year	$3,000 coinsurance maximum per plan year
Family	$4,000 coinsurance maximum per plan year	$6,000 coinsurance maximum per plan year
	Total coinsurance maximum does not include deductible, and copayments.	
Out-of-pocket limit		
Individual	$9,100 limit per plan year	
Family	$18,200 limit per plan year	
	Total out-of-pocket limit includes deductible, coinsurance and copayments.	
Physician services		
Primary care physician	$25 copayment per visit	$35 copayment per visit
Retail clinics	$25 copayment per visit	$55 copayment per visit
Virtual care (medical and behavioral health)	Services covered in full. No office visit copayment. Deductible does not apply.	Services covered in full. No office visit copayment. Deductible does not apply.
Specialist office visit	$40 copayment per visit	$50 copayment per visit
Routine pre and post-natal care	Services covered in full. No office visit copayment.	Services covered in full. No office visit copayment.
Allergy care	Allergy testing covered in office visit copayment. Allergy serum and injections covered in full.	Allergy testing covered in office visit copayment. Allergy serum and injections covered in full.
Preventive care including well-child care	Services covered in full. No office visit copayment. Deductible does not apply. Refer to Priority Health preventive care guidelines available on priorityhealth.com	Services covered in full. No office visit copayment. Deductible does not apply. Refer to Priority Health preventive care guidelines available on priorityhealth.com
Outpatient services		
Chemotherapy	20% coinsurance up to the coinsurance maximum of $2,000 per person, not to exceed $4,000 per family, per contract year. Physician office visit copayment may also apply. Deductible applies.	30% coinsurance up to the coinsurance maximum of $3,000 per person, not to exceed $6,000 per family, per contract year. Physician office visit copayment may also apply. Deductible applies.
Hemodialysis	20% coinsurance up to the coinsurance maximum of $2,000 per person, not to exceed $4,000 per family, per contract year. Physician office visit copayment may also apply. Deductible applies.	30% coinsurance up to the coinsurance maximum of $3,000 per person, not to exceed $6,000 per family, per contract year. Physician office visit copayment may also apply. Deductible applies.
X-ray/high-tech radiology	20% coinsurance after deductible. NOTE: $150 copayment for high tech radiology which includes but is not limited to the following: CT, CTA, MRI, MRA, nuclear cardiology studies and PET scanning after deductible.	30% coinsurance after deductible. NOTE: $150 copayment for high tech radiology which includes but is not limited to the following: CT, CTA, MRI, MRA, nuclear cardiology studies and PET scanning after deductible.
Labs	20% coinsurance after deductible	30% coinsurance after deductible
Labs-CBC, CMP, and Vitamin D	Covered in full, deductible does not apply	Covered in full, deductible does not apply

Priority Health HMO medical plan

Basic benefits (cont.) Rehabilitative medicine services	Tier 1 network only	Tier 2 network only
Physical therapy and occupational therapy	$25 copayment up to a combined benefit maximum of 60 visits per contract year.	$35 copayment up to a combined benefit maximum of 60 visits per contract year.
Speech therapy	$25 copayment up to a benefit maximum of 30 visits per contract year.	$35 copayment up to a benefit maximum of 30 visits per contract year.
Spinal manipulation	$25 copayment up to a benefit maximum of 30 visits per contract year.	$35 copayment up to a benefit maximum of 30 visits per contract year.
Physical and occupational therapy for the treatment of autism spectrum disorder	$25 copayment	$35 copayment
Speech therapy for the treatment of autism spectrum disorder	$25 copayment	$35 copayment
Applied behavioral analysis (ABA) for the treatment of autism spectrum disorder	20% coinsurance. Deductible applies. Prior approval required	30% coinsurance. Deductible applies. Prior approval required
Habilitative Services for treatment of non-autism spectrum disorder physical and occupational therapy	$25 copayment up to a combined benefit maximum of 60 visits per contract year.	$35 copayment up to a combined benefit maximum of 60 visits per contract year.
Habilitative Services for treatment of non-autism spectrum disorder speech therapy	$25 copayment up to a benefit maximum of 30 visits per contract year.	$35 copayment up to a benefit maximum of 30 visits per contract year.
Cardiac and pulmonary rehabilitation	$25 copayment up to a combined benefit maximum of 30 visits per contract year.	$35 copayment up to a combined benefit maximum of 30 visits per contract year.
Hospital services		
Inpatient services (semi-private room)	20% coinsurance. Deductible applies.	30% coinsurance. Deductible applies.
Inpatient hospital professional services	20% coinsurance. Deductible applies.	30% coinsurance. Deductible applies.
Outpatient surgery at hospital or ambulatory center	20% coinsurance. Deductible applies.	30% coinsurance. Deductible applies.
Outpatient hospital professional services	20% coinsurance. Deductible applies.	30% coinsurance. Deductible applies.
Emergency medical care		
Emergency department	$150 copayment per visit (waived if admitted).	$150 copayment per visit (waived if admitted).
Ambulance	$150 copayment	$150 copayment
Urgent care	$55 copayment per visit	$65 copayment per visit
Family planning/Infertility services		
Voluntary sterilization	Covered in full only when performed in physician's office. 20% coinsurance after deductible only when in connection with other covered inpatient or outpatient surgery.	Covered in full only when performed in physician's office. 30% coinsurance after deductible only when in connection with other covered inpatient or outpatient surgery.
Family planning/infertility services (limited coverage)	20% coinsurance for diagnostic, counseling and planning services for treatment of the underlaying cause of infertility. Deductible applies.	30% coinsurance for diagnostic, counseling and planning services for treatment of the underlaying cause of infertility. Deductible applies.
Infertility Treatment Services (extended coverage for assisted reproduction)	50% coinsurance. Limitations and exclusions apply. Deductible applies. Plan includes expanded rider. See Medical Benefits rider section of this book.	50% coinsurance. Limitations and exclusions apply. Deductible applies. Plan includes expanded rider. See Medical Benefits rider section of this book.

Priority Health HMO medical plan

Basic benefits (cont.) Behavioral health services	Tier 1 network only	Tier 2 network only
Inpatient substance abuse	Covered as Tier 1. 20% coinsurance. Deductible applies $650/$1,300. Prior authorization required with the exception of emergency services.	
Outpatient substance abuse	Covered as Tier 1. $25 copayment per visit. *Priority Health encourages members to coordinate coverage with the Priority Health behavioral health department.	
Inpatient mental health	Covered as Tier 1. 20% coinsurance. Deductible applies $650/$1,300. Prior authorization required with the exception of emergency services.	
Outpatient mental health	Covered as Tier 1. $25 copayment per visit. No charge for first 6 visits with participating provider within 90 days of discharge from a participating hospital for mental health inpatient care. *Priority Health encourages members to coordinate coverage with the Priority Health behavioral health department.	
Other benefits		
Durable medical equipment	20% coinsurance. Deductible applies. Prior approval required for devices over $1,000	30% coinsurance. Deductible applies. Prior approval required for devices over $1,000
Cranial prosthesis for hair loss due to a medical condition	20% coinsurance. Deductible applies. Prior approval required for prosthesis over $1,000	30% coinsurance. Deductible applies. Prior approval required for prosthesis over $1,000
Diabetic supplies (when using a DME provider),excluding continuous glucose monitors and supplies.	Covered at 100%, deductible does not apply. Limitations apply.	Covered at 100%, deductible does not apply. Limitations apply.
Vision care	Coverage is limited to medical conditions and diseases of the eye.	Coverage is limited to medical conditions and diseases of the eye.
Skilled nursing care	Covered at 100% up to a combined benefit maximum of 135 days per contract year Deductible applies. Prior approval required. Services received in a skilled nursing care facility, subacute facility, inpatient rehabilitation care facility or hospice care facility are limited to a combined 135 days per contract year.	30% coinsurance up to a combined benefit maximum of 135 days per contract year Deductible applies. Prior approval required. Services received in a skilled nursing care facility, subacute facility, inpatient rehabilitation care facility or hospice care facility are limited to a combined 135 days per contract year.
Prescription coverage		
Prescription drugs	$15 tier 1/$50 tier 2/$100 tier 3, 4 & 5 copayment	$15 tier 1/$50 tier 2/$100 tier 3, 4 & 5 copayment
Contraceptives	Certain contraceptive methods for women are covered at 100% under Preventive Health Services benefit. Other contraceptive methods are covered at applicable copayment.	Certain contraceptive methods for women are covered at 100% under Preventive Health Services benefit. Other contraceptive methods are covered at applicable copayment.
Disposable needles and syringes for diabetics	$15 tier 1/$50 tier 2/$100 tier 3, 4 & 5 copayment	$15 tier 1/$50 tier 2/$100 tier 3, 4 & 5 copayment
Infertility prescriptions limitations and exclusions apply	50% coinsurance, plan includes expanded rider. See Medical Benefits rider section of this book.	50% coinsurance, plan includes expanded rider. See Medical Benefits rider section of this book.
Mail order prescription program (up to a 90-day supply)	$30 tier 1/$100 tier 2/$200 tier 3, 4 & 5 copayment.	$30 tier 1/$100 tier 2/$200 tier 3, 4 & 5 copayment.
Continuous glucose monitors and supplies	Covered at 100%. Deductible does not apply.	Covered at 100%. Deductible does not apply.

Medical benefits

Coverage summary: Priority Health HSA/POS medical plan

Employed by Corewell Health: plan available to all no matter where you live.

The Priority Health HSA/POS medical plan is a high deductible health insurance plan with a health savings account. In most cases the plan will cover a large portion for outpatient and inpatient services after you meet the current annual deductible. A deductible is the dollar amount you pay before the plan begins to pay benefits. The out-of-pocket limit includes any deductible, coinsurance or copayments paid for any covered services and/or prescriptions throughout the year. Once the total limit has been paid the plan will pay 100 percent for covered services and/or prescriptions.

To be eligible to enroll in the HSA/POS medical plan, you must not have any other health insurance coverage, unless the second health insurance coverage is a high deductible health plan. For example, if you elect this plan, you may not be covered by an HMO that is not considered a high deductible health plan elsewhere or Medicare/Medicaid. This is an IRS regulation.

If you enroll in the Priority Health HSA/POS medical plan, you are eligible to contribute, on a pretax basis, to a Health savings account to help cover the deductible and any expenses associated with this plan. **Corewell Health will contribute to the account up to $500 per year for single coverage or $750 per year for all other coverage tiers.** Refer to the Health Savings Account section for more information.

The Priority Health HSA/POS medical plan covers preventive care such as yearly physicals, as well as treatment of sickness or injury. You are not required by Priority Health to get a referral from your PCP to see other participating physicians or specialists; however, the specialist may require a referral from your PCP. The HSA/POS medical plan also allows you to choose providers that do not participate with Priority Health. This is called “alternate” care or “out-of-network alternate” care. While you pay more for this “alternate” care, most services are covered. Referrals for mental health and substance abuse conditions are coordinated through the Priority Health behavioral health department 800.673.8043.

You are required to select a PCP for yourself and each covered member of your family. If a PCP is not chosen, Priority Health will assign one for each member of your family covered under your plan. **Your deductible and level of coverage is dependent on where you live and provider/facilities chosen, see medical benefit providers and service areas section of this book for details**

Covered services included in the HSA/POS medical plan:

- **Hospitals:** 90/70/60 percent coverage, deductible applies, coinsurance up to annual coinsurance maximum.
- **Preventive care:** 100 percent covered in-network/60 percent covered out-of-network alternate.
- **Primary Care Physician:** 90/70/60 percent coverage, deductible applies, coinsurance up to annual coinsurance maximum.
- **Virtual care (medical and behavioral health):** 100 percent coverage in-network., deductible will apply for illness injury virtual care. Due to an extension of the CARES Act behavioral health virtual care will be covered in full prior to deductible, there is no guarantee this will continue into the future.
- **Specialist office visit:** 90/70/60 percent coverage, deductible applies, coinsurance up to annual coinsurance maximum.
- **Urgent care:** 90/70/60 percent coverage, deductible applies, coinsurance up to annual coinsurance maximum.
- **Prescriptions:** $15 tier 1/$50 tier 2/$80 tier 3, 20% up to max $150 Tier 4 & 20% up to max $300 Tier 5 copayment, copayments apply after deductible has been met.
- **ER:** $150 copayment per visit, deductible applies (waived if admitted)
- **Mental health and substance abuse services:** 90/70/60 percent coverage, deductible applies, coinsurance up to annual coinsurance maximum**.**
- **Ancillary services:** 90/70/60 percent coverage, deductible applies, coinsurance up to annual coinsurance maximum.

Priority Health HSA/POS medical plan

Annual deductible	Tier 1 network only	Tier 2 network only	Out-of-network (alternate)
Individual	$1,600	$2,000	$5,000
Family	$3,200	$4,000	$10,000

A deductible is the amount of covered expenses you must incur during the contract year before benefits will be paid. Deductible amounts are included in the out-of-pocket limit. The deductible is applicable where indicated, including prescription drugs. Team member only coverage tier is subject to the single deductible, Team member + Spouse, Team member + Child(ren) and Team member + Family coverage tiers are subject to the full family deductible, even if only one family member had services.

Out-of-pocket limit		
Individual	$5,000 limit per plan year	$10,000 limit per plan year
Family	$10,000 limit per plan year (no more than $9,100 per person)	$20,000 limit per plan year
	Total out-of-pocket limit includes deductible, coinsurance and copayments.	

Basic benefits Physician services			
Primary care physician	10% coinsurance after deductible.	30% coinsurance after deductible.	40% coinsurance of reasonable and customary charges after deductible
Retail clinics	10% coinsurance after deductible.	30% coinsurance after deductible.	40% coinsurance of reasonable and customary charges for evaluation & management services only after deductible.
Virtual care (medical and behavioral health)	Covered in full, after deductible. Due to an extension of the CARES Act behavioral health virtual care will be covered in full prior to deductible, there is no guarantee this will continue into the future. .	Covered in full, after deductible. Due to an extension of the CARES Act behavioral health virtual care will be covered in full prior to deductible, there is no guarantee this will continue into the future.	40% coinsurance of reasonable and customary charges after deductible.
Specialist office visit	10% coinsurance after deductible.	30% coinsurance after deductible.	40% coinsurance of reasonable and customary charges after deductible
Routine pre and post-natal care	Services covered in full. No office visit copayment.	Services covered in full. No office visit copayment.	40% coinsurance of reasonable and customary charges after deductible
Allergy care	10% coinsurance after deductible.	30% coinsurance after deductible.	40% coinsurance of reasonable and customary charges after deductible.
Preventive care including well-child care	Services covered in full. No office visit copayment. Deductible does not apply. Refer to Priority Health preventive care guidelines available on priorityhealth.com.	Services covered in full. No office visit copayment. Deductible does not apply. Refer to Priority Health preventive care guidelines available on priorityhealth.com.	40% coinsurance of reasonable and customary charges after deductible. Refer to Priority Health preventive care guidelines available on priorityhealth.com.
Outpatient services			
Chemotherapy	10% coinsurance after deductible.	30% coinsurance after deductible.	40% coinsurance of reasonable and customary charges after deductible
Hemodialysis	10% coinsurance after deductible.	30% coinsurance after deductible.	40% coinsurance of reasonable and customary charges after deductible
X-ray/high-tech radiology	10% coinsurance after deductible. NOTE: $150 copayment for high tech radiology which includes but is not limited to the following: CT, CTA, MRI, MRA, nuclear cardiology studies and PET scanning after the deductible.	30% coinsurance after deductible. NOTE: $150 copayment for high tech radiology which includes but is not limited to the following: CT, CTA, MRI, MRA, nuclear cardiology studies and PET scanning after the deductible.	40% coinsurance of reasonable and customary charges after deductible

Priority Health HSA/POS medical plan

Basic benefits (cont.)	Tier 1 network only	Tier 2 network only	Out-of-network (alternate)
Labs	10% coinsurance after deductible.	30% coinsurance after deductible.	40% coinsurance of reasonable and customary charges after deductible
Labs-CBC, CMP, and Vitamin D	Covered in full, after deductible	Covered in full, after deductible	40% coinsurance of reasonable and customary charges after deductible
Rehabilitative medicine services			
Physical therapy and occupational therapy	10% coinsurance after deductible, up to a combined benefit maximum of 60 visits per contract year.	30% coinsurance after deductible, up to a combined benefit maximum of 60 visits per contract year.	40% coinsurance of reasonable and customary charges after deductible up to combined benefit maximum of 60 visits per contract year.
Speech therapy	10% coinsurance after deductible, up to a combined benefit maximum of 30 visits per contract year.	30% coinsurance after deductible, up to a combined benefit maximum of 30 visits per contract year.	40% coinsurance of reasonable and customary charges after deductible up to combined benefit maximum of 30 visits per contract year.
Spinal manipulation	10% coinsurance after deductible, up to a combined benefit maximum of 30 visits per contract year.	30% coinsurance after deductible, up to a combined benefit maximum of 30 visits per contract year.	40% coinsurance of reasonable and customary charges after deductible up to combined benefit maximum of 30 visits per contract year.
Physical and occupational therapy for the treatment of autism spectrum disorder	10% coinsurance. Deductible applies.	30% coinsurance. Deductible applies.	40% coinsurance of reasonable and customary charges. Deductible applies.
Speech therapy for the treatment of autism spectrum disorder	10% coinsurance. Deductible applies.	30% coinsurance. Deductible applies.	40% coinsurance of reasonable and customary charges. Deductible applies.
Applied behavioral analysis (ABA) for the treatment of autism spectrum disorder	10% coinsurance after deductible. Prior approval required.	30% coinsurance after deductible. Prior approval required.	40% coinsurance of reasonable and customary charges. Deductible applies. Prior approval required
Habilitative Services for treatment of non-autism spectrum disorder physical and occupational therapy	10% coinsurance after deductible, up to a combined benefit maximum of 60 visits per contract year.	30% coinsurance after deductible, up to a combined benefit maximum of 60 visits per contract year.	40% coinsurance of reasonable and customary charges after deductible up to combined benefit maximum of 60 visits per contract year.
Habilitative Services for treatment of non-autism spectrum disorder speech therapy	10% coinsurance after deductible, up to a combined benefit maximum of 30 visits per contract year.	30% coinsurance after deductible, up to a combined benefit maximum of 30 visits per contract year.	40% coinsurance of reasonable and customary charges after deductible up to combined benefit maximum of 30 visits per contract year.
Cardiac and pulmonary rehabilitation	10% coinsurance after deductible. Prior approval required	30% coinsurance after deductible. Prior approval required	40% coinsurance of reasonable and customary charges after deductible up to combined benefit maximum of 30 visits per contract year.
Hospitals services			
Inpatient services (semi-private room)	10% coinsurance after deductible.	30% coinsurance after deductible.	40% coinsurance of reasonable and customary charges after deductible.
Inpatient hospital professional services	10% coinsurance after deductible.	30% coinsurance after deductible.	40% coinsurance of reasonable and customary charges after deductible.

Priority Health HSA/POS medical plan

Basic benefits (cont.)	Tier 1 network only	Tier 2 network only	Out-of-network (alternate)
Outpatient surgery at hospital or ambulatory center	10% coinsurance after deductible.	30% coinsurance after deductible.	40% coinsurance of reasonable and customary charges after deductible.
Outpatient hospital professional services	10% coinsurance after deductible.	30% coinsurance after deductible.	40% coinsurance of reasonable and customary charges after deductible.
Emergency medical care			
Emergency department	$150 copayment after deductible	$150 copayment after deductible	$150 copayment per visit after deductible (waived if admitted).
Ambulance	Covered in full. Deductible applies.	Covered in full. Deductible applies.	Ambulance services with participating and non-participating providers are covered at the Tier 1. Reasonable and customary limitations apply. Deductible applies.
Urgent care	10% coinsurance after deductible.	30% coinsurance after deductible.	40% coinsurance of reasonable and customary charges after deductible
Family planning/Infertility services			
Voluntary sterilization	10% coinsurance for physician and facility services; coverage limited only to when performed in physician's office or when in connection with other covered inpatient or outpatient surgery. Deductible applies.	30% coinsurance for physician and facility services; coverage limited only to when performed in physician's office or when in connection with other covered inpatient or outpatient surgery. Deductible applies.	Not covered
Family planning/infertility services (limited coverage)	10% coinsurance for diagnostic, counseling and planning services for treatment of the underlaying cause of infertility. Deductible applies.	30% coinsurance for diagnostic, counseling and planning services for treatment of the underlaying cause of infertility. Deductible applies.	Not covered
Infertility Treatment Services (extended coverage for assisted reproduction)	50% coinsurance, deductible applies. Limitations and exclusions apply. Plan includes expanded rider. See Medical Benefits rider section of this book.	50% coinsurance, deductible applies. Limitations and exclusions apply. Plan includes expanded rider. See Medical Benefits rider section of this book.	Not covered
Behavioral health services			
Inpatient substance abuse	Covered as Tier 1. 10% coinsurance. Deductible applies $1,600/$3,200. Prior authorization required, with the exception of emergency services.		40% coinsurance of reasonable and customary charges. Prior authorization required with the exception of emergency services. Deductible applies.
Outpatient substance abuse	Covered as Tier 1. 10% coinsurance. Deductible applies $1,600/$3,200. *Priority Health encourages members to coordinate coverage with the Priority Health behavioral health department.		40% coinsurance of reasonable and customary Charges. Deductible applies *Priority Health encourages members to coordinate coverage with the Priority Health behavioral health department.
Inpatient mental health	Covered as Tier 1. 10% coinsurance. Deductible applies $1,600/$3,200. Prior authorization required, with the exception of emergency services.		40% coinsurance of reasonable and customary charges. Prior authorization required with the exception of emergency services. Deductible applies.

Priority Health HSA/POS medical plan

Basic benefits (cont.) Behavioral health services	Tier 1 network only	Tier 2 network only	Out-of-network (alternate)
Outpatient mental health	Covered as Tier 1. 10% coinsurance. Deductible applies $1,600/$3,200. No charge for first 6 visits with participating provider within 90 days of discharge from a participating hospital for mental health inpatient care. *Priority Health encourages members to coordinate coverage with the Priority Health behavioral health department..		40% coinsurance of reasonable and customary Charges. Deductible applies *Priority Health encourages members to coordinate coverage with the Priority Health behavioral health department.
Other benefits			
Durable medical equipment	10% coinsurance Deductible applies. Prior approval required for devices over $1,000	30% coinsurance Deductible applies. Prior approval required for devices over $1,000	40% coinsurance of reasonable and customary charges. Deductible applies. Prior approval required for devices over $1,000
Cranial prosthesis for hair loss due to a medical condition	10% coinsurance Deductible applies. Prior approval required for prosthesis over $1,000	30% coinsurance Deductible applies. Prior approval required for prosthesis over $1,000	40% coinsurance of reasonable and customary charges. Deductible applies. Prior approval required for prosthesis over $1,000
Diabetic supplies (when using a DME provider),excluding continuous glucose monitors and supplies.	100% coverage, deductible does not apply. Limitations apply.	100% coverage, deductible does not apply. Limitations apply.	40% coinsurance of reasonable and customary charges after deductible
Vision care	Coverage is limited to medical conditions and diseases of the eye.	Coverage is limited to medical conditions and diseases of the eye.	Not covered
Skilled nursing care	Covered at 100%, after deductible, up to a combined benefit maximum of 135 days per contract year Deductible applies. Prior approval required. Services received in a skilled nursing care facility, subacute facility, inpatient rehabilitation care facility or hospice care facility are limited to a combined 135 days per contract year.	30% coinsurance up to a combined benefit maximum of 135 days per contract year Deductible applies. Prior approval required. Services received in a skilled nursing care facility, subacute facility, inpatient rehabilitation care facility or hospice care facility are limited to a combined 135 days per contract year.	40% coinsurance of reasonable and customary charges after deductible. Up to combined 135 days per contract year (combined benefit for both benefit levels). Prior approval required. Services received in a skilled nursing care facility, subacute facility, inpatient rehabilitation care facility or hospice care facility are limited to a combined 135 days per contract year.
Prescription coverage			
Prescription drugs	*$15 tier 1/$50 tier 2/$80 tier 3, 20% to max $150 tier 4 & 20% to max $300 tier 5 copayment	*$15 tier 1/$50 tier 2/$80 tier 3, 20% to max $150 tier 4 & 20% to max $300 tier 5 copayment	Not covered
Contraceptives	*Certain contraceptive methods for women are covered at 100% under preventive health services benefit. Other contraceptive methods are covered at applicable copayment.	*Certain contraceptive methods for women are covered at 100% under preventive health services benefit. Other contraceptive methods are covered at applicable copayment.	Not covered
Disposable needles and syringes for diabetics	*$15 tier 1/$50 tier 2/$80 tier 3, 20% to max $150 tier 4 & 20% to max $300 tier 5 copayment	* $15 tier 1/$50 tier 2/$80 tier 3, 20% to max $150 tier 4 & 20% to max $300 tier 5 copayment	Not covered
Infertility prescriptions limitations and exclusions apply	* 50% copayment, plan includes expanded rider. See Medical Benefits rider section of this book.	* 50% copayment, plan includes expanded rider. See Medical Benefits rider section of this book.	Not covered
Mail order prescription program (up to a 90-day supply)	$30 tier 1/$100 tier 2/$160 tier 3, 20% to max $150 tier 4 & 20% to max $300 tier 5 **participating pharmacies only*	$30 tier 1/$100 tier 2/$160 tier 3, 20% to max $150 tier 4 & 20% to max $300 tier 5 **participating pharmacies only*	Not covered
Continuous glucose monitors and supplies	Covered at 100%. Deductible does not apply.	Covered at 100%. Deductible does not apply.	Not covered

Medical benefits

Selecting a primary care physician (PCP)

If you enroll in a medical plan through Priority Health, you are *required* to choose a PCP for each person in your family who is receiving coverage. If you do not select a PCP, **you will be assigned one by Priority Health.** You are not required by Priority Health to get a referral from your PCP to see other participating physicians or specialists.

What is a PCP? a PCP is a physician who specializes in internal medicine, pediatrics, general practice, OB/GYN, or family practice. You must choose a PCP from the Priority Health physician network. Each person in your family may have a different PCP. Your PCP is responsible for managing your total health care. This means your PCP knows your health history, coordinates services, and arranges for hospital care.

Visit Priority Health's website at prioritythealth.com for a complete listing of providers or call PriorityGPS at 866.518.1769. If you would like to change Primary Care Physicians at this time or at any time throughout the year, you can call PriorityGPS at 866.518.1769 to make the change. Priority Health will make this change the first of the following month after you notify them.

PriorityGPS

Priority Health has partnered with Accolade, a care delivery, navigation and advocacy services company, to offer you PriorityGPS. PriorityGPS gives you and your family access to personalized support from a Health Assistant and nurse for all your healthcare and benefits questions. You can also view all your benefits in one place with the Accolade member portal and mobile app. PriorityGPS helps to make healthcare easier for you to navigate. PriorityGPS can be reached at 866.518.1769 and is the one-stop-shop for all your Priority Health customer service and benefits questions. You can also text at ACCD01 to connect with a Health Assistant.

Through one point of contact you can access:

- **Health care navigation and advocacy** – including appointment scheduling, guidance to high-value providers, and treatment decision support.
- **Benefits and coverage guidance** – including cost estimation, prior authorization, claims processing, coverage and other employer benefits-related questions.
- **Condition management and prevention** – including nurse triage, virtual care, expert second opinion, proactive and targeted clinical interventions.

PriorityGPS 2nd.MD program

2nd.MD provides members with a third-party second opinion for complex treatment plans including procedures, surgeries, and other medical situations. 2nd.MD is a nationwide second medical opinion service that offers an external third-party review of a member's treatment plan by a leading provider with the goal of providing members additional objectivity, credibility, and confidence in treatment. Corewell Health members targeted for a second opinion will receive email and phone outreach from 2nd.MD representatives on behalf of the PriorityGPS offering.

Priority Health account and app

Managing your health insurance is easier than ever with the Priority Health app. Download the Priority Health app from the App Store or Google Play or sign up at member.prioritythealth.com to view your personalized health insurance information anytime, anywhere. Getting started is easy, click sign up and follow the instructions within the app or online. In your member account you can easily: Track spending balances, search your claims, compare costs of medical procedures and prescriptions based on your plan so you can save money, Find in-network providers, set up a video visit and get virtual care, including virtual behavioral health care, when and where you need it

Emergency travel services

Assist America® provides emergency travel assistance services for Priority Health members and their dependents. If you or your dependent becomes ill or injured while traveling more than 100 miles from home or in a foreign country, Assist America provides support with medical referrals, monitoring, evacuation, repatriation and much more. Visit Priority Health's website at prioritythealth.com for more details regarding this service.

1. Call Assist America's 24-hour operations center at 800.872.1414
2. Download the Assist America app (Priority Health reference number: 01-AA-PHP-12123)

Medical benefits

Riders on the Corewell Health medical plan

Expanded infertility rider

All Priority Health medical plans cover diagnostic, counseling, and planning services for the treatment for the underlying cause of infertility and prescription drugs used for the purpose of treating infertility. Examples of covered services include endometrial biopsy, diagnostic laparoscopy or hysteroscopy, hormone evaluation, and semen analysis.

The expanded infertility rider provides coverage for assisted reproduction and artificial conception services regardless of provider participation. Examples of covered assisted reproduction and artificial conception services include within the expanded rider: Sperm count, egg freezing, thawing and storage, in vitro fertilization (IVF), artificial insemination (AI) and services associated with the treatment and underlying conditions of assisted reproduction and artificial conception such as ultrasounds and imaging. Services specific to this rider have a $50,000 lifetime maximum benefit.

Chronic conditions rider for prescriptions

Specific to the HSA/POS medical plan, **t**his rider allows those with a Chronic Condition such as Asthma, Cholesterol, Depression, Diabetes, Heart Conditions and/or Osteoporosis to get certain defined medications and services prior to the deductible needing to be met, refer to your Priority Health certificate of coverage for additional details.

Obesity medication rider for prescriptions

A rider for prescription medication related to obesity treatment is covered by our medical plans (after deductible with the HSA/POS plan). As with all other prescription medication, the medication must be on the Priority Health formulary.

Habilitation coverage rider

This rider provides coverage for habilitation services which are defined as those health care services that help a person keep, learn, or improve skills and functioning for daily living e.g., therapy for a child who isn't walking or talking at the expected age.

All of the following must be met for coverage of habilitative services not related to autism spectrum disorder:

- Treatment must be evidence-based physical or occupational therapy provided by an appropriately licensed therapist under the direction of a physician or advanced practice nurse in accordance with a written treatment plan established or certified by the treating physician or advanced practice nurse.
- One of the following diagnoses:
    - Developmental delay
    - Developmental coordination disorder
    - Mixed developmental disorder
    - Developmental speech or language disorder

Lab coverage for CBC, CMP and Vitamin D

CBC, CMP and/or vitamin D labs at 100% prior to deductible with the HMO plan and 100% after the deductible with the HSA/POS plan.

Cranial Prosthesis rider

This coverage rider provides coverage for cranial prosthesis for hair loss due to a medical condition as described in the Priority Health schedule of copayments and deductibles. Cranial prosthesis (wig, toupee, headband) is covered when performed by a health professional.

Medical benefits

Additional benefits and programs available through the medical benefits

There are many programs and additional benefits available to you as a Priority Health member. If you enroll in the medical benefits through Corewell Health, you have access to the following benefits through Priority Health.

Cost Estimator

Make conscious, cost-effective, and smart health care decisions. Search for hundreds of procedures and prescriptions to find the costs based on location and type. Access this through member center at priorityhealth.com

Care management

licensed nurses and social workers offer you support and guidance managing chronic conditions. Access more information at priorityhealth.com/caremanagement

Priority Health Connect

Online resources that helps connect individuals living in the state of Michigan with free or reduced-cost programs and critical social services. Service is included in your health plan at no cost to you. Start by going to priorityhealth.com/connect

TruHearing

As a Priority Health member, you and your extended family have access to discounts on hearing exams and hearing aids through our partnership with TruHearing. The program includes State-of-the-art technology, personalized care and help along the way. Access more information at priorityhealth.com/truhearing

Behavioral Health

Licensed social workers are available 24-hours a day, 7 days a week to: refer to a specialist, give advice on your situation and offer support for substance abuse. Call the number on your member id for assistance.

Diabetes Prevention Program

Members at risk of or diagnosed with pre-diabetes may be eligible to participate in our Diabetes Prevent Program. DPP offers tools and resources to prevent diabetes and is offered, online through Omada, locally through in-person sessions. More information can be found at priorityhealth.com/prevent-diabetes

BenefitHub

Enjoy Priority Health's member discount program, which gives you access to thousands of discounts or cash back offers on local businesses and national brands. Find deals on travel, restaurants, shopping, family care, car rentals and more through an easy-to-use online marketplace. Visit priorityhealth.benefithub.com

PriorityMOM

Designed to help navigate health care costs and coverage throughout pregnancy and beyond. The goal of the program is to promote more full-term pregnancies and offer helpful information on ways to stay happy and healthy through the pregnancy. Priority Health will contact you if you qualify for this program.

Active&Fit Direct

Offers fitness center membership programs well under market price. Provides the option to switch fitness centers so participants can find the right fit. Access to 2,500+ digital workout videos and live online classes. 250 fitness centers in Michigan – and more than 9,000 nationwide. Learn more about this program at priorityhealth.com/activeandfit

Teladoc Health Mental Health wellness tool

Corewell Health team members have access to Teladoc Mental Health program. This free mental wellness resource offers support for stress, depression, sleep and more to help you live your happiest and healthiest life. It's safe, secure and personalized – just for you. Track your health, enjoy activities and become inspired.

Team members with Priority Health: Set up your free account using the access code PHMH.
Team members that do not have Priority Health: Set up your free account using the access code PHEMPLOYEE

Livongo diabetes management program

offers members a no-cost solution for managing type 2 diabetes to help lower A1c and improve overall health. This program is an integrated digital system comprised of connected technologies offering expert 1:1 telephonic health coaching, digital blood glucose monitor, in-app messaging with 24/7 monitoring and support, lifestyle, nutrition, exercise, and emotional health monitoring tools. If you're eligible, you'll receive outreach from Livongo with information on how to get started with the program.

Voluntary benefits: supplemental medical plans

Our partner: Voya
website: presents.voya.com/EBRC/CorewellHealth

Introduction

Corewell Health offers additional benefits you can enroll in which complement your medical benefits. Many are policies you can continue if you leave employment assuming you continue to pay premiums directly to the vendor.

The benefits are designed to complement your medical coverage, by paying a cash benefit to you when you seek treatment. The cash payments from the policies are designed to assist you with covering expenses such as deductibles, coinsurance, copayments or other expenses related to a covered event. Three policies that are available are listed below. You chose which plan or plans you would like to purchase.

Enrolling in these benefits

Enrollment in these benefits occurs in Workday and is during new hire, newly eligible and/or annual benefits open enrollment periods only. You will not be able to start, stop or make changes to these benefits in the middle of the year. Changes can be made during annual benefits open enrollment.

Visit for presents.voya.com/EBRC/CorewellHealth more detailed information on these plans and how they work.

Group accident
Voya

Pays a benefit when you receive medical treatment for injuries due to an accident. Treatment can be performed in a physician office visit, emergency room or urgent care. Additional benefits payable for specific injuries, hospitalization, and surgery.

per pay period cost

Team member: $3.46
Team member+spouse: $6.69
Team member+child(ren): $6.92
Team member+family: $10.15

Group hospital indemnity
Voya

Pays a benefit for initial hospitalization due to an accident or illness, including pregnancy. Additional benefits are payable for daily hospitalization.

ICU benefits: Additional benefits are payable for daily hospitalization, Intensive Care and Inpatient Rehabilitation.

per pay period cost

Team member: $7.75
Team member+spouse: $14.16
Team member+child(ren): $12.66
Team member+family: $19.07

Wellness Benefit: Get an annual benefit payment of $75, after completing a covered health screening. Wellness benefit payments are also available to covered spouses and child(ren), up to $150.

Group critical illness
Voya

Pays a lump-sum benefit when a specified event, such as heart-attack, stroke, or cancer occurs. Multiple benefits may be payable including reoccurrence. Special occupational infectious disease coverage exists for healthcare team members.

Plan amounts are the maximum you would be paid for self, spouse and/or child(ren) enrolled in the plan.

Plan Options:
Plan: $10,000/$10,000/$5,000
Plan: $20,000/$20,000/$10,000
Plan: $30,000/$30,000/$15,000

Rates are in Workday and are based on:

- Age
- Tobacco use – when enrolling make sure to select the plan based on your tobacco use, this will matter at claim.
- And coverage tier elected*

*Coverage is available for team member +Spouse, +Child(ren) or +Family.

Health savings account (HSA)

Our partner: HealthEquity
phone: 1.866.296.2859
website: learn.healthequity.com/corewellhealth

Health savings account

If you enroll in the HSA/POS medical plan, you may have a health savings account. A health savings account is only available to participants in an HSA/POS medical plan. **If you live outside of the United States you will not be able to have a HSA bank account.**

A health savings account is a unique way to pay for health care expenses. Contributions to the account are made on a pretax basis and reimbursements from the account are tax-free as long as they are used to pay for qualified health care expenses. Money in the account can be used to pay for eligible medical, dental, and vision expenses not covered by insurance, COBRA premiums, long-term care premiums, and retiree health expenses. The account is portable; if you retire or change employers, you take your account balance with you. In addition, unused money rolls over each year, unlike a health care flexible spending account where remaining account balances are forfeited at the end of the year.

The health savings account (HSA) is a bank account, similar to a checking account. Once your account is set up, you will receive a Visa health account card. You can use the Visa debit card or online account to pay for eligible expenses. Because the account works similar to a checking account, you may only use the funds that have accumulated in the account. Any amounts remaining at the end of the year will roll over to the next year.

To be eligible to enroll in the HSA/POS medical plan and to contribute money on a pretax basis to the account, you must not have any other health insurance coverage, unless the second health insurance coverage is a high deductible health plan. For example, if you elect this plan, you may not be covered by an HMO that is not considered a high deductible health plan elsewhere or Medicare/Medicaid. This is an IRS regulation. You must also not be enrolled in a traditional health care flexible spending account through Corewell Health or any other employer. You may, however, contribute to a limited health care flexible spending account. Refer to the flexible spending account section for more details.

What is the difference between an HSA and FSA?

	HSA (Health Savings Account)	FSA (Health Care Flexible Spending Account)
Pre-tax contributions (tax-advanced)	X	X
Funds accumulate year over year	X	
IRS contribution maximum	X	X
Deducted from paycheck	X	X
Funded up-front and paid back each paycheck		X

HealthEquity health savings account details

The Corewell Health HSA account partner is HealthEquity. HealthEquity offers a number of services to ensure HSA plan participants reap the full benefits of an HSA account, such as **simple electronic setup, integrated claims data with Priority Health and direct payment to providers**. This bank account is an interest-bearing account with additional investment opportunities as your account balance grows.

Once you enroll in the HSA/POS medical plan you will receive a welcome packet from HealthEquity which will provide you additional information as to how to manage your HSA account. Once you receive this welcome packet follow instructions on how to set-up your account. Once you have set your account up you will receive your debit card so that you can start using the funds within your account. For additional information visit learn.healthequity.com/corewellhealth or for information on the go, be sure to download the HealthEquity app from the App Store or Google Play. If you have questions about your health savings account, you can contact HealthEquity 24 hours a day, 7 days a week at 1.866.296.2859.

Health savings account (HSA)

Health savings account contributions

Contributions to your HSA account are deducted from each paycheck. You are not required to contribute to the account. The maximum annual contribution (including any contributions you may be eligible for from Corewell Health) is $4,150 per year for single coverage and $8,300 for all other coverage level tiers. If you became eligible after January 1, to be eligible to contribute the maximum, you must remain enrolled in the HSA/POS medical plan for the entire year after you first became enrolled. Note: If you are age 55 or older, you are eligible for a “catch-up” contribution of $1,000 in 2024, in addition to the contribution amounts listed above. You will have until the end of the tax filing deadline to max out your HSA for the year.

Things to consider: You may change or stop the employee contribution at any time during the plan year. If you elect to make a change to your contribution during the year, the change can be made in the self-service portal of Workday. The change will be effective the next paycheck, based on the date of the change made in Workday. **Any lump sum contributions to the HSA will need to be completed using the member portal at HealthEquity, these will be after-tax contributions.** Contributions through your paychecks are based on 26 pay periods and the annual IRS limits. Corewell Health will not be able to adjust or correct funding if you were to over contribute to your account.

Employer contributions to the health savings account

Team members that enroll in the HSA/POS medical plan are eligible for a Corewell Health employer contribution to the HSA account. For single coverage, the employer contribution is up to $500 per year. For all other coverage tiers, the employer contribution is up to $750 per year. **The employer contributions to your HSA will be deposited on a per pay period basis. For single coverage $19.23 per pay period, for all other coverage $28.85 per pay period.**

	Single Coverage	Family Coverage
Amount contributed by employer per pay period	$19.23	$28.85
Based on the month you enroll in this plan, here is the total contribution amount you would receive in your HSA		
January	$500.00	$750.00
February	$461.52	$692.40
March	$423.06	$634.70
April	$384.60	$577.00
May	$326.91	$490.45
June	$288.45	$432.75
July	$249.99	$375.05
August	$211.53	$317.35
September	$173.07	$259.65
October	$115.38	$173.10
November	$76.92	$115.40
December	$38.46	$57.70

Transferring current HSA funds to HealthEquity

After your account is open, you may transfer an existing HSA to your HealthEquity account. Moving your HSA is simple:
1. Download the HealthEquity transfer form at: HealthEquity.com/form
2. Complete the form entirely. Since HSAs are individually held accounts, only you (the account owner) can request your account be closed and the balance be transferred.
3. Send the completed form to HealthEquity via email transfer@healthequity.com, fax 520.844.7090, or mail HealthEquity, Attn: Employer services 15 W Scenic Pointe Drive, Ste 100 Draper, UT 84020

HealthEquity will submit the form to your prior administrator to initiate the transfer of your balance to your HealthEquity HSA (less any applicable closing fees assessed by your prior administrator). **The transferred amount will appear in your HealthEquity account within four to six weeks (processing timeframes and blackout periods vary by administrator). Funds may not be available during this time. You are encouraged to plan accordingly.**

Health savings account (HSA)

Health savings account and Medicare enrollment

If you are currently age 65 or older or will turn age 65 on or before December 31, 2024 and plan to elect the HSA/POS medical plan, please keep the following in mind. (This relates to you as the HSA account holder).

- If you are enrolled in Medicare, you are not eligible to contribute to the Corewell Health HSA savings account on a pre-tax basis due to IRS regulations. This also applies to the employer contribution that Corewell Health provides on your behalf throughout the year, if you are eligible for that contribution.
- The IRS and Medicare recommend that you stop contributing to your HSA at least 6 months before you enroll in any Medicare plans to avoid penalties (see below graph). You may be subject to tax penalties if your HSA contributions and your Medicare enrollment overlap. You are eligible to contribute 1/12 of the annual allowed contribution for each month you are eligible for the HSA, this includes the employer contributions to your HSA.
- If you enroll in the HSA/POS medical plan, the employer contribution that Corewell Health provides, does not stop, even if you stop contributions to your HSA.
- If you are currently not enrolled in Medicare and don't anticipate enrolling in Medicare for 2024, you are able to contribute to your HSA savings account on a pre-tax basis and Corewell Health will contribute, if eligible, as well.

We advise you speak with a tax professional regarding the implications to your 2024 tax filings.

The chart below may help you decide when it is best to stop your HSA contributions.

If you sign up for Medicare:	During the initial enrollment period 2 months after your initial enrollment period ends	You can avoid a tax penalty by making your last HSA contribution the month before you turn 65.
If you wait to sign up for Medicare:	Less than 6 months after you turn 65	You can avoid a tax penalty by stopping HSA contributions the month before you turn 65.
	6 or more months after you turn 65	You can avoid a tax penalty by stopping HSA contributions 6 months before the month you apply for Medicare.

While you are enrolled in the HSA/POS plan the employer contributions cannot be stopped, so you will want to figure that monthly amount in when determining your estimated allowed maximum contribution.

	Single Coverage		Family Coverage	
	Under 50	Over 50	Under 50	Over 50
1/12th of the annual contribution	$345.83	$429.16	$691.66	$775.00

To calculate:

1. Take the 1/12th of the annual contribution amount based on your coverage and age
2. Times that number by the number of months you are eligible for the HSA/POS plan
3. The result is the total allowed contribution for the year for both your personal contribution and the Corewell Health contribution.

Dental benefits

Our partner: Delta Dental
phone: 800.524.0149
website: deltadentalmi.com

Introduction

The Corewell Health benefit program offers you two dental plans from which to select. The dental coverage is available for you and your eligible dependents.

When calling the dentist's office for an appointment, identify yourself as a Delta Dental of Michigan participant, and indicate that you work at Corewell Health. The Corewell Health group number is 11532. Delta Dental does not provide identification cards. The dentist office will obtain the necessary authorization and information about your eligibility and coverage.

Log on to your member portal on the Delta Dental website at deltadentalmi.com. In your portal you can retrieve eligibility, find your unique identification number, print cards, find claim status information, as well as a cost estimator.

Delta Dental dentist details

About 90 percent of dentists in Michigan participate with Delta Dental. Additional information can be found on the Delta Dental website at deltadentalmi.com. As shown below, your lowest out-of-pocket costs result from going to either a Delta Dental PPO or Delta Dental Premier dentist.

Example savings for a crown by network

	Delta Dental PPO	Delta Dental Premier	Out-of-network
Submitted charge	$1,100.00	$1,100.00	$1,100.00
Maximum allowed fee	$754.00	$989.00	$799.00
Percentage paid by Delta Dental	50%	50%	50%
Amount Delta Dental pays	$377.00	$494.00	$399.00
Amount dentist can balance bill	$0,00	$0.00	$301.00
Total Deductible	$50.00	$50.00	$50.00
Total amount you pay	$377.00	$494.00	$701.00
Total network savings	$296.00	$62.00	$0.00

*Payment examples above are illustrative only. Fees and reimbursements can vary by location and dentist. They do however represent how payment is determined.

Delta Dental PPO dentists	• No balance billing on covered services • Most significant network discounts • Dentists file claims
Delta Dental Premier dentists	• No balance billing on covered services • Significant network discounts • Dentists file claims
Out-of-network dentists	• Balance billing • No network discounts • May need to file own claims

To find which network your dentist is in visit deltadentalmi.com. Delta Dental has the largest network of dentist across the United States and Puerto Rico, so even if you live outside of Michigan there will be providers near you.

Dental benefits

Comparing the dental plans

You are not able to switch dental plans during the year, even if you experience a qualifying employment status change or family status change.	Basic plan	Enhanced plan
Class I benefits		
Diagnostic and preventive services—includes: prophylaxis, exams, fluoride treatments, and space maintainers (twice in a calendar year)	100%	100%
Emergency palliative treatment	100%	100%
Bitewing x-rays (once per calendar year)	100%	100%
Deductible for Class II and Class III benefits**	$50 per person $150 family	$50 per person $150 family
Class II benefits		
Minor restorative services—includes: amalgams fillings (silver), composite resin fillings (white) and resin restorations	80%	90%
X-rays—all others	80%	90%
Sealants (age limitations – see certificate of coverage)	80%	90%
Oral surgery	80%	90%
Periodontics (gum disease)	80%	90%
Endodontics (root canals)	80%	90%
Class III benefits		
Major restorative services—includes: cast restorations	50%	60%
Prosthodontics—includes fixed bridgework and dentures	50%	60%
Class IV benefits		
Orthodontics (no age limit, child and adult coverage)	No Coverage	50%
Plan maximums*		
Annual maximum for class II & III benefits	$1,000	$2,000
Orthodontic lifetime maximum for class IV benefits	No Coverage	$2,000

Benefits provided under the Dental plan are as follows:

Diagnostic and preventive services: The plan will pay 100 percent of eligible expenses for preventive services such as oral exams and teeth cleaning **(twice in a calendar year)**. Services do not apply to plan maximums.

Minor services: The plan will pay percent* of eligible expenses, after deductible, for such minor dental services as fillings, extractions, other x-rays, lab tests, oral surgery, and sealants

Major services: The plan will pay percent* of eligible expenses, after deductible, for such major dental services as crowns, bridgework, and dentures, up to the annual plan maximum.

Orthodontic coverage: The enhanced plan will pay percent of eligible expenses for covered orthodontic treatment. These benefits are available to all ages. Coverage is subject to the lifetime maximum. Orthodontics is not covered under the basic plan.

*The annual maximum benefit is per person for minor, and major services. The lifetime maximum benefit for orthodontic services is per participant.

**Annual deductible is $50 per person, not to exceed $150 for the family (which would be three family members each hitting the per person deductible for the year).

The plan will pay percentage of the services reflected above, until the annual maximum has been reached. Once the annual maximum has been met, the plan will no longer pay for services until the next calendar year. ****A pre-treatment estimate of benefits is suggested before you have any work done. Corewell Health will not be responsible for claims that are not paid. If you do not enroll in the dental plan, Corewell Health is not responsible for any dental expenses you may incur.**

Dental benefits

Team member contributions for dental benefits

Your benefit premiums will be deducted from each of your paychecks. Amounts below are per pay period.

Per pay period		Basic plan	Enhanced plan
Full time (72-80 hours per pay period)	Team member	$7.09	$14.83
	Team member+spouse	$14.18	$29.67
	Team member+child(ren)	$15.60	$32.64
	Team member+family	$22.68	$47.47
Part time (40-71 hours per pay period)	Team member	$12.54	$20.48
	Team member+spouse	$25.07	$40.97
	Team member+child(ren)	$27.58	$45.06
	Team member+family	$40.11	$65.55

Orthodontic payments

Delta Dental requires your dentist to submit an orthodontic treatment plan to them. When orthodontic treatment starts, they will pay a percentage of the total fee. Delta Dental will continue to make payments based on the type of treatment (18 months for comprehensive, 10 months for interceptive and 8 months for limited) or until the lifetime orthodontic maximum is reached. Payments will be made on a quarterly basis.

For treatment that began prior to eligibility with Delta Dental, they will make payments only for the months of treatment while eligibility is active with Delta Dental. Delta Dental will calculate payments based on the original claim form from the provider. The initial/banding fee will be subtracted from the total fee (as this was incurred prior to eligibility with Delta Dental) and divide by the standard number of payment months. Delta Dental will then pay for the remaining payment months or until the lifetime orthodontic maximum is reached.

For further details on how Delta Dental will pay for your specific orthodontic services contact the customer service department at 1.800.524.0149.

Delta Dental's Special Health Care Needs Benefit

Your Delta Dental plan includes enhanced benefits for covered members (children and adults) with a qualifying special health care need. Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma or environmental cause, and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

What is included in this benefit?	• Additional visits to the dentist's office and/ or consultations that can be helpful prior to the first treatment to help patients learn what to expect and what is needed for a successful dental appointment. Additional exam benefits will be allowed for this purpose. • Up to four total dental cleanings in a benefit year • Treatment delivery modifications necessary for dental staff to provide oral health care for patients with sensory sensitivities, behavioral challenges, severe anxiety or other barriers to treatment.
How do I/my spouse/my dependent use this benefit?	• Members with a qualifying special health care need should let their dentist know that their Delta Dental plan includes the Special Health Care Needs Benefit and that they have a qualifying special health care need. No network discounts May need to file own claims. • To help your dentist better understand the benefit and how to bill Delta Dental for services provided, it is suggested you take the "Special Health Care Needs Benefit Provider Instructions" flyer with you to your next dental visit (download the flyer at deltadental.pub/shcn-provider)

Vision benefits

Our partner: Vision Service Plan (VSP)
phone: 800.877.7195
website: vsp.com

Introduction

The vision care plans are designed to provide benefits for eye exams and corrective lenses. This coverage is available for you and your eligible dependents. Either participating or non-participating providers may provide vision care services with benefits payable as follows.

Comparing the vision plans

	Basic plan		Enhanced plan	
	VSP Provider	Non-VSP Provider	VSP Provider	Non-VSP Provider
Exam copayment	$10	Covered up to $45	$10	Covered up to $45
Material copayment	$20*	Not Applicable	$20*	Not Applicable
Frame allowance	Up to $200	Covered up to $70	Up to $250	Covered up to $70
Featured frames allowance	Up to $220	Covered up to $70	Up to $270	Covered up to $70
Lenses				
Single lenses	Covered*	Covered up to $30	Covered*	Covered up to $30
Bifocal lenses	Covered*	Covered up to $50	Covered*	Covered up to $50
Trifocal lenses	Covered*	Covered up to $65	Covered*	Covered up to $65
Progressive lenses	Covered*	Covered up to $50	Covered*	Covered up to $50
Contacts Exam copayment	Up to $60	Covered up to $105	Up to $60	Covered up to $105
Contacts allowance	Up to $200	Covered up to $105	Up to $200	Covered up to $105
Materials Frequency: Exam/Lenses/Frames	12/12/12 (months)	12/12/12 (months)	12/12/12 (months)	12/12/12 (months)

Under the vision plans you can get coverage for either frames/lenses **OR** contact lenses one time per calendar year.

1. Based on calendar year beginning January 1 to December 31.
2. 20 percent off additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision exam*.
3. Polycarbonate lenses are covered.
4. Patients choosing contacts are not eligible for frames and lenses. Patients are eligible for contacts OR frames and lenses one time per calendar year (January 1 to December 31).
5. When you choose contacts instead of glasses, your allowance applies to the cost of your contact lenses. The evaluation exam is in addition to your vision exam to ensure proper fit of contacts.
6. Contacts copayment will not exceed the amount reflected for the fitting and evaluation, 15 percent off the cost of a contact lens exam (fitting and evaluation).
7. Laser vision correction (PRK and LASIK surgery) is available through contracted laser centers. Program availability may vary based on location and regulatory approval.

*VSP offers exclusive special offers to you and your covered dependents, which includes discounts on brand name eyewear, contacts, prescription sunglasses as well as discounts on digital hearing aids and batteries. Additional details can be found at vsp.com.

Vision benefits

Team member contributions for vision benefits

Your benefit premiums will be deducted from each of your paychecks. Amounts below are per pay period.

Per pay period		Basic plan*	Enhanced plan
Full time & Part time (40-80 hours per pay period)	Team member	$4.51	$5.21
	Team member+spouse	$7.17	$8.27
	Team member+child(ren)	$7.32	$8.45
	Team member+family	$11.82	$13.62

Participating providers

To access your vision care benefits, simply contact your VSP participating provider to make an appointment. If you need help locating a VSP participating provider, call VSP at 800.877.7195 or visit their website at vsp.com. VSP is a national network, if you live outside of Michigan there will be providers near you.

When calling the provider's office for an appointment for you or your covered dependent, identify yourself as a VSP member, and indicate that you work at Corewell Health. VSP does not provide identification cards. The VSP participating provider will obtain the necessary authorization and information about your eligibility and coverage.

Non-Participating Providers

If you use a vision care provider who is not part of the VSP network, the vision care plan provides benefits based on a specific schedule of vision care coverage..

You will have to pay the entire bill when you see the non-participating provider. To obtain reimbursement for services provided by a non-participating provider, call VSP for a claim form and obtain an itemized receipt. It is your responsibility to file this claim with VSP. Include the following:

1. The provider's bill, including a detailed list of the services you received
2. The covered member's VSP member identification number (social security number)
3. The name of the organization that provides your VSP coverage (Corewell Health/Spectrum Health)
4. Your name, date of birth, phone number, and address
5. Your relationship to the covered VSP member

Claims must be filed with VSP within six months after seeing the provider. Please keep a copy of the information for your records and send originals to:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

Claims can also be filed directly on the VSP website at vsp.com.

Eyeconic online eyewear store

Your vision and wellness come first with VSP. Once you have visited your VSP provider for exam, check out Eyeconic and browse the frame brands you love, visit eyeconic.com.

Online shopping with benefits

- A huge selection of contact lenses and designer frames 24/7 – and the Virtual Try-On tool
- Free shipping and returns (terms and conditions apply, visit eyeconic.com/help-center)
- Free frame adjustment or contact lens consultation
- Verification of your prescription and the 25-point inspection process to ensure your eyewear is just right.

Vision benefits

Additional benefits offered through VSP (must be enrolled in the VSP plan to participate in these programs).

KidsCare program

The VSP KidsCare program meets the eye care and eyewear demands of active and growing children by providing two comprehensive eye exams and one pair of glasses every year, plus additional lenses covered-in-full when needed (minimum of .50 diopter change required). Additional details can be found at vsp.com.

Laser vision correction

Details about VSP's laser vision care program, as well as comprehensive information about laser vision correction surgery, can be found on VSP's website at vsp.com.

Essential Medical Eye Care

VSP is committed to providing eye care that supports our members' overall health and wellness. That's why we offer Essential Medical Eye Care. With your vision benefits from VSP, you have access to supplemental coverage for urgent and medical eye care.

Essential medical eye care included:

- Fully covered retinal screening for members with diabetes. These high-resolution images of the inside of the eye are a non-invasive way to monitor diabetes.
- Exams and services to treat immediate issues like pink eye and sudden changes in vision.
- Treatment options to monitor ongoing health conditions such as dry eye, diabetic eye disease, glaucoma, and more.

VSP will cover these services after a $10 copayment. Visit the VSP website at vsp.com for more information.

TruHearing hearing aid discount program

TruHearing makes hearing aids affordable by providing exclusive savings to all VSP members. You can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible too. Reach out to TruHearing for more details at 1.877.396.7194 Mon-Fri 8am – 8 pm, For TTY, dial 711 or TruHearing.com/vsp

In addition to great pricing, TruHearing provides you with:	• One year of follow-up visits for fittings, adjustments, and cleanings • 60-day trial • Three-year manufacturer warranty for repairs and one-time loss and damage replacement • 80 free batteries per hearing aid for non-rechargeable models
Plus, with TruHearing you'll get:	• Access to a national network of more than 7,000 hearing healthcare providers • Discounted pricing on a wide selection of the latest brand name hearing aids • High-quality, low-cost batteries delivered to your door
Here's how it works:	• **Contact TruHearing,** you and your family members must mention VSP • **Schedule exam,** TruHearing will answer your questions and schedule a hearing exam with a local provider • **Attend appointment,** The provider will perform the hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Flexible spending accounts (FSA)

Our partner: isolved Benefit Services
phone: 866.370.3040
website: isolvedbenefitservices.com

Introduction

Flexible spending accounts (FSA) provide you with two options to help reduce your taxes and meet your living expenses. By participating in the plan, you will be able to convert certain expenses from after-tax dollars to before-tax dollars. This means you will save on federal taxes and, in most cases, state and local taxes as well.

Once you have incurred a claim, submit claims for reimbursement directly to isolved at isolvedbenefitservices.com using the FSA portal*, use the iFlex mobile app, or you may use your prepaid benefits card to pay for your expenses directly. **When using the prepaid benefits card to pay your expenses directly, you may still be required to submit documentation of your expense.**

*When logging into the FSA portal for the first time, you will be asked to enter your social security number. You should enter 000-Employee ID (000-xx-xxxx). Once you have logged in you will be prompted to set up your account with new username and password.

Your options are outlined below:

- **Health care flexible spending account -** allows you to set aside up to $3,200 (or up to IRS limit if limit changes) from your before-tax pay to cover any eligible health care expenses.
    - If you elected the HSA/POS medical plan, this account will be a “limited” purpose health care flexible spending account. You will only be able to use funds in this account for dental and vision expenses until you reach the deductible on the HSA/POS medical plan.
- **Daycare/dependent care flexible spending account** - allows you to set aside up to $5,000 from your before-tax pay to cover any daycare/dependent care expenses so that you and your spouse can work.

Special rules apply

If you decide to enroll in either account, you need to plan your election carefully. To avoid forfeiting any money, it is important that you make a careful and conservative estimate of what your expenses may be. You must follow these rules if you use either account:

- You cannot transfer money between accounts.
- You cannot change or cancel your election during the year unless you have a qualifying family status change. Some family status changes do not allow changes and if changes are allowed those changes must correlate with the family status change.
- You lose any money remaining in your account after the claims filing deadline.
- Only itemized bills/receipts or insurance statements are proof of expenses. Itemized bills must include patient name, name of provider, date of service, description of expense and the amount you are responsible for paying after insurance.

A word about taxes

If you decide to deposit money in one of the accounts, it is deducted from your paycheck on a pretax basis. This means you will not pay federal, social security, state, or local taxes on the money you deposit. It also reduces your total income, thus lowering the amount of tax you must pay. Therefore, you may not claim a tax deduction for medical expenses reimbursed from the health care FSA. Likewise, you may not use expenses reimbursed from the daycare/dependent care FSA to calculate your federal dependent care tax credit. You have already received a tax advantage from participating in the account(s).

Flexible spending accounts (FSA)

Based on your medical plan election, what savings accounts are your eligible for?

	HMO Medical plan	HSA/POS Medical plan
Health Savings Account (HSA)		X
Health Care (Flexible Spending Account (FSA)	X	
Daycare/Dependent Care (Flexible Spending Account (FSA)	X	X
Limited Purpose Health Care (Flexible Spending Account (FSA)		X

How flexible spending accounts work

Important: Read before signing up for flexible spending accounts.

1. You decide how much, within certain minimum and maximums, you want to deposit into your account each pay period.
2. If you are enrolling (or enrolled) in the HSA/POS medical plan and elect to participate in the health care flexible spending account, you understand the health care flexible spending account can only be used for dental and vision expenses until you have met your deductible under the HSA/POS medical plan. Your insurance explanation of benefits (EOB) showing that you have met your HSA/POS medical plan deductible is required when submitting a medical claim under the "limited" health care FSA.
3. Save all your receipts (see special rules on the prior page). **Even though you may use your prepaid benefits card to make purchases, you may still be required to submit a receipt or proof of expense.**
4. If your health care claim is partially covered through a group health plan, submit your claim to that plan first. When you receive the explanation of benefits (EOB) form showing what the plan covered, submit the EOB when you file your health care FSA claim with the administrator, isolved benefit services.
5. You may use your prepaid benefits card to pay your expenses directly or you may submit a claim with your receipts or proof of incurred expense to the administrator, isolved at isolvedbenefitservices.com or via the iFlex app on your smartphone.
6. You'll be reimbursed from your account through the administrator. No taxes will be withheld on contributions or reimbursements.
7. You have until March 31, 2025, to file claims you incurred during 2024 (January 1 to December 31).
8. You may only submit claims that are incurred during your participation in the account(s). For example, if you began your account March 1, 2024, you will only be able to claim expenses incurred between March 1, and December 31, 2024 OR until the end of the month in which your account terminated. See points 9 and 10 below.
9. If you are a health care FSA participant who terminates or is no longer benefit eligible, you can only be reimbursed for expenses incurred through the end of the month of your status change. You have 60 days from loss of eligibility to submit for reimbursement.
10. If you are a daycare/dependent care FSA participant who terminates or is no longer benefit eligible, you can only be reimbursed for expenses incurred through December 31 (during the calendar year that your status change occurred). You have until March 31st of the following calendar year to submit claims.
11. The IRS requires the plan to pass several eligibility and contribution tests in order to take contributions on a pretax basis. If the plan fails to pass any of those tests, your annual contribution may be adjusted accordingly. You will be notified if this applies to you.

What is the difference between an HSA and FSA?

	HSA (Health Savings Account)	FSA (Health Care Flexible Spending Account)
Pre-tax contributions (tax-advanced)	X	X
Funds accumulate year over year	X	
IRS contribution maximum	X	X
Deducted from paycheck	X	X
Funded up-front and paid back each paycheck		X

Flexible spending accounts (FSA)

Health care flexible spending account

The health care flexible Spending Account (HCFSA) lets you set aside pretax money to cover certain health care expenses. The account is designed to help you pay for expenses, such as medical and dental deductibles, which are not fully covered or are not eligible for payment through your Corewell Health benefit program. **If you elected the HSA/POS medical plan, this account will be a "limited" purpose health care flexible spending account. You will only be able to use funds in this account for dental and vision expenses until you reach the deductible on the HSA/POS medical plan*.** After you meet your deductible on the medical plan, you may use this account for medical, dental and vision expenses. Some eligible expenses may include:

- Deductibles, copayments and coinsurance under the medical and dental plans.
- Eye care expenses, including exams, eyeglasses, and contact lenses.
- Hearing expenses such as exams, hearing aids, and batteries.
- Orthodontia and other expenses not covered under your dental plan.
- Most over-the-counter medications are not eligible for reimbursement without a prescription.

Please note that any cosmetic procedures, such as teeth whitening, elective plastic surgery, etc. are not eligible for reimbursement.

*To be reimbursed out of the "limited" purpose health care flexible spending account, you may use your prepaid benefits card for dental and vision expenses. Once your deductible is met you can be reimbursed expenses beyond dental and vision, however, you will need to submit a manual claim using isolvedbenefitservices.com or the iFlex mobile app to be reimbursed for those expenses. You may need to include documentation that you have met the deductible in your medical plan.

Whose expenses can be claimed under my health care FSA?
You may be reimbursed for expenses incurred by you and your dependents, even if you/your dependents are not enrolled in your group health plan. *For the specific definition of a dependent, please refer to the summary plan description.*

If you have any questions about what expenses are eligible for coverage, check with your tax advisor, call your local IRS office for a free publication (Publication 502), or visit the IRS website at irs.gov/formspubs. Generally, most health care expenses that are eligible for a deduction on your income taxes are eligible for reimbursement from a HCFSA. Refer to the following pages for examples of eligible expenses.

Deciding to use the health care flexible spending account

If you decide to contribute to the health care FSA, the maximum is $123.07 per pay period, based on 26 pay periods per year, not to exceed $3,200 per year. The maximum you can be reimbursed for a claim is the amount of your annual election.

If you enroll January 1, divide the total amount that you intend to deposit into the account for the year by 26 to determine your per paycheck deduction. If your account begins later in the year, count the number of paychecks from the effective date of your coverage. Deductions for this benefit are taken from each paycheck.

Flexible spending accounts (FSA)

Using your prepaid benefits card

Once you have incurred a claim, submit claims for reimbursement directly to isolved, isolvedbenefitservices.com, use the iFlex mobile app, or you may use your prepaid benefits card to pay for your expenses directly. When using the prepaid benefits card to pay your expenses directly, you may still be required to submit documentation of your expense. **You will be notified by isolved if documentation for your claim is needed.**

Submitting requested supporting documentation for your claim

- Send in an itemized receipt or insurance EOB to substantiate the transaction. Please do not send additional information that isolved does not request.
- isolved will review your documentation within 2-5 business days.
- Your card will be placed on a temporary hold if you do not reply or if the documentation does not meet IRS requirements.
- If you delete or lose your original request from isolved you can always view a copy on the FSA portal.

Documentation can be submitted using the isolved iFlex app, or through isolvedbenefitservices.com, email fsa@isolvedhcm.com, fax 800.379.5670, or mail PO Box 488, Coldwater, MI, 49036.

If your prepaid benefit card is declined

- Check your FSA portal at isolvedbenefitservices.com or isolved iFlex app to see if there are any outstanding debit card transactions that need to be substantiated. isolved sends out three notifications requesting documentation. If documentation is not sent to isolved by the time the third request is sent, your prepaid benefits card will be placed on a temporary hold. **Please note:** Once your documentation has been submitted to isolved it takes 2-5 business days to process and remove the temporary hold on the card.
- Check your FSA balance through the FSA portal or isolved iFlex app. Your prepaid benefits card will decline if you try to swipe for more than your available balance.
- Your prepaid benefit cards are good for 5 years. Check your card's expiration date. Your prepaid benefits card will work during the month in which it expires. A new set of cards will be mailed during the expiration month. If you do not receive new cards, contact isolved.
- There is a $5.00 charge that will be deducted from your FSA balance for ordering additional cards, replacement cards or cards that are marked lost/stolen.
- You may use the card for select expenses:
    - A health care FSA prepaid benefits card can be used at merchants that are coded as medical, pharmaceutical, dental, and vision providers.
    - A "limited" health care FSA prepaid benefits card can be used at merchants that are coded as dental and vision providers.

If you have any additional questions regarding your FSA plan, contact isolved, email fsa@isolvedhcm.com, or call 866.370.3040.

Flexible spending accounts (FSA)

Health care flexible spending account - examples of eligible expenses

This is not a complete list. Visit the IRS website irs.gov/formspubs and search Publication 502 for a complete and update to date list.

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limbs
- Bandages
- Birth-control pills
- Blood pressure monitoring devices
- Blood sugar test kits and test strips
- Body scans
- Braces and supports
- Catheters
- Chiropractic care
- Coinsurance amounts
- Cold/hot packs (if sold as medical supplies)
- Condoms
- Contact lenses (corrective lenses – not cosmetic)
- Contact lenses supplies and solutions
- Contraceptives
- Copayments
- Crutches
- Deductibles
- Dental cleaning, x-rays, filings, braces, extractions
- Dentures and adhesives
- Diabetic supplies
- Diagnostic tests and monitors
- Drug addiction treatment
- Elastic bandages and wraps
- Eye exams, eyeglasses (corrective lenses), equipment and materials (excluding clip-on sunglasses/non-RX sunglasses
- First aid kits
- Flu shots
- Hearing aids
- Hospital services
- Immunizations
- Incontinence supplies
- Insulin
- Laboratory fees
- Laser eye surgery/Lasik
- Medical alert bracelet or necklace
- Medical monitoring and testing devices
- Medical records charges
- Mileage for person to receive medical care
- Obstetrical expenses
- Occlusal guards to prevent teeth grinding
- Operations (non-cosmetic)
- Optometrist/ophthalmologist
- Organ donors
- Orthodontia
- Orthopedic shoe inserts
- Osteopath fees
- Ostomy products
- Ovulation monitor
- Oxygen
- Physical exams
- Physical therapy
- Pregnancy tests
- Prescription drugs/medicines
- Preventive care screening
- Prosthesis
- Psychiatric care
- Reading glasses
- Screening tests
- Smoking cessation programs
- Speech therapy
- Support braces
- Therapy (medically related only - *not* marriage counseling, general mental health wellness, relief of stress)
- Surgery (non-cosmetic)
- Transportation expenses for person to receive medical care
- Vaccinations
- Vasectomy and vasectomy reversal
- Vision correction procedures
- Walkers, wheelchairs, canes
- X-rays

Flexible spending accounts (FSA)

Health care flexible spending account - examples of ineligible expenses

This is not a complete list. Visit the IRS website irs.gov/formspubs and search Publication 502 for a complete and update to date list.

- Amounts paid by health insurance or any other plan (FSA, HRA, HSA)
- Appearance improvements
- COBRA premiums
- Cosmetic procedures
- Cosmetics
- Dental floss
- Deodorant
- Diet foods
- Electrolysis
- Expenses you claim on your federal tax return
- Expenses incurred before you began participating in the FSA
- Face creams
- Funeral expenses
- Hair removal/transplants
- Hand lotion
- Household Help
- Illegal operations and treatments
- Insurance premiums
- Late fees
- Makeup
- Maternity clothes
- Marijuana or other controlled substances in violation of federal law
- Missed appointment fees
- Moisturizers
- Mouthwash
- Nail polish
- Nursing services for health baby
- Prepayments for services
- Recliner chairs
- Safety glasses (non-prescription)
- Shampoo
- Shaving cream/lotion
- Soap
- Tanning salons/equipment
- Teeth whitening
- Toiletries
- Toothbrush/toothpaste
- Vision discount program service agreements/warranties

Flexible spending accounts (FSA)

Health care flexible spending account - examples of over-the-counter medications

This is not a complete list. Visit the IRS website irs.gov/formspubs and search Publication 502 for a complete and update to date list.

Most over-the-counter medication will be eligible for reimbursement only when the request is submitted with a doctor's prescription*.

- Acid controllers
- Allergy and sinus products
- Antibiotic products
- Anti-diarrheal products
- Anti-gas products
- Anti-itch and insect bite products
- Anti-parasitic treatments
- Baby rash ointments/creams
- Cold sore remedies
- Cough, cold, flu medicine
- Digestive aids
- Feminine anti-fungal/anti-itch products
- Hemorrhoid products
- Laxatives
- Motion sickness aids
- Pain relievers
- Respiratory treatments
- Sleep aids and sedatives
- Stomach remedies

*As of March 2020, with the passage of the CARES Act, reimbursement for over-the-counter medications are allowed without a prescription from a doctor. It is unclear exactly how long this act will remain in place.

The following are examples of the types of categories that remain eligible for reimbursement without a doctor's prescription:

- Bandages
- Birth control
- Braces and supports
- Catheters
- Contact lens supplies/solutions
- Denture adhesives
- Diagnostic tests/monitors
- Elastic bandages and wraps
- Feminine hygiene products**
- First aid kits
- Insulin and diabetic supplies
- Ostomy supplies
- Reading glasses
- Walkers, wheelchairs, canes

**As of March 2020, with the passage of the CARES Act, menstrual care products like tampons and pads are fully FSA-/HSA-eligible. According to the text of the bill, menstrual care products include, "tampon, pad, liner, cup, sponge, or similar product used by individuals with respect to menstruation. It is unclear exactly how long this act will remain in place.

Receipts for over-the-counter medications must include the name/description of the item purchased, the date of purchase, the provider/store information and the price. The patient's name must be indicated on the reimbursement form. In some instances, you may be asked to provide additional substantiation from the treating physician including the diagnosis relating to your purchase.

Flexible spending accounts (FSA)

Daycare/dependent care flexible spending account

Do you pay someone to care for your children, so you can work? Do you pay for the care of a disabled spouse or an elderly parent who is a dependent? If you do, the daycare/dependent care flexible spending account (FSA) lets you set aside pretax dollars to reimburse yourself for these expenses.

You may enroll in this account if you have an eligible dependent and one of the following is true:

- You're a single parent,
- You have a working spouse,
- Your non-working spouse is a full-time student for at least five months during the year while you're working
- Your spouse is disabled and unable to provide for their own care

Eligible dependents include:

- Any person under age 13 whom you claim as a dependent for income tax purposes
- Any other dependent that isn't able to care for themselves. **This person must spend at least eight hours in your home each day.**

Eligible expenses include care provided:

- In or out of your home.
- In a dependent care center or a childcare center that complies with all required state and local regulations.
- By a housekeeper whose services include, in part, care of an eligible dependent.

Care may **not** be provided by your spouse, your child under age 19, or anyone you claim as a dependent on your income tax return. **If you have any questions about what expenses are eligible for coverage, check with your tax advisor.**

Deciding to use the daycare/dependent care flexible spending account

If you decide to contribute to the daycare/dependent care FSA, the maximum is $192.31 per pay period, based on 26 pay periods per year, not to exceed $5,000* per year, unless regulations limit you to a smaller amount based on the graph below.

If you are:	Your annual contribution limit is:
Single	$5,000*
Married and file a joint income tax return	A total of $5,000* contributed by you and/or your spouse
Married and file a separate income tax return	$2,500*
Married and you OR your spouse earns less than $5,000 a year (see last category if your spouse is a student or disabled)	The lower of your two salaries
Married and your spouse does not work, is not a student, and is not disabled	$0 (you are not eligible for this account)
Married and your spouse is a full-time student or disabled person incapable of self-care. (Your spouse is considered to have earned income of at least $250/month for one qualifying individual and $500/month for two qualifying individuals for each month he or she is a full-time student, or if he or she is incapable of self-care and lives with you for more than half the year.)	Your spouse's earned income up to $5,000*.

*If your annual base salary is $130,000 or greater you will be limited to a maximum annual election of $1,400. This limit is in place to insure that Corewell Health will not need to lower your contribution in the middle of the year when the IRS testing is not passed, see notes below on the testing requirements in these plans.

Please note, the IRS requires the plan to pass certain eligibility and contribution tests in order to take contributions on a pretax basis. If the plan does not pass, your contribution may be changed. You will be notified if this applies to you.

Healthy Lifestyles Program

Our partner: Virgin Pulse
phone: 855.927.2166
website:member.priorityhealth.com

Living a healthy lifestyle means being empowered to make healthier choices to achieve personal well-being for your mind, body, and spirit. Healthy Lifestyles is a voluntary program designed to support Corewell Health team members in pursuing their well-being goals. The program is tailored to each participant and is customizable to change and evolve from year to year.

Healthy Lifestyles rewards

If you enroll in Healthy Lifestyles and are also enrolled in the medical plan at Corewell Health, you will be able to elect one of the following during annual benefits open enrollment. Note the LSA is a reward option only available during annual benefits open enrollment. If you are a new hire you will not be able to elect the LSA option until the next annual benefit open enrollment period. New hires will only have access to the medical plan premium credit within the year of hire.

Medical plan credit

The medical plan credit is for $25 per pay period. The credit is effective Jan. 1 through Dec. 31. This credit will begin the first paycheck after your enrollment in Healthy Lifestyles has been completed.

If no election is made, this medical plan credit will be the default reward.

OR

Lifestyles Spending Account (LSA)

The LSA is a Corewell Health funded account that can be used for goods or services to support your well-being. These funds can be used toward a gym membership, massage therapy, day care expenses, student loan reimbursement, travel, utility bills and so much more! You will receive reimbursement for up to $650 a year in eligible expenses.

We are excited to be able to bring you a Lifestyle Spending Account as part of our well-being program to assist you on your well-being journey. We have made the full $650 available to you up front, even though this account accrues on a per pay period basis, to make it easier for you to meet your needs. As a result, if you voluntarily leave employment mid-year, Corewell Health may request that you repay any non-accrued amounts upon departure.

ServiceNow keyword: Lifestyles Spending Account.

How do you enroll?

Everyone* is eligible! Team members must complete the Virgin Pulse online health assessment through your Priority Health member portal during the annual enrollment period. The assessment takes about 15 minutes to complete and provides you with immediate feedback around possible risks and/or opportunities to support your well-being. Visit priorityhealth.com to complete your online health assessment and get started.

- Team members employed at the time of an annual enrollment period will need to enroll during the annual enrollment period. Corewell Health encourages enrollment in Healthy Lifestyles even if you are not currently enrolled in the medicals plan.
- New hires have 90 days from date of hire or transition to enroll.

* If you have an individual ACA or Medicare plan directly through Priority Health, or Choice Benefits through another employer with Priority Health benefits, your Virgin Pulse account will reflect the opportunities and incentives available for those programs, not Healthy Lifestyles.

Healthy Lifestyles Program

Healthy Lifestyles incentives

You do not need to be benefits-eligible or enrolled in a Priority Health medical plan to be rewarded. All team members are eligible to enroll in Healthy Lifestyles and earn reward points that turn into PulseCash for ongoing engagement in your health and well-being. You can earn points for the activities you choose, and those points turn into PulseCash - up to $150 throughout the program year.

Looking ahead

To be eligible for Healthy Lifestyles Rewards in future program years you will need to complete specific program requirements within the year to be eligible for the rewards in the following year.

Here's how it will work:

- 2023 to 2024 plan year, rewards for 2024 calendar year:
    - **Step 1 - Enroll:** Complete the health assessment between October 3, 2023 - December 15, 2023 (new hires have 90 days after hire date). Once completed, you are enrolled and eligible for rewards and incentives for the current 2023 - 2024 Healthy Lifestyles program year.
      Step 2 - Engage: Complete a Preventive Care Physical Exam with your primary care doctor by September 30, 2024. Accepted exam dates are October 1, 2022 - September 30, 2024. Check your Virgin Pulse Rewards page for credit. Once both steps are completed you are enrolled and eligible for rewards and incentives in the 2024-2025 Healthy Lifestyles program year.

In 2024-2025 and beyond, the program requirements in the current year will determine eligibility for premium credit and LSA in the next medical plan/calendar year. *Program requirements are subject to change year over year.*

New hires are granted some exemptions to these program requirements within the first year of employment. Specific exemptions are based on month of hire.

For more details about the program search ServiceNow using keyword: healthy lifestyles.

Income Securities Benefits

Corewell Health provides the following income securities benefits. Explore the details of these benefits in the following pages:

- **Life insurance**
  - Travel Assistance
  - Funeral Planning, Will Prep and Concierge Services
- **Accidental death and dismemberment insurance**
- **Disability benefits**
- **Additional benefits**
  - Retirement benefits
  - Paid time off (PTO)
  - Michigan Leave Act (MLA)
  - Parental leave
  - Financial Hardship Assistance
  - Payactiv – on-demand pay
  - Volunteer time off (VTO)
  - Holiday Pay
  - Bereavement Pay
  - Compassionate PTO
  - Paid time off (PTO) hardship
  - Paid time off (PTO) sell back

Life insurance

Our partner: Voya
phone: 888.238.4840
website: voya.com

Introduction

Life insurance is important for your long-term financial protection. It can provide the necessary level of financial protection for your family if you or a family member dies. Corewell Health provides you with a core group life insurance benefit paid for by Corewell Health. In addition, you will have the option to purchase supplemental coverage for yourself, as well as coverage for your dependents.

Core life benefit - provided by Corewell Health

- Team members receive one times their annual salary* rounded to the next $1,000 to a maximum of $1,000,000.
- Physicians, residents, fellows, executives, directors and/or principals receive 2 times their annual salary* rounded to the next $1,000 to a maximum of $1,000,000.

*annual salary for life insurance for physicians, residents, fellows and/or commission based Priority Health team members is the greater of current base salary OR prior year W2 whichever is greater.

Supplemental life benefit options - pretax deduction
Full time and part time team members who are benefit eligible may elect the following life insurance amounts for themselves:

Supplemental life options
1, 2, 3, 4, 5, 6, 7 or 8 times annual base salary* rounded to the next $1,000 to a maximum of $1,500,000. Guarantee issue is the lesser of 3 times salary or $750,000, this means that elections made over the guarantee issue amount will be subject to evidence of insurability (EOI), see section below for details. *Physicians/residents/fellows and Priority Health sales commission team members, “base salary” is defined as the greater of current annual base salary OR the prior year W2 earnings.

Dependent life benefit options - aftertax deduction
Full-time and part-time team members who are benefit eligible may elect the following life insurance amounts for legally married spouse and/or eligible dependents:

Spouse life options
$20,000, $40,000, $60,000, $80,000, $100,000, $120,000, $140,000, $160,000, $180,000 or $200,000. Guarantee issue is $60,000, this means that elections made over the guarantee issue amount will be subject to evidence of insurability (EOI), see section below for details.
Child life options
$10,000, $15,000, $20,000 or $25,000 There is no EOI for child life

Life insurance

Guarantee issue and evidence of insurability (EOI)

Guarantee issue is the amount of life insurance a team member can obtain for themselves and/or their dependents without the proof of good health, otherwise known as evidence of insurability (EOI).

Guarantee Issue:

- Supplement life has a guarantee issue amount of the lesser of 3 times annual salary or $750,000, any amount elected over the guarantee issue will be subject to EOI.
- Spouse life has a guarantee issue amount of $60,000, any amount elected over guarantee issue will be subject to EOI.
- Child life, there is no EOI for child life.

New team members, newly integrated team members (does not apply to the Spectrum Health and Beaumont Health integration) and newly benefit eligible team members do not have to show EOI for amounts below guarantee issue for supplemental and dependent life insurance coverage you choose to elect. If you decline coverage when first eligible, you will need to show EOI to obtain coverage in the future.

During annual enrollment, if you previously waived coverage or elect to increase your supplemental life or spouse life coverage, EOI will be required. After the annual enrollment, Voya Financial will contact you via your Corewell Health email to complete the EOI process.

In the event of EOI:

- No Action: if you never complete the EOI process, the prior coverage amount will continue.
- Approved: if EOI is approved, the new amount will go into effect the date the EOI was approved. Your benefit deductions will automatically increase to account for the additional coverage.
- Denied: if EOI is denied, the prior coverage amount will continue.

Naming a beneficiary

It is important to name a beneficiary(ies) for your life insurance benefits. Benefits for loss of life will be paid to the person(s) you designate on the beneficiary section within Workday. You can update your beneficiary(ies) at any time by reporting your changes online using the online benefit enrollment system within Workday.

The primary beneficiary(ies) will receive your life insurance amount first. If you and your primary beneficiary(ies) were to both or all pass away, then your contingent beneficiary(ies) would receive your life insurance benefit. You may indicate the specific percentage amount that you want each beneficiary to receive and the amount will be divided accordingly. If two or more beneficiaries are listed and no percentages are indicated, then the benefit will automatically be divided equally between the beneficiaries. If there is no eligible beneficiary, the proceeds will be paid to the first survivor(s), who is living on the date of your death, in the following order: your spouse, your natural or adopted children, your parents or your estate.

If you elect dependent life insurance, you are automatically named the beneficiary.

Life insurance

Team member costs for supplemental life and dependent life

Supplemental Life and Spouse Life Monthly premium rate per $1,000 of coverage			Child Life Monthly rate per month	
Age	**Team member**	**Spouse**	**Coverage amount**	**Per pay period***
<25	$0.025	$0.026	$10,000 per child	$.46
25-29	$0.031	$0.032	$15,000 per child	$.69
30-34	$0.040	$0.041	$20,000 per child	$.92
35-39	$0.046	$0.047	$25,000 per child	$1.15
40-44	$0.056	$0.057		
45-49	$0.076	$0.078	**Rate for child life is the same no matter how many children are covered on the plan.**	
50-54	$0.117	$0.119		
55-59	$0.219	$0.223		
60-64	$0.336	$0.343		
65-69	$0.647	$0.660		
70-74	$1.050	$1.071		
75+	$1.050	$1.071		

*Premiums for all life insurance elections are taken from all paychecks. Monthly rates will be used to figure an annual amount, then divided by 26 pay periods.

How to calculate your life insurance cost

For example, you wish to elect $60,000 coverage for a spouse age 42.

To figure:
$60,000 / $1,000 = 60
60 x $0.057 = $3.42 per month, $41.04 per year, $1.58 per pay period (take annual and divide by 26 pay periods).

Voya Travel Assistance

Being in an unfamiliar place can be stressful at times, especially if something goes wrong. Get the peace of mind you need when you travel. Voya Travel Assistance offers you and your dependents four types of services when traveling more than 100 miles from home, including: pre-trip information, emergency personal services, medical assistance services and emergency transportation services.

Voya Travel Assistance services are provided by International Medical Group (IMG), Indianapolis, IN.

For more information contact IMG at 317.659.5841. Download the IMG App, or visit their website at http://www.imglobal.com/member/login create an account using the referral code VOYATRAVEL.

Funeral Planning, Will Prep and Concierge Services

Planning a funeral can be time-consuming and emotionally draining. Help ease the burden on you and your family. Funeral Planning, Will Prep and Concierge Services connect team members with professionals who can help with funeral planning for themselves and eligible family members. Services also include Will Prep, an online tool designed to help users create customized legal documents such as a Will, Health Care Directive, Power of Attorney, and more.

Funeral Planning, Will Prep and Concierge Services are provided by Everest Funeral Package, LLC, Houston, TX.

For more information call Everest Funeral Package at 1.800.913.8318 or visit their website at everestfuneral.com/voya .

Life insurance

A word about taxes – Excess Life

The Internal Revenue Service (IRS) requires Corewell Health to report the “value” of your life insurance coverage over $50,000 as taxable income because the premium for this benefit is taken pretax. “Value” means the cost of life insurance based on an age-related table provided by the IRS.

The taxes you pay are based on your age and coverage level and, therefore, vary from one person to another. In addition, since the value of life insurance coverage increases with age, the amount of taxes you pay on coverage also increases over the years.

For instance, a team member earns $60,000 per year and receives core life insurance equal to one times pay, or $60,000. The additional income that would be taxed is the value of the coverage over $50,000, which in this case is $10,000. Any core life plus supplemental life amounts are considered when determining the excess over $50,000. For tax purposes, this amount is called excess Life and will appear on your paycheck stub under “Excess Life”. The amount you pay to purchase any supplemental life insurance will show on your check as a deduction. The monthly value of your “excess Life” will appear on your check as income as the amount is taxable to all payroll taxes. This amount is based on IRS tables and is generally a very small amount.

Disability waiver of premium

If you are approved for long term disability benefits with Prudential, you may also be approved for the waiver of supplemental life insurance benefit with Voya Financial. Voya will mail you a letter confirming the waiver approval. If you have any questions, contact the leaves management team through the HR Support Center at 877-AskHR11 (877.275.4711).

Coverage reduction due to age

Your life Insurance benefit reduces to 65% of the original coverage at age 70 and 50% of the original coverage at age 75. This age reduction occurs on the January 1 following the date in which you obtain these ages. The reduction will apply to all life and AD&D policies that cover team members in force immediately prior to that January 1. The reduced amount of coverage will be rounded to the next higher multiple of $1,000, if not already a multiple of $1,000.

Accidental death and dismemberment insurance

Our partner: Voya
phone: 888.238.4840
website: voya.com

Introduction

Accidental death and dismemberment (AD&D) insurance is available under the Corewell Health benefit program. This plan is designed to pay a death benefit to your beneficiary if you should die as the result of a covered accident, or to pay benefits directly to you for certain covered severe accidental injuries.

Core AD&D benefit - provided by Corewell Health

- Team members receive one times their annual salary* rounded to the next $1,000 to a maximum of $1,000,000.
- Physicians, residents, fellows, executives, directors and/or principals receive 2 times their annual salary* rounded to the next $1,000 to a maximum of $1,000,000.

*annual salary for AD&D insurance for physicians, residents, fellows and/or commission based Priority Health team members is the greater of current base salary OR prior year W2 whichever is greater.

Supplemental AD&D benefit options - after-tax deduction
Full time and part time team members who are benefit eligible may elect the following AD&D amounts for themselves, legally married spouse as well as your child(ren). Remember, this plan pays for losses resulting from covered accidents only.

Supplemental AD&D benefit

1, 2, 3, 4, 5, 6, 7 or 8 times annual base salary rounded to the next $1,000 to a maximum of $1,500,000*

Two plans to choose from:

- Team member only coverage
- Team member + family coverage (coverage for you, your legally married spouse and/or child(ren)).

How the benefit works in the event of a death:

- **Team member accidental death**, the face value of the elected benefit of 1-8 times annual base salary will be paid out to your beneficiary(ies).
- **Spouse accidental death**, if no child(ren) are covered under the plan, you will receive 60% of the face value of the elected benefit of 1-8 times annual base salary, if child(ren) are covered under the plan, you will receive 50% of the face value of the elected benefit of 1-8 times annual base salary, maximum payout of $500,000.
- **Child accidental death**, if no spouse is covered under the plan, you will receive 25% of the face value of the elected benefit of 1-8 times annual base salary, if spouse is covered under the plan, you will receive 20% of the face value of the elected benefit of 1-8 times annual base salary, maximum payout of $200,000.

There is no EOI for this AD&D coverage.

*Physicians/residents/fellows and Priority Health sales commission team members, “base salary” is defined as the greater of current annual base salary OR the prior year W2 earnings.

Accidental death and dismemberment insurance

In addition to benefits paid in the event of an accidental death, this benefit also may pay a portion of the benefit for accidental dismemberment. Remember the legally married spouse and/or child(ren) coverage is a percent of the face value of the policy as stated above. In the event of accidental dismemberment, you would be paid the following percentage of that face value percent. See below for examples.

Benefits payable to you for supplemental AD&D are:

Type of loss	% of coverage, amount payable
Life	100%
Sight in both eyes	100%
Sight in one eye	50%
One hand or one foot	50%
Speech	50%
Hearing loss in both ears	50%
Thumb and index finger of same hand	50%

Refer to the summary plan certificate for more benefit details.

Team member costs for team member and team member + family AD&D coverage

Supplemental AD&D coverage Monthly premium rate per $1,000 of coverage		
	Team member	Team member + family
	$0.015	$0.029

How to calculate your supplemental AD&D insurance cost

For example, you wish to elect 4 times salary and your annual base salary is $45,560 and you choose to elect the team member + family coverage.

To figure:
$45,560 * 4 = $182,240 rounded to the next $1,000 = $183,000
$183,000 / $1,000 = 183
183 x $0.029 = $5.31 per month, $63.72 per year, $2.45 per pay period (take annual and divide by 26 pay periods).

Naming a beneficiary

Beneficiary(ies) for your life insurance benefits is the same beneficiary(ies) for the AD&D benefit. Benefits for loss of life will be paid to the person(s) you designate on the beneficiary section within Workday. You can update your beneficiary(ies) at any time by reporting your changes online using the online benefit enrollment system within Workday. You are automatically named the beneficiary for any dependent life insurance or family AD&D coverage.

Disability insurance coverage

Introduction

The disability insurance plans have been designed to provide you the ability to protect your income if you become disabled because of illness or injury. Many of us will be fortunate to enjoy good health and never collect any benefits under these plans. However, all of us will have the comfort and satisfaction of knowing that the plans are there when we need them.

Family medical leave act (FMLA)

The family medical leave act (FMLA) entitles qualified team members up to 12 weeks of leave per year for the birth or adoption of a child, to care for a spouse or an immediate family member with a serious health condition, when unable to personally work because of a serious health condition for self, or for certain military related situations. Team members are eligible if they have worked for Corewell Health for at least one year and worked 1,250 hours over the previous 12 months.

Short-term disability (STD) coverage

Corewell Health provides you with a short-term disability (STD) plan to protect you financially in the event that you are unable to work due to an illness or injury that is not work related, including maternity leave due to the birth of a child. STD is a core benefit that is given to all eligible team members at no cost to you.

Core short-term disability benefit - provided by Corewell Health

Team members*:

- 60% income replacement for up to 26 weeks*
- Benefit begins the first of the month following date of hire or date of status change.
- If you are a **full time team member (72-80 hours per pay period)** – *You are eligible for this benefit the first of the month following date of hire or date of your status change*.*
- ***Full-time exempt team members** after 7 day waiting period, you will receive 100% income replacement for days 8-60 of eligible leave, day 61 and after will be paid at 60%.*
- If you are a **part time team member (40-71 hours per pay period)** *–benefits are only payable for disabilities that are incurred on or after you satisfy your eligibility waiting period of 26 weeks (6 months) of employment.*
- Once eligible, you must satisfy a 7 calendar day waiting period for this benefit to begin.
- PTO can be used for the 7 day waiting period, but is not required to be used. PTO will automatically be paid, unless you request to not be paid.

Physicians, executives, directors and/or principals:

- 100% income replacement for up to 26 weeks
- You are eligible for this benefit, the first of the month following date of hire or date of status change.
- Once eligible, there is no waiting period for this benefit.

Resident and fellows:

- 100% income replacement for up to 26 weeks
- You are eligible for this benefit, date of hire or date of status change.
- Once eligible, there is no waiting period for this benefit.

*team members within a union role at AFSCME Dearborn LTC have a variation in benefit based on current union agreement, benefit is 50% income replacement up to $400 weekly benefit. See union agreement for more details..

Payment for STD is received through normal payroll and is considered taxable income. Any benefits deductions will continue to be taken from the STD pay. If you are not receiving 100% income replacement, you may supplement STD with PTO to receive full pay. This benefit continues for up to 26 weeks (182 days). If you are unable to return to work after 182 days, you may be eligible for long-term disability benefits.

Disability insurance coverage

Core long-term disability coverage

Benefits under LTD generally begin after you have met the definition of disability for greater than 182 days. Under the core long-term disability (LTD) plan, if you meet the definition of disability, you may be eligible for monthly benefits from this plan. Payment under this benefit may begin upon the carrier's approval. The long-term disability benefits are subject to the rules and restrictions of the insurance company. If you become disabled, Human Resources will work with you and the carrier to ensure that your claim is filed, and you receive payments as soon as possible. However, remember that you may be required to submit medical evaluations periodically to the carrier. If you do not follow the guidelines, payments can be delayed. A claim for benefits can also be denied or terminated if you refuse requested examinations.

Benefits are offset by the amounts you receive from other sources, such as social security or workers compensation. The LTD benefit will continue as long as you meet the definition of disability. Your benefits will terminate if you no longer meet the definition of disability, you reach your maximum benefit period, you fail to submit proof of disability, or you lose your life. Refer to your summary plan description for more details.

Core long-term disability benefit - provided by Corewell Health

Team members:

- 50% income* replacement for up to $10,000 per month
- Covers annual earnings up to $240,000

Physicians, residents and/or fellows:

- 60% income* replacement for up to $15,000 per month
- Covers annual earnings up to $300,000
- Includes own-occupation, specialty coverage

Executives, directors and/or principals:

- 60% income* replacement for up to $30,000 per month
- Covers annual earnings up to $600,000

*income for disability benefits for physicians, residents, fellows and/or commission based Priority Health team members is the greater of current base salary OR prior year W2 whichever is greater.

Disability insurance coverage

Buy-up long-term disability coverage

These buy-up LTD options allow you to have a greater percent income replacement in the event of disability. These buy-up plans also cover annual earnings at a higher level. The buy-up plans are paid for by you. Your buy-up LTD insurance costs are deducted from each paycheck.

Buy-up long-term disability benefit – elected and paid for by you

Team members:

- You pay for this benefit
- 60% income* replacement up to $15,000 per month
- Covers annual earnings up to $300,000
- Deductions are taken pre-tax, LTD benefits become taxable when paid out

Physicians, residents and/or fellows:

- You pay for this benefit
- 66 2/3% income* replacement for up to $25,000 per month
- Covers annual earnings up to $450,000
- You have the choice to deduct your premiums on a pre-tax or post-tax basis, when selecting pre-tax the LTD benefits become taxable when paid out, when selecting post-tax the LTD benefit is not taxable when paid out. Regardless of selection a portion of your LTD benefit will be taxable. Since the core LTD benefit is employer provided, any benefit paid out as a part of the core LTD plan is always considered taxable.
- Includes own-occupation, specialty coverage
- Additional benefits under this buy-up LTD plan: cost of living adjustments, payments will increase by 3%, not to exceed 10 increases while receiving disability payments.

Executives, directors and/or principals:

- No buy-up option available

*income for disability benefits for physicians, residents, fellows and/or commission based Priority Health team members is the greater of current base salary OR prior year W2 whichever is greater.

Things to consider: Team members will have a one-time opportunity to enroll for buy-up LTD insurance without proof of good health. Any future elections will require proof of good health. A review of pre-existing conditions may apply to your elected coverage. Please refer to your Plan Summary or Plan Certificate for more details.

Once on LTD you will begin to receive payment from the carrier directly, payment will no longer be issued by Corewell Health.

Team member costs for buy-up long-term disability

Monthly rate per $100 of coverage		
	Team member	**Physician, resident, fellow**
	$0.251	$0.679

Additional benefits – income securities

We have made great strides in benefits harmonization for Corewell Health. As we continue benefit program harmonization efforts into 2024 and beyond, there may be variations in these other benefits until harmonized.

For the most up to date information on the below benefits visit ServiceNow and use the keywords mentioned below to find more information on each of these benefits and what is offered to you based on your common law employer in Workday, refer to the first part of this book for more details on common law employer.

Here are some of the additional benefits offered to team members at Corewell Health:

Retirement Benefits

As your employment partner, we are here to help you prepare for a financially rewarding retirement. The retirement programs at Corewell Health are designed to support your savings goals using the combination of our retirement savings plans, social security and your personal savings.

There are programs available to all

ServiceNow keyword: Retirement

Paid time off (PTO)

Corewell Health offers eligible team members PTO. Our PTO programs are built to recognize and reward you for your commitment to the organization. Using PTO is encouraged, allowing team members time for rest and relaxation, as well as time to handle other personal matters without missing pay.

There are programs for all

ServiceNow keyword: paid time off

Michigan Leave Act (MLA)

The Michigan paid leave act (MLA) is legislation that was passed by the State of Michigan. It is intended to compensate eligible team members for protected time away from work for medical or other covered reasons.

There are programs for all

ServiceNow keyword: MPMLA

Payactiv – on-demand pay

Payactiv gives you access to the money you worked for but haven't been paid yet. The money that you access is then deducted from your next paycheck, giving you the flexibility to pay for things on your own schedule.

Available to all

ServiceNow keyword: Payactiv

Financial Hardship Assistance

We all have a life outside of work, which sometimes gets complicated. Corewell Health is here to support our team members through all stages of life, including financial hardships.

There are programs for all

ServiceNow keyword: financial hardship

Additional benefits – income securities

For the most up to date information on the below benefits visit ServiceNow and use the keywords mentioned below to find more information on each of these benefits and what is offered to you based on your common law employer in Workday, refer to the first part of this book for more details on common law employer.

Here are some of the additional benefits offered to team members at Corewell Health:

Paid time off (PTO) sell back

Eligible team members can sell back portions of the accrued PTO banks for cash payment. There is a defined irrevocable election period, with payouts occurring after the close of the election period.

There are programs for all

ServiceNow keyword: paid time off

Holiday Pay

Corewell Health provides holiday benefit pay to eligible team members in recognition of seven national holidays and/or premium pay for non-exempt team members working the recognized holidays.

There are programs for all

ServiceNow keyword: holiday pay

Bereavement Pay

Corewell Health provides paid time off for eligible team members to plan or attend the funeral service for qualified family members.

There are programs for all

ServiceNow keyword: bereavement

Lifestyle Benefits

Corewell Health provides the following lifestyle benefits. Explore the details of these benefits in the following pages:

- **Voluntary benefits - lifestyle**
  - Identity theft protection
  - Group legal
  - Pet insurance
  - Auto
  - Home
  - Discount Program
- **Additional benefits**
  - Tuition Assistance
  - Employee Assistance Program (EAP)
  - Adoption Assistance
  - Child Development Center
  - Lactation rooms
  - Well-Being Resources

Voluntary benefits - lifestyle

Our partner: Aon
phone: 877.AskHR11
website: everyday.aon.com/corewellhealth

The benefits are designed to protect you and your family such as identity theft protection, legal services, pet insurance, auto insurance and/or home insurance. The benefits are designed to complement various needs. Costs for these benefits will be reflected within the enrollment platform. There are some benefits that may require enrollment be completed through the vendor specifically off of the platform.

Identity theft protection

Includes benefits for active credit monitoring with all three credit bureaus, identity, home title, social media, dark web monitoring & credit breach alerts, and support to fully restore any credit damage or losses related to breach, up to $1 million.

Norton LifeLock
800.607.9174
my.norton.com

Group legal

Includes benefits for commonly used legal services, such as will preparation, traffic violations or tax/IRS issues. When using an in-network attorney, benefits are completely covered with no additional out-of-pocket expense for covered legal needs.

LegalEASE
800.248.9000
legaleaseplan.com/corewellhealth

Pet insurance

Reimburses costs related to caring for dogs, cats, avian and exotic animals. Plan includes accident and illness services, at any licensed veterinary facility. No coverage for pre-existing conditions.

Auto

Auto insurance is a contract between you and the insurance company that protects you against financial loss in the event of an accident or theft. In exchange for your paying a premium, the insurance company agrees to pay your losses as outlined in your policy.

Home

Homeowners insurance covers damage to your home, property, personal belongings, and other assets in your home. It may also provide coverage for accidents or injuries that occur in your home or on your property.

Discount Program – Coming soon!

The discount program is a marketplace of exclusive discounts, negotiated by a team of experts, from top brands and local businesses. You can search by brand or category, discover personalized discounts relevant to your interests and enjoy savings on a variety of products and services.

When do benefits begin:

- Identity theft and group legal: If you enroll in coverage on the 1st to 15th of the month, coverage is effective 1st of the following month. If you enroll in coverage on the 16th to 30th/31st of the month, coverage is effective 1st of the next month. For example, if you enroll on Feb. 14, your coverage will be effective Mar. 1, if you enroll on Feb. 17, your coverage will be effective Apr. 1.
- Pet Insurance: Effective date determined by the carrier at enrollment.
- Auto and Home Insurance: Effective date determined by the carrier after call to Farmers to bind coverage.

Enrolling in voluntary benefits – through Everyday Benefits
Enroll online using: everyday.aon.com/corewellhealth. Team member login credentials for the Everyday Benefit platform will be employee number and zip code.

Paying for your voluntary benefits
As long as you remain benefits eligible, like your core benefits, benefit premiums for voluntary elections will be deducted from each of your paychecks as long as you are receiving active pay from Corewell Health. If you fall behind on premiums, you will be transferred to direct vendor billing outside of payroll deductions.

Additional benefits - lifestyles

We have made great strides in benefits harmonization for Corewell Health. As we continue benefit program harmonization efforts into 2024 and beyond, there may be variations in these other benefits until harmonized.

For the most up to date information on the below benefits visit ServiceNow and use the keywords mentioned below to find more information on each of these benefits and what is offered to you based on your common law employer in Workday, refer to the first part of this book for more details on common law employer.

Here are some of the additional benefits offered to team members at Corewell Health:

Tuition Assistance

The tuition assistance program gives benefit eligible team members the means to enhance education and career development through reimbursement for higher education and certificates.

There are programs available to all

ServiceNow keyword: Tuition Assistance

Employee Assistance Program (EAP)

Employee assistance is available to support all team members and their family members as a benefit provided at no cost to you. These confidential services address a variety of issues that may affect the quality of your work or personal life.

There are programs available to all

ServiceNow keyword: Employee Assistance

Adoption Assistance

Benefit eligible team members are eligible for adoption assistance reimbursement after working at least 12 consecutive months. Reimbursement of up to $5,000 per adoption process per 12-month period.

available to all

ServiceNow keyword: Adoption Assistance

Well-Being Resources

Corewell Health cares about your well-being, including your physical and emotional safety and health.

We have many resources, benefits and programs to help support your wellness goals.

There are programs for all

ServiceNow keyword: well being

Lactation rooms

Corewell Health provides comfortable, private rooms to support team members who are breastfeeding. For questions, call HR Support Center at 877-AskHR11 (877.275.4711).

Available to all

ServiceNow keyword: lactation rooms

Questions/contacts

Medical benefits

Priority Health
1231 East Beltline Ave NE
Grand Rapids, MI 49525-4501
priorityhealth.com

PriorityGPS – text ACCD01 or call 866.518.1769

TruHearing; 844.806.7074
priorityhealth.com/truhearing

Dental benefits

Delta Dental
800.524.0149
deltadentalmi.com

Claims: P.O. Box 9085 Farmington Hills, MI 48813
Claim Appeal: P.O. Box 30416
Lansing, MI 48909

Employee assistance program

Corewell Health East – Ulliance:
844.684.3422

Mail order prescription program

Express Scripts
844.586.5349

PriorityGPS – text ACCD01 or call 866.518.1769

Vision benefits

Vision Service Plan
3333 Quality Dr
Rancho Cordova, CA 95670
800.877.7195
vsp.com

TruHearing: 877.396.7194,
truhearing.com/vsp

Voluntary benefits

Aon
877.AskHR11 (877.275.4711)

everyday.aon.com/corewellhealth

Healthy Lifestyles

Virgin Pulse
855.927.2166

support@virginpulse.com
member.priorityhealth.com

Life insurance

Voya Financial
888.238.4840
voya.com

Claims: 877.AskHR11 (877.275.4711)
Submit a ServiceNow request

Leaves of absence

short-term disability, long-term disability

877.AskHR11 (877.275.4711)
Submit a ServiceNow request

Health savings account (HSA)

HealthEquity
866.296.2859
healthequity.com

Retirement benefits 403(b)

Corewell Health East: Fidelity
866.866.3818
netbenefits.com

Tuition assistance

Corewell Health East: 877-AskHR11 (877.275.4711)

Flexible spending accounts (FSA)

isolved benefits services
PO Box 488
Coldwater, MI 49036
866.370.3040
isolvedbenefitservices.com
fsa@isolvedhcm.com
COBRA: 800.594.6957

HR Support Center

Questions?
We're here to help.
Monday-Friday 7:30 am to 4:30 pm

877.AskHR11 (877.275.4711)
Submit a ServiceNow request

Glossary of terms

Annual benefit open enrollment period: The time frame you are provided an opportunity to review and make changes to your benefit elections. Open enrollment typically occurs in the fall for the following calendar year's benefit elections.
Consolidated omnibus budget reconciliation act (COBRA): If you or your covered dependents lose health benefits (medical, dental, vision, flexible spending), you may have the right to continue those group health benefits for limited periods of time by contributing the full premium.
Coinsurance: Your share of the cost of a health care service after any deductible.
Copayment (copay): A fixed dollar amount you pay for a health care service, usually when you receive the service. The amount can vary by type of service. You may also have a copay when you get a prescription filled. Unless otherwise specified, eligible covered services that have a copayment reflected are not generally subject to the deductible.
Chronic conditions rider: A rider that is attached to the HSA/POS Medical plan. This rider allows for certain qualified prescriptions to be purchased with a co-payment before reaching the deductible as an enrollee of the HSA/POS Medical plan.
Deductible: A fixed dollar amount you must pay out of your own pocket before the insurance will pay for an eligible covered service.
Team member premium contributions: An amount deducted from your paycheck to cover the cost of the benefits you elect.
Evidence of insurability (EOI): An application process in which you provide information on the condition of your health and/or your dependent's health to obtain approval for certain types of insurance coverage.
Explanation of benefits (EOB): A statement from the insurer that provides you a record of your health care expenses, and the coverage provided by the insurer.
Family medical leave act (FMLA): Allows eligible team members to take unpaid, job-protected leave for qualified medical and family reasons.
Flexible spending account (FSA): An account you put money into that you use to pay certain eligible expenses. Contributions to the account are pretax. A health care flexible spending account (HCFSA) allows you to be reimbursed for certain health care eligible expenses which are not paid by your insurance. For example, copayments. The daycare/dependent care flexible spending account (DCFSA) allows you to use pretax money to pay for eligible dependent care expenses.
Health maintenance organization (HMO) plan: A medical plan that covers care provided by in-network providers who have agreed by contract to treat you and your covered dependents. You must use participating (or 'in-network') providers and facilities except in the case of emergency. The HMO plan is a HMO.
HSA (health savings account) plan: A medical benefit plan in which you are responsible for all non-preventive care expenses until you reach the deductible. Once the deductible has been met, coinsurance and copayments will begin. If you enroll in this plan, you are eligible to open a health savings account. This type of plan may also be known as a high deductible health plan or HDHP. The HSA/POS plan is considered a HDHP plan.
Health savings account (HSA): A tax-advantaged medical savings account available if you enroll in the HSA/POS medical plan. The funds contributed to this account are pretax, roll over and accumulate year to year, if not spent.
Integration: When an organization becomes a part of the Corewell Health system for payroll/benefits purposes.
Medicare: A federal health insurance program that provides healthcare for people who are 65 or older. It also provides medical benefits to certain disabled persons.
Out of pocket limit: The total maximum amount you have to pay out of your own pocket in a plan year. This includes the deductible, coinsurances, and co-payments.
Preauthorization: Certain eligible covered services may require you or your physician to obtain approval prior to seeking treatment.
Primary care physician (PCP): A physician who provides both the first contact for you and your dependents care as well as continuing care. If you enroll in one of the Corewell Health offered medical plans, you and your dependents are required to elect a PCP who participates with Priority Health or one will be assigned.
Point of service (POS): A medical benefit plan which covers more of the cost of eligible covered services when you visit the preferred, in-network providers. You are also able to visit out-of-network providers with less of the cost of eligible services covered by the plan. The HSA/POS plan is considered a POS plan.
Qualifying life event: A change in your life that results in the opportunity to make changes to your benefit elections outside of an annual benefit open enrollment period. Benefit changes must be made within 31 days of the date of the life event.
Reasonable and customary charges is the amount paid for a medical service which is based on what providers in the area usually charge for the same or similar medical service.
Workday: Corewell Health's system for payroll/benefit administration as well as other areas within Corewell Health. You will see your personal information and job information within this system.

Coordination of medical and dental benefits

Traditional coordination of benefits

Under “traditional” coordination of benefits (COB), the secondary plan generally pays the part of the eligible expense that the primary plan does not pay. COB avoids duplicate benefit payments by paying for up to 100 percent of the eligible expense -- but no more.

This traditional COB will apply to both the Priority Health & Delta Dental plans. When a person is covered by two group medical or dental plans, one plan is “primary” and the other is “secondary”. The primary plan pays benefits first, and the secondary plan generally pays after that. Depending on the level of coverage the primary plan provides, and how the secondary plan coordinates benefits, you may choose to decline coverage under the secondary plan. Be sure to contact both insurance companies prior to electing coverage to make sure your plans coordinate.

Things to consider before deciding to coordinate benefits:

- You should have a complete understanding of how your plans will coordinate before you seek treatment.
- Consider the premium that you will pay for the plans versus how much benefit you will obtain. It may not be beneficial for you and your family to have two plans.
- Two Corewell Health plans:
    - Medical plans, it is not recommended that you have two Corewell Health medical plans due to many factors including deductible tracking in two plans (especially with the HSA/POS plans), secondary plans not picking up co-payments and remaining co-insurances etc. The added benefit may not make up for the additional premium cost.
    - Dental plans, you can choose to have two Corewell Health dental plans. These plans do coordinate with each other. You will want to consider premium paid compared to added benefit.
    - Vision plans, you can choose to have two Corewell Health vision plans. Just like the dental benefits these plans do coordinate with each other. You will want to consider premium paid compared to added benefit gained when considering enrolling in two Corewell Health vision plans.

Which plan pays first

Three rules can help you decide which plan is primary.

- A plan is always primary if it covers you as the team member.
- If your legal married spouse has medical or dental coverage through his/her employer, your spouse’s plan would be primary for your spouse and your Corewell Health plan (covering your spouse as a dependent) would be secondary.
- If your children are covered under two plans, the plan covering the parent whose birthday falls earlier in the calendar year would be primary.

For example: Your birthday is in April and your spouse’s birthday is in May. Your plan will be the primary plan for your children.

To receive maximum benefits, you need to follow the guidelines of both plans. If your primary plan denies charges because you did not comply with its rules, the secondary plan may also deny your claim. Identify yourself as having more than one health plan when you visit a health care provider. If your Priority Health plan is secondary:

- Be sure to follow your primary plan’s guidelines for receiving care.
- Contact your Priority Health primary care physician (PCP) to request authorization or referral for any services you need. Tell your PCP that Priority Health is secondary. If you do not coordinate your care through your PCP, and the Priority Health plan is secondary, you may receive no benefits from your Priority Health HMO medical plan or may receive only alternate-level benefits from the HSA/POS medical plan.

Coordination of medical and dental benefits

If you are eligible for Medicare

If you or your dependents are eligible for Medicare, you should enroll for Medicare part A as soon as eligible. Medicare part A is offered at no cost for most people. If your Corewell Health plan is your primary medical coverage, enrollment in Medicare part B is optional, but highly recommended.

Your Corewell Health plan is primary for:

- Active team members and their dependents (regardless of age or disability)
- Team members (under age 65) enrolled in COBRA
- Dependents (under age 65) of team members (under age 65) on COBRA
- Dependents (under age 65) of retirees enrolled in the retiree medical plan
- Team members or their dependents with end-stage renal disease (ESRD) for the first 30 months of Medicare entitlement

Your Corewell Health plan is secondary to Medicare for:

- Dependents (over age 65) of team members (under age 65) on COBRA*
- Retirees (over age 65) enrolled in the retiree medical plan
- Dependents (over age 65) of retirees enrolled in the retiree medical plan
- Disabled team members or their dependents on COBRA or in the retiree medical plan
- Team members or their dependents with ESRD after the first 30 months of Medicare entitlement

*If a dependent turns age 65 during COBRA period, Priority Health coverage will be dropped.

If your Corewell Health plan is secondary, Priority Health will pay claims assuming that you are enrolled in Medicare parts A & B, even if you have not enrolled. To obtain the highest level of coverage, as soon as your Corewell Health plan becomes secondary, you should enroll in Medicare parts A & B.

For more information on Medicare call 800.MEDICARE (633.4227) or visit medicare.gov. If you have questions about your Corewell Health plan's coordination with Medicare, contact the HR Support Center at 877-AskHR11 (877.275.4711).

There are special rules if you enroll in the HSA/POS medical plan and are planning to enroll in Medicare, see the HSA account section of this book for more information.

Appendix - required notices

Summary of benefits and coverage (SBC)

Corewell Health is required to provide summary of benefits and coverage (SBC) disclosures.

As a team member, the medical benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of medical coverage options. Choosing a medical coverage option is an important decision. To help you make an informed choice, your plan makes available a summary of benefits and coverage (SBC), which summarizes important information about your medical coverage option in a standard format, to help you compare across options.

The SBC documents are available on ServiceNow. A paper copy is available, free of charge, by calling the HR Support Center at 877-AskHR11 (877.275.4711).

Women's health and cancer rights act

The women's health and cancer rights act of 1998, a federal law, provides certain rights to participants. Group health plan expenses for a mastectomy include charges for the reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications relating to all stages of the mastectomy, including lymphedemas. Coverage will be provided in a manner determined in consultation with the attending physician and the patient.

Creditable coverage disclosure notice

Additional information about prescription drug coverage and options under Medicare's prescription drug coverage is available on ServiceNow. A paper copy is available, free of charge, by calling the HR Support Center at 877-AskHR11 (877.275.4711).

CHIPRA notice

If you reside in a state where possible premium assistance opportunities are available through Medicaid and the children's health insurance program (CHIP) you will receive a copy of this notice. Please note that the State of Michigan does not offer this opportunity. A paper copy is available, free of charge, by calling the HR Support Center at 877-AskHR11 (877.275.4711).

HIPAA – notice of privacy practices

The Corewell Health benefit plan maintains a notice of privacy practices that provides information on how protected health information (PHI) is used or maintained by the Plan. If you would like a copy of the plan's notice of privacy practices, contact the HR Support Center at 877-AskHR11 (877.275.4711). A copy of this notice is also available on ServiceNow.

State of Illinois Consumer Coverage Disclosure Act Notice

Under the Consumer Coverage Disclosure Act (CCDA) signed by state of Illinois Governor. Corewell Health must provide eligible team members with a notice that compares the coverage offered by Corewell Health to the "essential health benefits" required for coverage obtained through Get Covered Illinois (the Illinois insurance marketplace). This notice only applies to team members living in the state of Illinois. If you would like a copy of this notice, contact the HR Support Center at 877-AskHR11 (877.275.4711). A copy of this notice is also available on ServiceNow.

Appendix - required notices

Nondiscrimination notice

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

Corewell Health/Legacy Spectrum Health:

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

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

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

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact HR Support Center.

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

Corewell Health
100 Michigan, MC 108
Grand Rapids, MI 49504
877-AskHR11 (877.275.4711)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Director of Inclusion and Diversity is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
1.800.868.1019, 800.537.7697(TDD)

Complaint forms are available at *https://www.hhs.gov/ocr/office/file/index.html*.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 877-AskHR11 (877.275.4711).

877-AskHR11 (877.275.4711)- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم اتصل .

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 877-AskHR11 (877.275.4711)

Appendix - required notices

Nondiscrimination notice (cont.)

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877-AskHR11 (877.275.4711)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 877-AskHR11 (877.275.4711).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 877-AskHR11 (877.275.4711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 877-AskHR11 (877.275.4711) 번으로 전화해 주십시오.

ল�য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পাের্ন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল� আেছ। ের্ফান করন ১- 877-AskHR11 (877.275.4711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 877-AskHR11 (877.275.4711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 877-AskHR11 (877.275.4711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 877-AskHR11 (877.275.4711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。877-AskHR11 (877.275.4711) まで、お電話にてご連絡ください。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 877-AskHR11 (877.275.4711).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 877-AskHR11 (877.275.4711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 877-AskHR11 (877.275.4711).


Corewell
Health