

2026 BENEFITS GUIDE



Creative Foam Corporation

Dowagiac Union





INDEX

Carrier Contact Information / Where To Go For Help.....	3
2026 Enrollment Highlights	4
Online Enrollment	6
Eligibility	8
Elections	9
Key Words to Know.....	10
2026 Benefit Contributions.....	11
Medical Benefits	12
Virtual Care (Telemedicine)	17
Condition Management	18
Cancer Support.....	19
Hinge Health	20
Blue Cross Additional Programs	21
Mental Health Resource Guide	22
Wellness Program.....	23
Dental Benefits.....	24
Vision Benefits	27
Flexible Spending Accounts.....	28
Life/AD&D Benefits	30
Disability Benefits	30
Gallagher's Alternative Health Solutions.....	31
EAP.....	32
401k	33
Scholarship Program	34
Employee Discounts	35
Your Right to Know	36
Notice of Creditable Coverage	39
Children's Health Insurance Program Notice (CHIP)	41
Summary of Benefits and Coverage (SBC).....	45

MEDICARE PART D PRESCRIPTION DRUG INFORMATION

If you are enrolled in or will be eligible for Medicare in the next 12 months, Federal law gives you more choices for prescription drug coverage. See pages 39-40 for more information.



CARRIER CONTACT INFORMATION

	Contact	Via the web, email or phone	
Medical and Prescription	Blue Cross Blue Shield of Michigan (BCBSM)	www.bcbsm.com	877.790.2583 Please refer to the number on the back of your ID card
Dental	Delta Dental of Michigan	www.deltadentalmi.com	800.524.0149
Vision	VSP	www.vsp.com	800.877.7195
Life/AD&D and Long-Term Disability	Prudential	www.prudential.com	Disability Claims and Questions 877.367.7781 Life Claims and Questions 800.524.0542
Flexible Spending Account (FSA)	iSolved	www.isolvedbenefitservices.com	866.370.3040
Gallagher Benefits Services	Benefit Advocate Center of Excellence Support on claims, eligibility, and insurance coverage information	Bac.creativefoamcso@ajg.com	833.830.1505 Monday-Friday 8am-6pm in local time zone
	Tammy Russo Client Manager	Tammy_Russo@ajg.com	586.943.0905
Human Resources	Please see your local HR representative	humanresources@creativefoam.com	Hr.creativefoam.com

DISCLOSURE: This benefit outline is intended for use only as a source of reference. This document is not a guarantee of benefits. Official benefits, conditions, exclusions, and limitations are governed by the insurance companies. Benefits are subject to change without advance notice from the insurance companies. Please contact your insurance company for verification of coverage and benefits. A booklet certificate with complete plan information, including all limitations and exclusions, is available on the Blue Cross Blue Shield member portal.

Scan this QR code with your smartphone to access the recorded presentation for 2026 benefits!





2026 BENEFIT HIGHLIGHTS

- **Teladoc Virtual Health has replaced One Drop** and will service as our health management program that assists eligible employees and family members at no cost with managing pre-diabetes, diabetes, and high blood pressure conditions. See the Teladoc Virtual page of this guide for more information.
- The **Gallagher Benefit Advocate Center of Excellence (BAC)** is a contact that you and your dependents can reach out to for benefits support. The BAC team can request replacement ID cards, answer questions on how your benefits work, search for in-network providers, and assist with pharmacy prescription and claim issues. They're available Monday through Friday from 8am-6pm in your local time zone, and can be reached by calling 833.830.1505 or emailing BAC.creativefoamCSO@AJG.com.
- **Flexible Spending Accounts:** Reminder that the healthcare FSA does not have a grace period to incur additional expenses beyond the current plan year. This was replaced with a rollover provision. Please read the FSA pages of this guide for more detail on the rollover.
- **Gallagher's Alternative Healthcare Solutions** offers a no-cost consulting service to Medicare-eligible employees and retirees to review coverage options. Medicare can feel complicated but this service will allow you to work with a Medicare-licensed agent who will take the time to explain your options so you can make an educated and informed decision about whether or not to enroll. Be on the lookout for additional Alternative Healthcare Solutions communications outside of open enrollment.
- **Cancer Support Program:** Personalized support that is available to you at no cost through your health plan. Cancer support is accessible through the OncoHealth virtual platform, Iris, and offers several different types of services including 24x7 access to oncology nurses and a peer mentor community.
- **Hinge Health:** In partnership with Blue Cross Blue Shield of Michigan, Hinge Health offers you easy access to virtual exercise therapy in 15 minutes or less to help you prevent or manage muscle and joint pain. Simply download the app and complete an application to get started.
- **401K:** A Roth option will be added to our 401K program effective 1/1/2026.

2026 BENEFIT HIGHLIGHTS

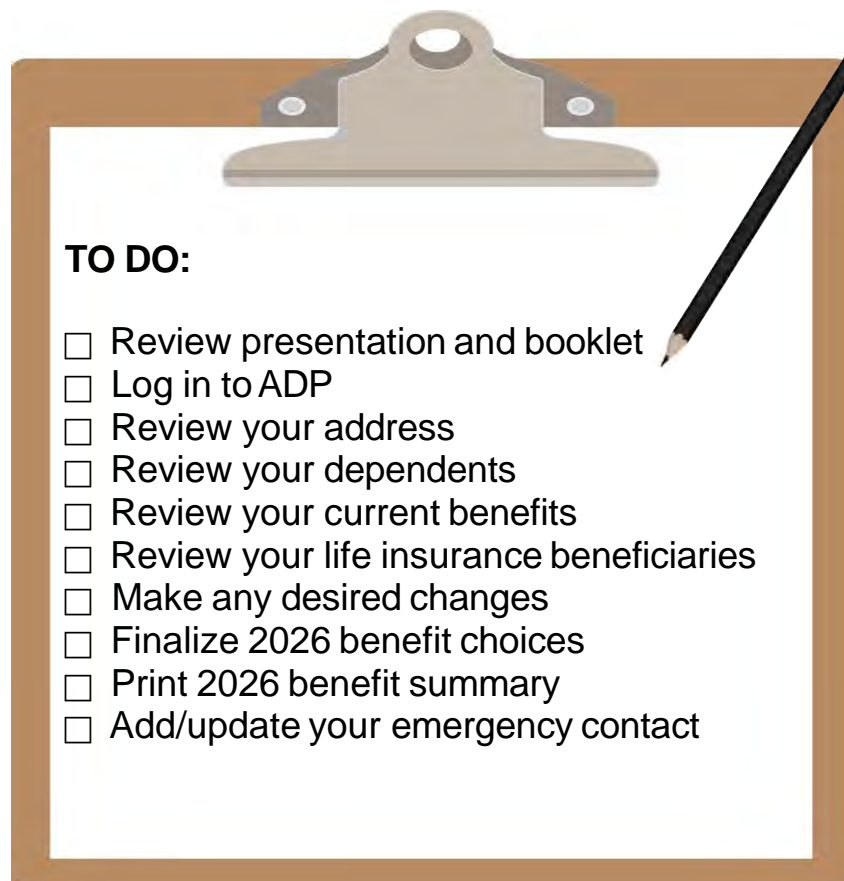
*Open enrollment will again take place within ADP. Please log in using your existing ADP credentials in order to access the open enrollment system.

We highly recommend that you review your benefit information in ADP during the open enrollment window even if you do not plan to make any changes. Once open enrollment ends, if no changes were made, the enrollments that are currently in place will remain as is for the entire 2026 calendar year unless you experience a qualifying life event.

***Please note:** Per IRS regulations, flexible spending accounts (FSAs) require active re-enrollment each year. Previous FSA elections will not re-start automatically for the following year.

OPEN ENROLLMENT CHECKLIST

Be sure to complete each step to ensure you complete the open enrollment process.



ONLINE ENROLLMENT

Employee Online Enrollment Guide

Log into your account at <https://workforcenow.adp.com>

- If you are registering in ADP for the first time, click Sign Up and enter the requested information. If you are unsure of the registration code, please contact your HR team.
- If you have forgotten your login, use the Forgot User ID/Forgot Password link to complete a quick verification and recover your information.

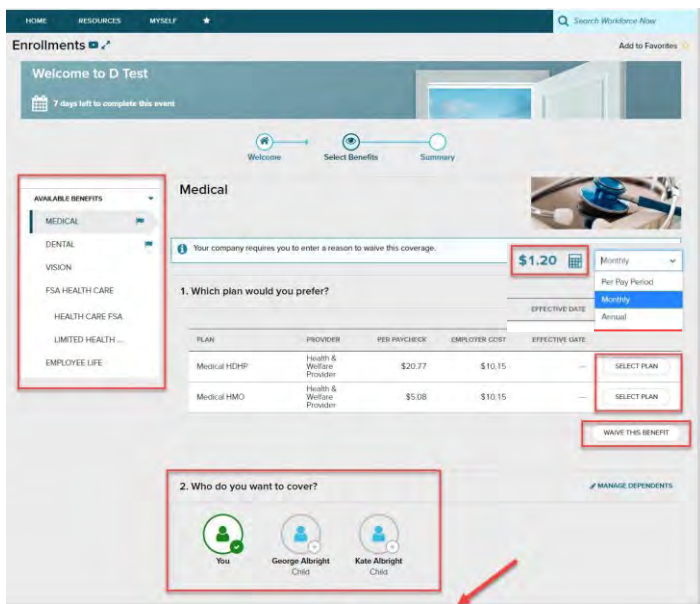
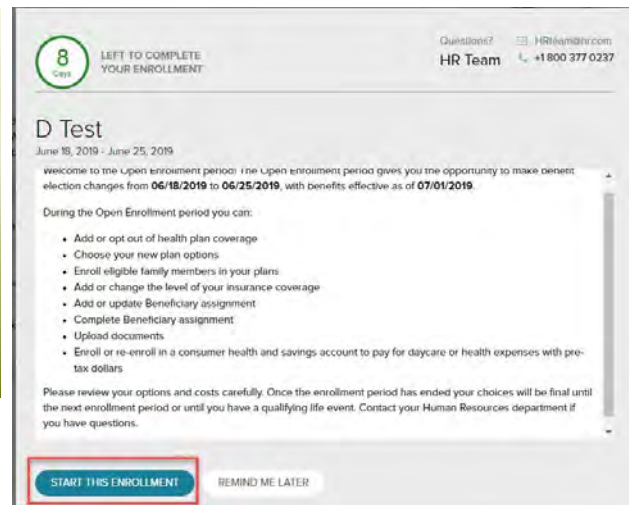
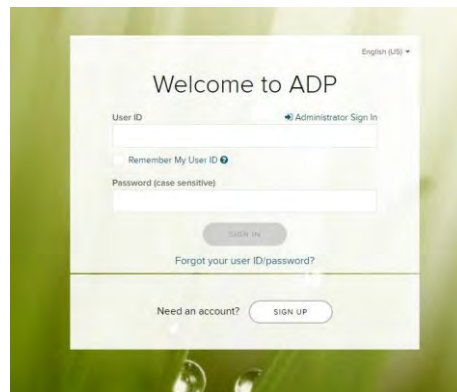
Items to Have Available During Enrollment

To help make the online enrollment process fast and easy we suggest you have the following information available:

- **Dependents' Legal Names**
- **Dates of Birth**
- **Social Security Numbers**

The benefit elections you make will remain in effect until December 31, 2026, unless you have a change in status.

1. Once you log in, you will see a pop-up about Open Enrollment. Click **Start This Enrollment**. Then click **Enroll Now** in the Open Enrollment card. Please review all information before clicking **Continue**.



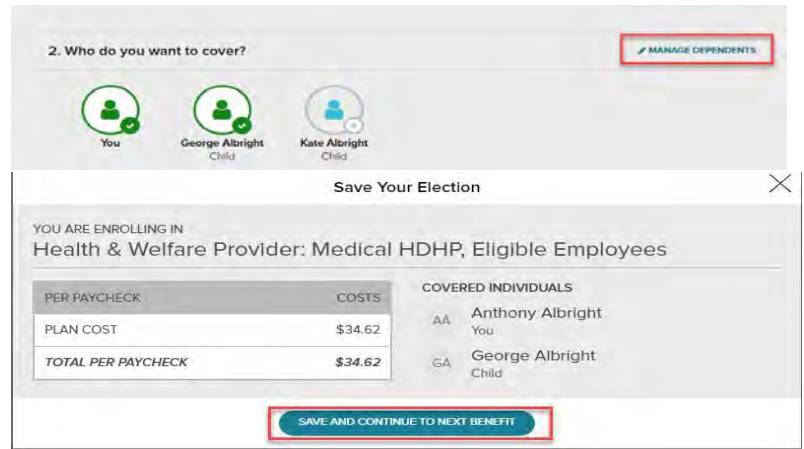
2. The left side of the screen indicates the different plan types available to enroll in. When viewing the selected plan type, all options will be displayed on screen. You may click **Select Plan** or **Waive This Benefit**. If you choose to waive, you may be required to select a reason.

When you enroll in a plan, you may review your costs on a **Per Pay Period, Monthly, or Annual** basis by selecting the desired view in the calculator drop-down. The rate displayed to the left will be updated based on your selection, and it will also be updated if dependents are added for coverage.

ONLINE ENROLLMENT

3. Select which dependents should be covered, if applicable. If you need to update or add a dependent, click the **Manage Dependents** link. Please note, the coverage level options (Employee Only, Employee + Spouse, Employee + Family) are driven by which dependents you select to enroll. Click **Continue to Preview**.

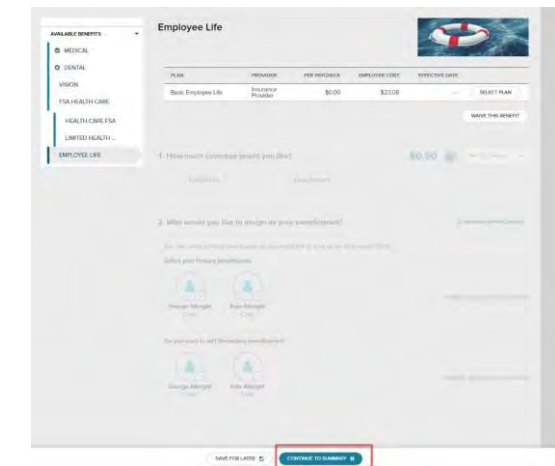
4. Review your enrollment, costs, and covered individuals carefully. Then click **Save and Continue to Next Benefit** to continue making your desired selections.



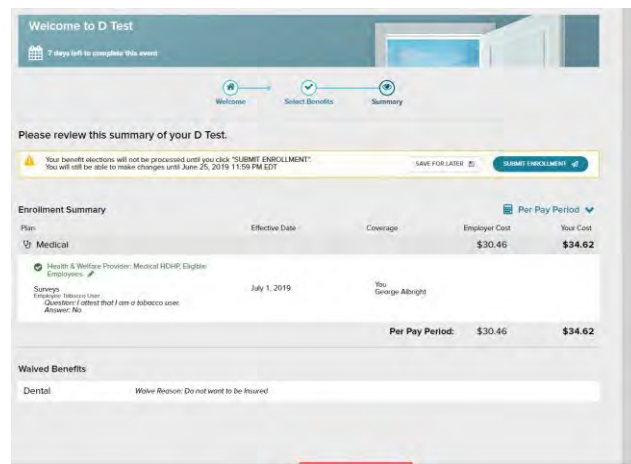
5. Continue through each step until all elections are complete and the **Continue to Summary** button is activated.

The following visual indicators are displayed to show different steps taken, action items, or enrollment statuses:

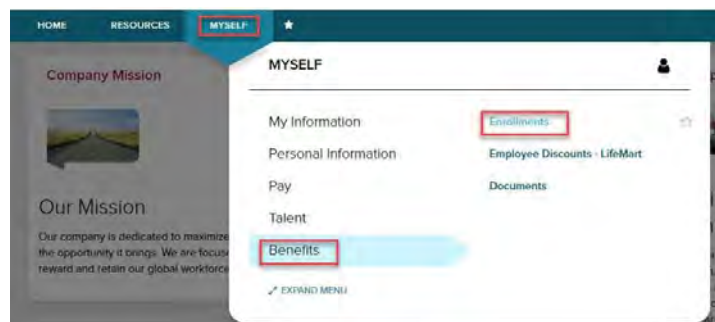
Symbol	Meaning
(flag icon)	The plan needs your attention.
(green check mark)	This is a current plan that you are enrolled in.
(gray X)	This plan has been waived.
(orange clock icon)	This plan is pending approval.



6. Review all of your selections. When you have confirmed them, click **Submit Enrollment**. Note that your benefit elections will not be processed until you click **Submit Enrollment**. If you click **Save for later** instead, these enrollments will not be submitted to your HR team until you fully submit the enrollment. Please ensure you receive the confirmation note indicating your elections have been submitted.



If you would like to make additional changes or modifications during the Open Enrollment Period, you may log in and navigate to **Myself > Benefits > Enrollments** and click the **Enroll Now** option again in the Open Enrollment box, which will bring you back to the beginning of the profile to make any desired election changes.



ELIGIBILITY

Dowagiac Union Employees

Effective January 1, 2026

Creative Foam is pleased to offer an excellent benefit program. These health and welfare benefits are designed to protect you and your family while you are an active employee. We encourage you to carefully review this information and share it with your covered dependents.

Benefit Eligibility

Health and welfare plans are available to all benefit eligible employees who work a minimum of 30 hours per week.

Eligible Dependents

If you wish, your dependents may also be covered under the **medical, dental and vision insurance**. Eligible dependents include:

Legal Spouses

Your spouse by legal marriage, as defined by federal law.

Dependent Children

Your children up to the end of the month in which they turn 26 regardless of their marital, student, or financial status.

New Hire Coverage

For newly hired employees, your benefits will begin on the 1st day after completion of 30 days of employment. You will have 30 days from your hire date to make your benefit selections. If you do not enroll within the first 30 days of your employment date, you will not be eligible for coverage until the next open enrollment period or you have a qualifying life event.

Termination

Your coverage will end on the date of your employment termination.

ELECTIONS

Your Elections

Knowing that every employee has different coverage needs, Creative Foam's Employee Benefit Program is specifically designed to provide you with basic benefits and also allow you the flexibility to elect additional types of coverage for you and your family.

Elections:

It is important that you make your choices carefully, since changes to those elections can generally only be made during the annual open enrollment period. Exceptions will be made for certain changes in status during the year, allowing you to make a mid-year benefit change consistent with the change in status. If you have a change in status, you must change your benefit elections **within 31 days** of the qualifying event, or you will need to wait until the next annual open enrollment period. A status change includes:

- ◆ Change in legal marital status (marriage, death of spouse, divorce or legal separation)
- ◆ Change in the number of dependents (birth, death, adoption or placement for adoption)
- ◆ Change in the employment status of the employee or the employee's spouse including start or end employment, change in eligibility (full time to part time), a strike or lockout, commencement of or return from an unpaid leave of absence or a change in worksite.
- ◆ Dependent satisfies or ceases to satisfy eligibility requirements (attains a particular age)
- ◆ Alternate open enrollment timeframe for spouse or loss of other coverage.

What happens if I do not enroll?

If you do not enroll within the required time period, you will not be eligible to receive voluntary or contributory coverage until the next annual open enrollment period or qualifying event. You may be subject to waiting periods or reduced benefits if you decide to enroll at a later date.

When can I change my benefits?

Your health and welfare benefits remain in effect throughout the plan year. Generally, you cannot change your benefit level, add or drop out of a plan until the next annual open enrollment. However, if there is a qualified change in your family status, you will be eligible to change your coverage **within 31 days** of the qualifying event.

COBRA Continuation Coverage:

When you or any of your dependents no longer meet the eligibility requirements for your employer's health and welfare plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986. In the event of divorce, legal separation or change in dependent status, it is your responsibility to notify Human Resources **within 60 days** for complete COBRA detail requirements.

Your Tax Advantage:

Your contributions to the medical, dental, vision and FSA plans are made on a pre-tax basis. Your taxable income will be reduced by the amount you contribute for each benefit – you pay no income tax on the amount you contribute, thus saving you tax dollars. The fact that your taxable income will be lowered does not affect your salary-related benefits, which will continue to be calculated upon your base earnings before contributions. You may, however, realize slightly lower Social Security benefits in the future because of this pre-tax feature.

KEY WORDS TO KNOW

It is important to be familiar with benefit terms to better understand your options. Take a moment to review these definitions, which may be referenced throughout this guide.



Coinsurance – Your share of the costs for health care services, calculated as a percentage of the allowed amount. You pay coinsurance after your deductible has been met. You pay that percentage for each charge until you meet your out-of-pocket maximum.

Copayment/Copay – Fixed dollar amounts you pay for a covered health care service, usually at the time of service. The amount can vary by type of service. You pay the copay before, during, and after the deductible is met, until you reach your out-of-pocket maximum.

Covered services or expenses – Services or expenses that your plan covers.

Deductible – The total dollar amount you are required to pay for health care services at 100% before your health insurance plan begins to pay. The amount is first reduced by any applicable network discount.

Embedded Deductible – Under family coverage, the individual deductible applies to each covered person until the family deductible is met.

Exclusions – Services or expenses that your plan does not cover.

Out-of-pocket maximum – The most you have to pay for covered health care services during a plan year. Once met, you do not have to pay any cost share amounts until the next plan year. This maximum includes your deductible, copays, and coinsurance, but does not include your premium, balance-billed charges, or services your plan does not cover.

Premiums – The amount you pay to receive coverage.

Preventive Care – All medical plans cover routine preventive care at 100%. Preventive visits to your doctor can help catch health risks early, potentially saving money, time, and even your livelihood. Take advantage of this care, including well-child visits, annual physicals, immunizations, and more!



2026 BENEFIT CONTRIBUTIONS

Weekly Medical Contributions

Employee	\$6.50
Employee and One Dependent	\$8.00
Employee and Family	\$10.00

Weekly Dental Contributions

	Plan A (Low Option)	Plan B (High Option)
Employee	\$7.43	\$10.40
Employee and One Dependent	\$10.46	\$14.84
Employee and Family	\$17.71	\$26.33

Weekly Vision Contributions

Employee	\$3.23
Employee and One Dependent	\$4.93
Employee and Family	\$8.85

All contributions are taken on a pre-tax basis through Section 125



MEDICAL BENEFITS

Creative Foam offers you a medical plan options through **Blue Cross Blue Shield of Michigan (BCBSM)**. This is a Preferred Provider Organization (PPO) plan utilizing the **BCBSM network**.

PPO Plan Specifics:

- This plan is provided through a Preferred Provider Organization (PPO), utilizing the BCBSM PPO network.
- If you use the network, you will receive the highest level of benefits offered by the plan.
- While the network is available, you are not required to use it. You always have the complete freedom to select any provider whenever you need care. However, the out-of-network benefits are lower and your out-of-pocket costs will be higher.
- This plan does not require any referrals to see a specialist.
- To find a PPO provider login to www.bcbsm.com, or call the phone number on the back of your ID card.
- The medical plan provide coverage for prescription drugs through OptumRx.

Elections:

You may elect medical coverage for yourself; you and your spouse; you and your child(ren); or for the entire family.

Plan Provisions and Exclusions:

Please refer to the carrier certificate or SBC for full details on all policy provisions, including any applicable exclusions. The information included in the benefit overview on the following pages is provided only as a brief summary.

Auto Insurance Coordination:

Medical services related to an injury which is a direct or indirect result of an automobile accident are covered under the Creative Foam self-funded medical plan, **secondary** to automobile insurance coverage or personal injury protection coverage.

It is important that you review the Coordination of Benefits provisions in the Plan Document and discuss this with your automobile insurance company to make sure that you have adequate coverage under your personal policy.

MEDICAL BENEFITS

The plan is designed to provide levels of benefits based on the choices you make. Benefits that are payable are subject to the terms and conditions of the plan.

BCBS of Michigan	PPO \$1,500	
	Network	Non-Network
Deductible <ul style="list-style-type: none"> Individual Family (embedded) 	\$1,500	\$3,000
Calendar year	\$3,000	\$6,000
	Expenses applied toward the Non-Network deductible will <u>not</u> be used to satisfy the Network deductible and expenses applied to the Network deductible will <u>not</u> be applied to the Non-Network deductible .	
	Any number of family members may help to meet the family deductible amount, however in no event will any one covered individual pay more than the individual deductible amount.	
Out-Of-Pocket Maximum <ul style="list-style-type: none"> Individual Family (embedded) 	Medical: \$3,000/\$6,000 Rx: \$2,000/\$4,000	Medical: \$6,000/\$12,000 Rx: \$2,000/\$4,000
Calendar year Includes deductible, coinsurance and co-pays for medical coverage and prescription drugs	Expenses applied toward the Non-Network out-of-pocket maximum will <u>not</u> be used to satisfy the Network out-of-pocket maximum and expenses applied to the Network out-of-pocket maximum will <u>not</u> be applied to the Non-Network out-of-pocket maximum .	
	Any number of family members may help to meet the family out-of-pocket maximum amount, however in no event will any one covered individual pay more than the individual out-of-pocket maximum amount.	
Preauthorization	<p>This plan requires preauthorization prior to some treatments and services.</p> <ul style="list-style-type: none"> Preservice non-urgent review: When you need to get a certain health care service, but it is not urgent, it can take up to 15 days for review. Preservice urgent review: When you need a certain health care service as soon as possible, but it is not an emergency, it can take up to three days for review. Urgent concurrent review: When you are already receiving care and you cannot wait for approval, it can take up to 24 hours for review. This often happens with trips to the emergency room. Postservice review: When you have already received the care you need and you request approval for it. It can take up to 30 days for review. <p>Examples of services that need approval (this is not a full list): some radiology services, inpatient care, interventional pain management, skilled nursing facility care, human organ transplant, radiation, rehabilitation</p>	
Annual Maximum	Unlimited	
Hospital-Inpatient	80% after deductible	60% after deductible
Surgery	80% after deductible	60% after deductible
Hospital Visits	80% after deductible	60% after deductible
Emergency Room <ul style="list-style-type: none"> Copay waived if admitted Should only be used when necessary and not for convenience 	\$250 copay, then 100% no deductible	\$250 copay, then 100% no deductible
Urgent Care	\$35 co-pay, then 100% no deductible	60% after deductible
Ambulance	80% after deductible	80% after deductible
Anesthesia	80% after deductible	60% after deductible
Blood	80% after deductible	60% after deductible
Cardiac Rehabilitation	80% after deductible	60% after deductible

MEDICAL BENEFITS

	PPO \$1,500	
	Network	Non-Network
Cardiac Rehabilitation	80% after deductible	60% after deductible
Chemotherapy	80% after deductible	60% after deductible
Chiropractic Care (50 visits in a calendar year)	\$30 co-pay, then 100% no deductible	60% after deductible
• Office Visits, Spinal Manipulations/ Adjustments		
Consultations		
• Inpatient	80% after deductible	60% after deductible
• Outpatient	\$40 co-pay, then 100% no deductible	60% after deductible
* Specialist	\$30 co-pay, then 100% no deductible	60% after deductible
* Primary Care Provider (PCP)		
Dialysis	80% after deductible	60% after deductible
Fertility Testing (Diagnostic only, to determine the cause of infertility)	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Hospice		
• Hospice Expenses (5 days of respite care)	80% no deductible	60% after deductible
• Bereavement (Up to 15 visits of bereavement counseling per family during the 6-month period following the patient's death)	50% after deductible	50% after deductible
Laboratory Testing	80% after deductible	60% after deductible
Medical Equipment	80% after deductible	60% after deductible
Medical Supplies (3 pairs max of prescribed Jobst/ compression stockings in a calendar year)	80% after deductible	60% after deductible
Mental Disorders and/or Substance Abuse Expenses		
• Inpatient	80% after deductible	60% after deductible
• Outpatient Visit	80% after deductible	60% after deductible
• Virtual Visit with provider	\$30 copay	60% after deductible
• BCBSM Virtual Care by Teladoc	\$0 copay	Not Covered
Nursing - Private Duty	80% after deductible	60% after deductible
Occupational Therapy	80% after deductible	60% after deductible
Office Visits		
• Specialist	\$40 copay, then 100% no deductible (applies to office visit and all services/ procedures rendered during the visit)	60% after deductible
• Primary Care Provider (PCP)	\$30 copay, then 100% no deductible (applies to office visit and all services/ procedures rendered during the visit)	60% after deductible
• BCBSM Virtual Care by Teladoc	\$0 copay	Not Covered

MEDICAL BENEFITS

	PPO \$1,500	
	Network	Non-Network
Orthotics	80% after deductible	60% after deductible
Physical Therapy	80% after deductible	60% after deductible
Pregnancy Related Expenses		
• Pre & Post-Natal Care /Visit	100% no deductible	60% after deductible
• Delivery	80% after deductible	60% after deductible
Prescription Drugs	<p><u>30 day supply (retail)*</u></p> <ul style="list-style-type: none"> Generic: \$10 co-pay Preferred Brand: \$35 co-pay Non-Preferred Brand: \$80 co-pay Specialty: not covered <p>*(Limited to 2 fills at retail. Must utilize home delivery or Smart90 pharmacy on 3rd fill.)</p> <p><u>90 day supply: 1x 30-day copay</u></p> <ul style="list-style-type: none"> Generic: \$10 co-pay Preferred Brand: \$35 co-pay Non-Preferred Brand: \$80 co-pay Specialty: not covered 	
<p>*Smart90 program that allows members to get up to a 90 day supply of long term maintenance medications either through home delivery from OptumRx Pharmacy or at a retail Walgreens pharmacy in the Smart90 network. To locate a Smart90 network pharmacy, login to www.bcbsm.com and click on "Locate a pharmacy" from the menu under "Manage Prescriptions", Smart90 network pharmacies will be noted in your search results.</p>		
Preventive Care (As recommended by the United States Preventive Services Task Force (USPSTF))		
• Annual visit, including well baby/ child visit	100% no deductible	Not Covered
• Testing		
• Immunization		
Cancer screenings	As the USPSTF recommendations may change periodically, please go to the website www.uspreventiveservicestaskforce.org for full coverage information.	
• Pap smears		
• Colonoscopy		
• Mammogram		
Prostate specific antigen (PSA) exam and related testing		
Women's Preventive Services		
• Well-women visits	100% no deductible	Not Covered
• Human papillomavirus testing		
• Contraceptive methods and counseling		
• Breastfeeding support, supplies and counseling		
• Screening and counseling:	As the HRSA recommendations may change periodically, please go to the website www.hrsa.gov/womens-guidelines for full coverage information.	
• Interpersonal and Domestic Violence		
• Human Immune-Deficiency Virus		
• Sexually Transmitted Infections		
• Gestational Diabetes		

MEDICAL BENEFITS

	PPO \$1,500	
	Network	Non-Network
Prosthetic Devices (Max of 1 wig or hair piece per course of treatment)	80% after deductible	60% after deductible
Radiation Therapy	80% after deductible	60% after deductible
Retail Establishment Health Clinics (MinuteClinic®, Take Care Health Clinic®, RediClinic®, etc.)	\$35 co-pay, then 100% no deductible	60% after deductible
Skilled Nursing Facility	80% after deductible	60% after deductible
Speech Therapy	80% after deductible	60% after deductible
Sterilization Procedures	100% no deductible	60% after deductible
Transplants Only available when using the transplant network	100% no deductible	Not Covered
Weight Management Preoperative evaluation, preparation, and postoperative treatment	Payment is based on service rendered*	Payment is based on service rendered*
	80% after deductible	60% after deductible
Bariatric surgery 1 per lifetime	* Payment is based according to the listed covered services (e.g. office visits will be covered as stated under the office visit listing, laboratory testing will be covered as stated under the laboratory testing, etc.)	
X-rays	80% after deductible	60% after deductible
All Other Covered Expenses	80% after deductible	60% after deductible
Cataract Eye Glass Frames (\$150 in a lifetime for frames after cataract surgery)	80% after deductible	60% after deductible

VIRTUAL CARE



Virtual care that's always there

GET CARE WHEN YOU NEED IT, WHEREVER YOU ARE.

With **Virtual Care** by Teladoc Health®, you and everyone on your health plan can get virtual medical and mental health care from a smartphone, tablet or computer. Virtual Care is included with your Blue Cross Blue Shield of Michigan health care plan.

24/7 CARE

For minor illnesses and injuries, talk with U.S. board-certified doctors 24/7. **You don't need an appointment.**

When to use

When your primary care provider isn't available, you can talk to a U.S. board-certified doctor about minor illnesses such as:

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

How do I sign up?

You can visit bcbsm.com/virtualcare for a link to download the Teladoc Health app or use the QR Code to the right. You can also open the Blue Cross Blue Shield of Michigan mobile app, click on *Find a Doctor* and then *Virtual Care*. You will need your Blue Cross member ID card. Remember to choose your health plan and enter your member ID number when updating or creating your account so your coverage is applied correctly.

Family members ages 18 and older will need to create their own Virtual Care accounts. When updating or creating an account, choose your plan name and enter your member ID so your coverage is applied correctly. Call 1.855.838.6628 with any questions about your account or to arrange a telephone visit.

MENTAL HEALTH

To meet your mental health needs, choose from licensed therapists and U.S. board-certified psychiatrists. **Available by appointment**, including nights and weekends.

When to use

You can have a virtual visit with a therapist or psychiatrist when you're struggling with challenges such as anxiety, depression and grief.

This private and confidential mental health care gives you more options and access for ongoing, long-term support. For immediate behavioral health care, call the Behavioral/Mental Health and Substance Abuse number on the back of your Blue Cross member ID card.

Virtual Care provides routine psychological and psychiatric treatment. Virtual Care does not provide treatment for complex mental health and substance use disorder conditions.



CONDITION MANAGEMENT



Condition Management programs

Getting healthy is easier with a little help.

Your health plan includes condition management programs that offer easy-to-use tools and support to help you manage the daily responsibilities of living with chronic conditions. Blue Cross Blue Shield of Michigan and Blue Care Network work with Teladoc Health® to provide these programs at no additional cost.

Diabetes Management

- Advanced blood glucose meter
- Unlimited test strips and lancets
- Personalized tips and expert coaching
- 24/7 real-time support for out-of-range readings

Diabetes Prevention

- Smart scale
- Expert guidance on nutrition and meal planning

Hypertension

- Connected blood pressure monitor
- Digital reports
- Goal-based action plans
- Nutrition tips and advice from expert coaches

Weight management

- Smart scale
- One-on-one expert coaching
- Guidance on creating healthy habits that last

All program resources are available at no extra cost, and you can conveniently stay on track with your care in one place through the Teladoc Health app.

Get started today

Let us take some of the load off your plate. Our program can help you manage your health while reducing your cost for care.

To enroll, call 1-800-835-2362. Your registration code is **BLUECROSSMI-START**. Or scan the QR code to enroll online.



CANCER SUPPORT

Cancer Support Program

Personalized support that's available to you at no cost through your health plan.



Scan to get started

When you're diagnosed with cancer, no amount of expert information, timely answers or personalized support is too much. Your oncologist leads your care. **Iris is there for the moments in between.**

That's why a no-cost program called Cancer Support is now part of your health plan. This program complements your oncologist's care and treatment plan. It provides immediate access to reliable information and resources that cancer patients often need between appointments and treatments.

Cancer Support is accessible through the OncoHealth virtual platform, Iris, which includes:



24 x 7 access to a team of oncology nurses

Who can provide personalized advice on managing side effects and symptoms



Weekly mental health sessions

With a therapist specializing in working with people and families dealing with cancer



Access to registered dietitians

Who focus on nutrition and cancer



A digital tracker

For recording goals and side effects



A library of more than 200 on-demand articles

And videos on cancer, treatments, side effects and procedures



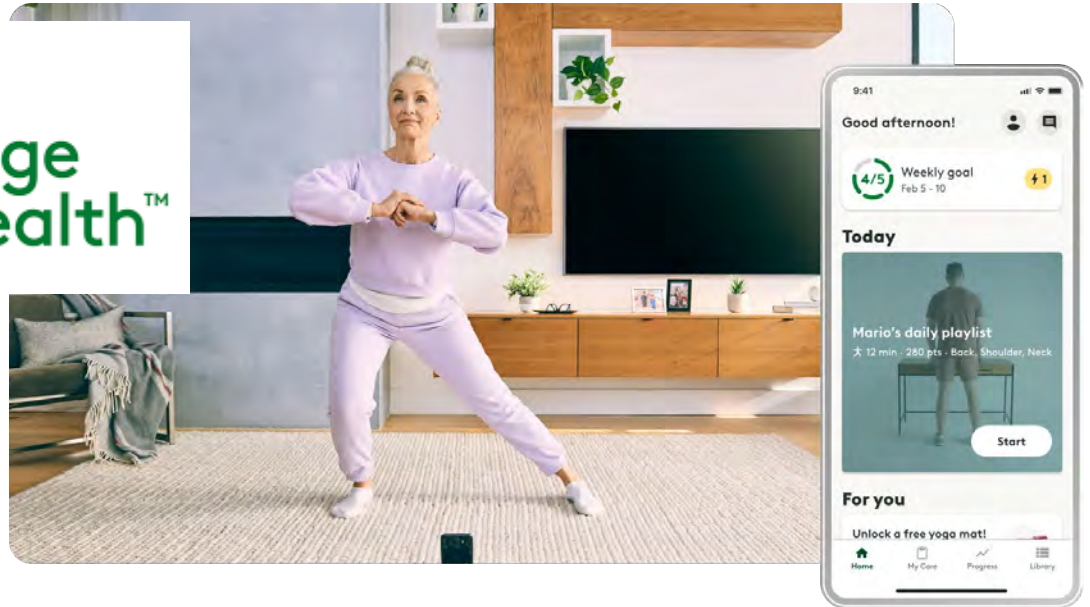
A peer mentor community

To connect with others who have been in similar situations with cancer



Get started in the Cancer Support program at bcbsm.com/cancersupport.

Or scan this QR code.



Hinge Health: Your Path to Pain-Free Movement

Hinge Health offers innovative digital care programs to help you conquer joint and muscle pain from the comfort of your home. Their expert team of physical therapists and health coaches are here to guide you every step of the way.

Key Benefits

- Personalized exercise therapy
- 1-on-1 health coaching
- Convenient app-based sessions
- Proven pain reduction and mobility improvement

Eligibility:

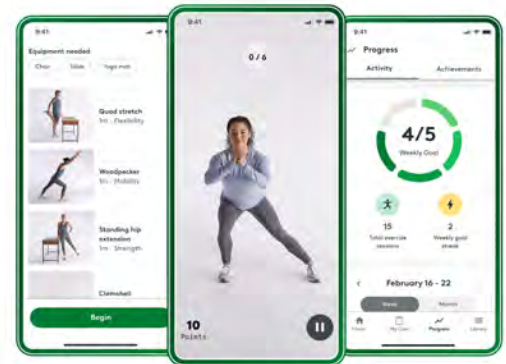
Employee and dependents 18+ enrolled in the company sponsored health insurance plan are eligible at no cost.

How to Sign Up:

1. Visit hinge.health/enroll-today
2. Enter Creative Foam as your employer or insurance information
3. Download the Hinge Health app and get started!

Contact Hinge Health Directly:

Have questions? Call them at 1-855-902-2777 or email hello@hingehealth.com



BLUE CROSS ADDITIONAL PROGRAMS

Blue365

Membership has its benefits

Blue Cross Blue Shield of Michigan members can score big savings on a variety of health-related products and services from businesses in Michigan and across the United States. We have plenty of deals to keep you and your family healthy.

Blue 365 offers exclusive deals on things like:

Fitness and wellness: Health magazines, fitness gear, and gym memberships

Healthy eating: Cookbooks, cooking classes, and weight-loss programs

Lifestyle: Travel and recreation

Personal care: Lasik and eye care services, dental care, and hearing aids

Cash in on discounts

Start saving today! Show your Blue Cross ID card at participating retailers or use an offer code online to take advantage of these savings. For a full list of discount offers, log in or register at www.bcbsm.com and click *Member Discounts with Blue365* on your home page. You can also conveniently access discounts on the go with the Blue Cross mobile app. Search BCBSM in Google Play or the App Store to download.

Fitness Your Way

\$29 a month gym membership
(with \$29 enrollment fee + three-month commitment)

- More than 10,000 national participating fitness locations including LA Fitness, Snap Fitness, and Anytime Fitness. Visit any participating location as often as you like
- 24/7 access to wellbeing support, health articles, and online health coaching
- Easy online tools to track exercise goals and activity, and ask an expert a question
- **How to enroll:**
 - Log in to your member account at www.bcbsm.com
 - Click Member Discounts with Blue365
 - Search for Fitness Your Way deal, click Redeem Now, then Continue
 - You can then search by zip code for participating locations and enroll or call 1.888.242.2060

Feeling stressed?
Overwhelmed?
Exhausted?

AbleTo can help



An eight-week evidence-based cognitive behavioral therapy program



Personalized care for symptoms of depression, anxiety or stress



Weekly one-on-one sessions that last up to 60 minutes



Are available to members 18 and older



Are subject to your health plan's behavioral health visit out-of-pocket costs



Offer digital tools and resources to support you between sessions

- Go to www.ableto.com/bcbsm
- Click *Get Started* to sign up and schedule an appointment with a therapist of your choice.
- Select a convenient day, time and device (phone or video) for your sessions. You'll receive an appointment confirmation.
- Attend your sessions through the AbleTo app, available in the App Store and Google Play, or online at www.ableto.com/bcbsm.
- Have your initial consultation. Your program will be tailored based on your personal care needs, medical history and preferences.

MENTAL HEALTH RESOURCES

Seeking help for mental health and wellbeing can be confusing, and it is hard to know where to start. Review your resources below based on the urgency of your issue and type of care you would like to explore.



“I am in crisis and need to talk to someone...now.”

Emergency Care

Suicide and Crisis Lifeline	Dial 988, or call 1-800-273-8255
------------------------------------	----------------------------------

“I’ve been struggling with something personal and would like some help.”

Virtual Care

Options	Description	How to Access
Blue Cross Virtual Care	Care with a behavioral health specialist from your smartphone, tablet, or computer.	Register at www.bcbsm.com/virtualcare and download the app
AbleTo	Personalized 8 week evidence-based cognitive behavioral therapy program via weekly one-on-one 60-minute sessions, for members 18 and older with symptoms of depression, anxiety, or stress. Includes access to over 2,000 licensed therapists nationwide.	Attend your sessions through the AbleTo app, available in the App Store and Google Play, or online at www.ableto.com/bcbsm
Virtual Visit	Care from a behavioral health specialist (including psychiatrists, psychologists, professional counselors, and social workers) by phone or video	Log into your member account at www.bcbsm.com , click the <i>Doctors & Hospitals</i> tab, and select <i>Find a Doctor</i>

In Person Care

Primary Care	The “first stop” on your journey to health and wellness, and a good resource for learning how to deal with mental health and substance use concerns. Your doctor can provide treatment or refer you to a behavioral health specialist.	To find a primary care provider, you can find one in your area by logging into your member account at www.bcbsm.com , click the <i>Doctors & Hospitals</i> tab, and select <i>Find a Doctor</i>
Behavioral Health Specialist	One-on-one sessions with a psychiatrist, psychologist, social worker, or professional counselor.	Log into your member account at www.bcbsm.com , click the <i>Doctors & Hospitals</i> tab, and select <i>Find a Doctor</i>

“What does wellbeing mean? I would like to learn more, but I don’t want to talk to a professional.”

Free Online Resources

BCBSM Behavioral Health website	A comprehensive resource for mental health and substance use disorder information and support	www.bcbsm.com/mentalhealth
Blue Cross Health & Well-Being, powered by WebMD	Free online tools and resources to help you improve and maintain your health and well-being	Log in to your member account at www.bcbsm.com or download the BCBSM mobile app and select WebMD under Health & Well-Being.
Blue Cross Virtual Well-Being	Free program offers weekly well-being webinars and meditation sessions to support your overall well-being	www.bluecrossvirtualwellbeing.com and click Webinars for Members
EAP	Resources for dealing with stress, grief, and relationship problems	www.guidanceresources.com Web ID: GEN311 Phone: 1.800.311.4327

WELLNESS PROGRAM

2026 WELLNESS PROGRAM



For more info go to: <https://hr.creativefoam.com/wellness/>

Eligibility

Available to our U.S. locations. All employees are eligible to participate in the Creative Foam Wellness Program regardless of medical insurance coverage.

Earning Points

Earn at least 50 points to earn a wellness credit. Up to four wellness credits can be earned per year.

In 2026

Financial Wellness Activities including monthly challenges and quizzes!

Paid out Monthly: Wellness credits will now be paid out the following month once 50 points has been earned.

Points earned within the calendar year **no longer expire** each quarter.

Employer Activities – 15 points

Watch videos (3-5 mins long) and take the corresponding quiz (5 questions) to earn wellness points. Each quiz can only be completed once during the year. Videos and quizzes can be found at: <https://hr.creativefoam.com/employer-activities/>

Employer Challenges – 20 points

Employer Challenges will start January 1st and run monthly. Information will be distributed before each challenge month begins.

Financial - \$100 Savings Challenge – 15 points

Save \$100 monthly. Log your savings on the **Financial Challenge log Sheet**. Ongoing every month.

Gym Attendance – 20 points

Visit your gym at least 4 times in a calendar month to earn 20 points. E-mail a document verifying your monthly attendance to receive credit.

Healthy Event – 20 points

Participate in a healthy event and submit the **Healthy Event Form** for Points.

*Examples: Fitness Program * Marathon * 5k Run/Walk * Defense Class * AND MORE!*

Monthly 100K Step Challenge – 15 points

Reach 100k steps monthly. Log your steps on the **Challenge Log Form**. Ongoing every month.

Peer Challenges- 15 points

Collaborate with one or more fellow co-workers and create a month-long challenge. You pick! Each participant must complete at least 10 days and turn in their own log sheet to qualify for points.

Preventative Care – 50 points

Participate in various types of preventative care. Bring a **Preventative Care Form** to your appointment for doctor's signature and turn in the signed form for points. **Care must have been completed within 1 year of form submission date and each occurrence can only be counted for wellness points once.**

*Examples: Physical * Eye/Hearing Exam * Flu Shot*

Weight Management Program – 20 points

Participate in a weight management program of your choice at least 4 times in a calendar month and turn in a registration form, log in sheet or receipt verifying your participation to earn credit.

Communication & Activity Submissions

- Email wellness@creativefoam.com directly to submit forms, obtain forms, ask questions, or request your current point status.
- Sign up on Remind, go to: rmd.at/cfwellness and follow the instructions. Submit your activities directly via Remind.





DENTAL BENEFITS

Creative Foam provides you with a choice of two different Preferred Provider Organization (PPO) dental plan options through **Delta Dental of Michigan**.

- ◆ **Delta Dental PPO High Plan**
- ◆ **Delta Dental PPO Low Plan**

PPO

Through the PPO, you are not required to use a network provider – you have freedom to select any dentist. However, benefits are highest if you receive care from a PPO network provider in the Delta Dental PPO network. To find PPO providers near you, you can refer to the network directory online at www.deltadentalmi.com or by calling Delta Dental at 800.524.0149.

Using a PPO dentist is the best way to maximize your dental benefits as these dentists agree to accept the PPO network pre-negotiated fee and are prohibited from billing you for amounts in excess of this fee. You are still responsible for any applicable copayment based on the type of service performed.

Delta Premier

Delta Premier dentists are not part of the PPO network, however Premier dentists agree to adhere to Delta Dental processing policies and are prohibited from billing a patient above the pre-negotiated fee for the Premier network. The pre-negotiated fee under the Premier network may be higher than the PPO network, potentially increasing your out-of-pocket expense.

Out-of-Network (Nonparticipating dentists)

If you use a nonparticipating provider you may be balance billed for up to the actual billed amount, even when it exceeds the amount Delta Dental approves. *Using an out-of-network dentist can significantly increase your out-of-pocket expense.*

Elections:

You may elect dental coverage for yourself; you and your spouse; you and your child(ren); or for the entire family. Even if you waive medical coverage, you may still elect a dental plan.

Policy Provisions and Exclusions:

Please refer to the carrier certificate for full details on all policy provisions, including any applicable exclusions. The coverage information on the following pages is provided only as a brief summary.

Effective January 1st, 2026, Delta Dental offers additional benefits to covered members (children and adults) with a qualifying special health care need. Please see Human Resources for more details.

DENTAL BENEFITS

Plan	Delta Dental High Plan #5323		
Network	PPO	Premier	Non- Participating
	Diagnostic and Preventive		
Diagnostic and Preventive Services: exams, cleanings, fluoride and space maintainers	100%	100%	100%
Sealants: to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy: to detect oral cancer	100%	100%	100%
Radiographs: x-rays	100%	100%	100%
	Basic Services		
Emergency Palliative Treatment: to temporarily relieve pain	80%	80%	80%
Minor Restorative Services: fillings and crown repair	80%	80%	80%
Endodontic Services: root canals	80%	80%	80%
Periodontics Services: to treat gum disease	80%	80%	80%
Other Oral Surgery: dental surgery	80%	80%	80%
Other Basic Services: miscellaneous services	80%	80%	80%
Relines and Repairs: to bridges, dentures and implants	80%	80%	80%
	Major Services		
Major Restorative Services: crowns, inlays, veneers	50%	50%	50%
Prosthetic Services: bridges, dentures, and implants	50%	50%	50%
	Orthodontic Services		
Orthodontic Services: braces	50%	50%	50%
Orthodontic Age Limit	Children & Adults Covered		

Maximum Payment- \$2,000 per person total per calendar year on Diagnostic and Preventive, Basic Services, and Major Services. \$2,000 per person total per lifetime on orthodontics.

Deductible—\$50 deductible per person per calendar year limited to a maximum deductible of \$150 per family per calendar year on all services except Diagnostic and Preventive Services, Sealants, Brush Biopsy, X-rays, and Orthodontic Services.

DENTAL BENEFITS

Plan	Delta Dental Low Plan #5323		
	Network	PPO	Premier
	Diagnostic and Preventive		
Diagnostic and Preventive Services: exams, cleanings, fluoride and space maintainers	100%	100%	100%
Sealants: to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy: to detect oral cancer	100%	100%	100%
Radiographs: x-rays	100%	100%	100%
	Basic Services		
Emergency Palliative Treatment: to temporarily relieve pain	80%	80%	80%
Minor Restorative Services: fillings and crown repair	80%	80%	80%
Endodontic Services: root canals	80%	80%	80%
Periodontics Services: to treat gum disease	80%	80%	80%
Other Oral Surgery: dental surgery	80%	80%	80%
Other Basic Services: miscellaneous services	80%	80%	80%
Relines and Repairs: to bridges, dentures and implants	80%	80%	80%

Maximum Payment- \$1,000 per person total per calendar year on Diagnostic and Preventive and Basic Services.

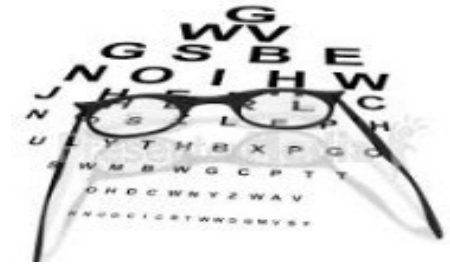
Deductible—\$50 deductible per person per calendar year limited to a maximum deductible of \$150 per family per calendar year on all services except Diagnostic and Preventive Services, Sealants, Brush Biopsy, and X-rays.



VISION BENEFITS

As an eligible employee you have the opportunity to elect vision benefits for you and your eligible dependents through VSP. By using participating VSP providers, your out-of-pocket expenses will be lower.

The plan is designed to provide periodic eye exams and corrective eyewear. Participating providers can be found on VSP’s website, www.vsp.com, or by contacting customer service at 800.877.7195.



In-Network Benefit	Details	Member Payment
Wellness Vision Exam	<ul style="list-style-type: none"> Once per calendar year 	\$20 copay
Frames	<ul style="list-style-type: none"> \$150 frame allowance 20% discount over allowance Once per calendar year 	\$20 copay plus any amount over the allowance
Lenses for prescription glasses	<ul style="list-style-type: none"> Single vision, lined bifocal, lined trifocal lenses Polycarbonate lenses for dependent children Once per calendar year 	Cost for lenses included in \$150 allowance
Lens options for prescription glasses	<ul style="list-style-type: none"> Progressive lenses Anti-reflective coating Tints Scratch-resistant coating 	Covered 100%
Contact lenses (instead of glasses)	<ul style="list-style-type: none"> \$150 allowance Fitting and evaluation included in allowance Once per calendar year 	\$60 copay



FLEXIBLE SPENDING ACCOUNTS

Creative Foam's Health Care and Dependent Care reimbursement accounts (Flexible Spending Accounts) allow you to use tax-free dollars to reimburse yourself for a wide variety of health and/or dependent daycare expenses that are not covered through your other benefit plans.

The annual amount you elect to contribute to each account will be divided into equal amounts and deducted from each paycheck during the plan year before federal, and in most cases, state and local income taxes are withdrawn. The Plan Year is January 1, 2026 through December 31, 2026.

- Health Care Reimbursement Account (includes a Debit Card)**
 Health Care expenses for yourself and your IRS Tax dependents, such as deductible, coinsurance, copays, glasses and dental care, are eligible for reimbursement from your Health Care Account. The annual election maximum amount is **\$3,400** for the plan year. **Your plan has incorporated a rollover provision, which allows you to rollover up to \$680 into the following calendar year.**
- Dependent Care Reimbursement Account (No Debit Card)**
 Expenses for **daycare** services for children under age 13, a disabled spouse or incapacitated parent are eligible for reimbursement from your Dependent Care FSA if you incur them while you and your spouse work or attend school fulltime. The annual election maximum amount is **\$7,500** for the 2026 Plan year. **Your plan has incorporated a grace period, which allows you to incur additional expenses from January 1 - March 15 of the following calendar year, and apply those expenses to your previous plan year funds to help prevent forfeitures.**

FSA Rules

Plan your contributions to each of these accounts carefully. **The election you make when you enroll is binding for the entire Plan Year** unless you have a qualifying status change. In addition, the IRS has additional rules and restrictions on the way you can use FSA's.

- You must incur eligible expenses prior to the end of the plan year (December 31, 2026)
- If you incur fewer expenses than you expected, you forfeit any money remaining in your Health Care FSA at the end of the plan year that is in excess of the **\$680** rollover amount;
- All reimbursement claims must be submitted by March 31st;
- You can not transfer money from one account to another. Money in your Health Care FSA cannot be used for dependent care expenses and money in your Dependent Care FSA cannot be used for health care expenses.

Online FSA Services with iSolved

- Seamless member portal access
- Submission of reimbursement requests via mail, fax, or online upload
- Instant account status available 24/7 online or by phone
- Online Tax Savings Calculator can be used to estimate tax savings

Remember that under IRS rules, your supporting documentation must clearly identify all of the following items for every expense:

- The nature of the service
- The name of the provider
- The date the service was incurred
- The amount of the expense

DEBIT CARD

The debit card deducts each claim payment directly from your FSA account. It is as convenient as using an ordinary credit card, reducing paperwork and eliminating reimbursement wait time.

Reimbursement requests are processed on a daily basis. The debit card can be used to pay for eligible expenses at clinics, optometrists, dentists and pharmacies (including approved over-the-counter medications). With this card, a dependent of the Participant (spouse, adult child, etc.) can draw funds from the Participant's account to pay for eligible expenses. **Please keep all receipts as they may be requested from time to time to validate debit card charges.**

FLEXIBLE SPENDING ACCOUNTS

(FLEXIBLE SPENDING ACCOUNT)

FSA ELIGIBLE EXPENSES



ELIGIBLE EXPENSE EXAMPLES

There are thousands of eligible expenses for tax-free purchase with your account funds, including prescriptions, doctor's office copays, health insurance deductibles, and coinsurance. Many over-the-counter (OTC) treatments are also eligible.

- ✓ Acupuncture
- ✓ Alcoholism treatment
- ✓ Ambulance
- ✓ Artificial limb
- ✓ Birth control pills
- ✓ Blood pressure monitoring device
- ✓ Breast pumps and related supplies
- ✓ Chiropractic care
- ✓ Contact lenses and related materials
- ✓ Dental treatment
- ✓ Dentures
- ✓ Diagnostic services
- ✓ Drug addiction treatment
- ✓ Eye examination, eye glasses, and reading glasses
- ✓ Family planning items
- ✓ Fertility treatment
- ✓ Flu shot
- ✓ Hearing aids
- ✓ Hospital services
- ✓ Immunization
- ✓ Insulin and diabetic supplies
- ✓ Laboratory fees
- ✓ Laser eye surgery
- ✓ Medical testing devices
- ✓ Menstrual care products
- ✓ Nursing services
- ✓ Obstetrical expenses
- ✓ Orthodontia (not for cosmetic reasons)
- ✓ Over-the-counter (OTC) treatments containing medicine—cold treatments, ointments, pain relievers, stomach remedies, etc.
- ✓ Over-the-counter (OTC) treatments without medicine—bandages, wraps, medical testing devices, etc.
- ✓ Oxygen
- ✓ Physical exam
- ✓ Physical therapy
- ✓ Prescription drugs
- ✓ Psychiatric care
- ✓ Smoking cessation program and medications
- ✓ Surgery
- ✓ Sunscreen & sun block (SPF 15+, broad spectrum)
- ✓ Transportation for medical care
- ✓ Weight loss program necessary to treat a specific medical condition
- ✓ Wheelchair, walkers, crutches, and canes

INELIGIBLE EXPENSE EXAMPLES

These items are not generally eligible for tax-free purchase with your account funds.

- ✗ Concierge service fees (billed for future services; no treatment provided)
- ✗ Cosmetics and cosmetic surgery
- ✗ Deodorant
- ✗ Exercise equipment
- ✗ Fitness programs
- ✗ Funeral expenses
- ✗ Hair transplants
- ✗ Household help
- ✗ Illegal operations and treatments
- ✗ Maternity clothes
- ✗ Teeth whitening

DUAL PURPOSE ITEMS

Items that can be used for a medical purpose or for general health and well-being are considered "dual purpose" and are eligible only with a prescription, doctor's directive or letter of medical necessity. Examples include:

- ✓ Dietary and weight loss supplements
- ✓ Fiber supplements
- ✓ Orthopedic shoes and inserts
- ✓ Snoring cessation aids
- ✓ Vitamins and herbal supplements

Shop online for FSA-eligible products: <https://fsastore.com/>



LIFE/AD&D BENEFITS

Basic Term Life

Creative Foam provides Basic Term Life and AD&D insurance benefits to all eligible employees through **Prudential** at no cost to you. The Basic Life benefit is payable to your beneficiary at the time of your death. The amount of coverage is \$50,000. The amount of AD&D coverage is the same as your Basic Life amount. Please see the certificate for exclusions. Contact your Human Resource representative to obtain more information on this important benefit.

Beneficiary Designation:

It is important that you confirm/update your Beneficiary Designation. Your beneficiary may be updated at any point based on your request. If you intend to name a minor as beneficiary, carriers recommend that you establish a trust.

Disability Insurance

All eligible employees are provided with short- and long-term disability coverages to protect their income in the event of disability. The short-term disability coverage is self-funded by Creative Foam. The long-term disability coverage is provided through an insurance policy issued by **Prudential**.

Short-Term Disability

A short-term illness or injury, although not necessarily serious, can still prevent you from working for a period of time. Should this happen, the short-term disability plan (STD) will replace a portion of your lost income. Please contact your local Human Resources representative for more information related to this plan.

Long-Term Disability

A catastrophic illness or injury can prevent you from working for months or even years. Should this happen, the long-term disability plan (LTD) will replace a portion of your lost income following the completion of an Elimination Period. The monthly benefit amount is:

66 2/3% of Base Monthly Earnings
\$6,000 Monthly Maximum

Benefits are payable following the completion of a 180-day elimination period.

Elections:

No election is required as this coverage is automatically provided to you following the completion of your new hire waiting period.

Contributions:

Creative Foam provides this coverage at no cost to you.

Policy Provisions and Exclusions:

Please refer to the carrier certificate for full details on all policy provisions, including any applicable exclusions. The information included above is provided only as a brief summary.

Gallagher's Alternative Health Solutions

We're Alternative Health Solutions, Your Medicare Advisors

Offering a no-cost consulting service to Medicare eligible employees and retirees to review coverage options.

FIND THE BEST PLAN IN 4 STEPS

1

Meet Your Advisor

Contact us to schedule your free one-on-one consultation.

2

Learn About Medicare

Discuss your insurance needs and enrollment status.

3

Explore Your Options

Choose the right coverage plan for you.

4

Choose Your Coverage

Sign up for your Medicare plan and start receiving benefits.

Let's Find the Right Coverage for Your Needs

Employer-Sponsored Coverage

Health coverage that's offered through you or your spouse's employer. Usually offered to active staff of the company, federal laws allow you to extend employer coverage from 18–36 months after employment.

Original Medicare: Parts A and B

The most essential element of Medicare, Part A covers inpatient care and skilled nursing facilities. Part B focuses on outpatient and preventative services.

Medicare Part C

Also known as the Medicare Advantage Plan, Part C combines the coverage of other Parts of Medicare in a comprehensive, privately offered package.

Medicare Part D

Medicare Part D covers prescription drugs, giving you peace of mind about your medication expenses.

Medicare Supplements

Medicare supplements are insurance plans that fill the gaps in your Medicare coverage — like co-payments, coinsurance, and deductibles.

Plans Are Ready for Review

Alternative Health Solutions is your trusted partner to educate and answer questions around coverage options.

[AJG.com](https://www.ajg.com)

The Gallagher Way. Since 1927.

We do not offer every plan available in your area. Currently, we represent 7 organizations that offer over 200 products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options.

Consulting and insurance brokerage services to be provided by Gallagher Benefit Services, Inc. and/or its affiliate Gallagher Benefit Services (Canada) Group Inc. Gallagher Benefit Services, Inc. is a licensed insurance agency that does business in California as "Gallagher Benefit Services of California Insurance Services" and in Massachusetts as "Gallagher Benefit Insurance Services." Neither Arthur J. Gallagher & Co., nor its affiliates provide accounting, legal or tax advice.

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Contact Alternative Health Solutions:

[AHS.AJG.com/AP-LV-NCA](https://www.AHS.AJG.com/AP-LV-NCA)
(833) 200-9676

EMPLOYEE ASSISTANCE PROGRAM

GuidanceResources®



An Overview of Your GuidanceResources® Program

No matter what's going on in your life, GuidanceResources® is here to help.

Personal problems, planning for life events or simply managing daily life can affect your work, health and family. GuidanceResources is a company-sponsored service that is available to you and your dependents, at no cost, to provide confidential support, resources and information to get through life's challenges. This flyer explains how GuidanceResources can help you.

Confidential Counseling on Personal Issues

Your Employee Assistance Program (EAP) is a confidential assistance program to help address the personal issues you and your dependents are facing. This service, staffed by experienced clinicians, is available by phone 24 hours a day, seven days a week. A GuidanceConsultant™ is available to listen to your concerns and refer you to a local provider for in-person counseling or to resources in your community. Call any time with personal concerns, including:

- Depression
- Marital and family conflicts
- Job pressures
- Stress and anxiety
- Alcohol and drug abuse
- Grief and loss

Financial Information, Resources and Tools

Financial issues can arise at any time, from dealing with debt to saving for college. Our financial professionals are here to discuss your concerns and provide you with the tools and information you need to address your finances, including:

- Saving for college
- Getting out of debt
- Retirement planning
- Tax questions
- Estate planning

Legal Information, Resources and Consultation

When a legal issue arises, our attorneys are available to provide confidential support with practical, understandable information and assistance. If you require representation, you can also be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call any time with legal issues including:

- Divorce and family law
- Debt obligations
- Landlord and tenant issues
- Real estate transactions
- Bankruptcy
- Criminal actions
- Civil lawsuits
- Contracts

Online Information, Tools and Services

GuidanceResources® Online is your one stop for expert information to assist you with the issues that matter to you, from personal or family concerns to legal and financial concerns. Create your own account by going to www.guidanceresources.com. Each time you return to the site, you will find personalized, relevant information based on your individual life needs. You can:

- Review in-depth HelpSheetsSM on topics you select
- Get answers to specific questions
- Search for services and referrals
- Use helpful planning tools

**WE ARE AVAILABLE 24 HOURS A DAY,
7 DAYS A WEEK.**

Call: 800.311.4327

TDD: 800.697.0353

Online: guidanceresources.com

Your company Web ID: GEN311

401K PROGRAM

Creative Foam Corporation has automatic enrollment and automatic escalation features within our 401(k) program.

All new employees who have met eligibility requirements are automatically enrolled in the plan with a 5% payroll deduction. This deduction will begin 30 days after employment and will be contributed into your 401(k) account.

Each year on the anniversary of your hire date, your contribution to your account will automatically increase by 1% until you have reached the automatic escalation cap of 10%. You can always choose to increase above that if you wish.

The company match also begins after 30 days of employment. The company match is 50 cents for every dollar of employee contribution up to 5%. Match funds are 100% vested once one year of service is reached.

A Roth option will be added to our 401K program effective 1/1/2026.

You may choose to opt out of the program, lower your contribution, or raise your contribution at any time. The maximum per pay contribution allowed is 75%. To make any changes or to opt out, please contact Empower Retirement by one of the two ways listed below.

Please contact Human Resources with any questions.

Empower Contact Information

Online at <http://empowermyretirement.com/>

by phone at 855-756-4738

Creative Foam Plan Number: 523826-01



Dr. Peter T. Swallow Founder's Education Fund

The late Dr. Peter T. Swallow (our company founder) was passionate about the importance of education. So much so, that he set up a corporate scholarship fund to help support the continuing education of Creative Foam family members.

Applications are distributed in February of each year.

Eligible Applicants must be:

- Dependent children* or dependent grandchildren** of full time Creative Foam employees who have a minimum of six (6) months of employment with the company as of the application deadline date
 - *Dependent children are defined as biological, stepchildren or legally adopted children living in the employee's household or primarily supported by the employee.
 - **Dependent grandchildren are defined as grandchildren living in the employee's household and primarily supported by the employee.
- High school seniors or graduates who plan to enroll or students who are already enrolled in full-time undergraduate study at an accredited two-year or four-year college, university, or vocational-technical school for the entire upcoming academic year

~Dependents of executive level employees are not eligible.

~Dependents who are also employees of Creative Foam are not eligible to apply.

EMPLOYEE DISCOUNTS



Car Rental Discounts

Enterprise	Discount Code: XZ20203
National	Discount Code: XZ20203
Budget	Discount Code: U289410
Avis	AWD# Q301386

Vehicle Purchase Discounts

Stellantis	FORD
<p>Supplier number: S 27698 www.FCAUSaffiliates.com 1-888-444-4321 Online form for applicant to complete</p>	<p>Supplier number: C 864 A fordpartner.com Online form for applicant to complete</p>
GM	VW
<p>Company code: 801801 gmsupplierdiscount.com Obtain your personal authorization number and take it to your GM dealer to receive your vehicle discount</p>	<p>Partner program: 6369PC www.vwpartnerprogram.com</p> <ul style="list-style-type: none"> • Enter the partner program #, your name, and email address • Click “get certificate” • Take certificate and a copy of your recent paystub to local VW Dealer

Cellular Service Discounts

AT&T	VERIZON
<ul style="list-style-type: none"> • Save 18% on qualifying Mobile Share Value Plans • Share monthly data allowance with smartphones, tablets, laptops, and more • Unlimited Talk & Text for all phones • Visit in store or online: att.com/wireless/creativefoam • Proof of eligibility: employee badge or paystub • Mention FAN: 2486398 	<ul style="list-style-type: none"> • Save 19% on monthly access fees • Visit in store or online: www.verizonwireless.com/discounts • Proof of eligibility: recent paystub or Creative Foam email address
	



YOUR RIGHT TO KNOW

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Blue Cross Blue Shield of Michigan PPO \$1,500 (Individual: 80% coinsurance and \$1,500 deductible; Family: 80% coinsurance and \$3,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 810.936.2134 or mlbaldwin@creativefoam.com.

ACA Nondiscrimination

This group health plan does not discriminate on the basis of race, color, national origin, sex, age, or disability.

YOUR RIGHT TO KNOW

HIPAA Special Enrollment Rights

Creative Foam Corporation Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Creative Foam Corporation Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Melissa Baldwin - Benefits Manager at 810.936.2134 or mlbaldwin@creativefoam.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

YOUR RIGHT TO KNOW

Notice Regarding Wellness Program

Creative Foam Corporation is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees of Creative Foam Corporation. Contact Human Resources if you have any questions as to how to earn the wellness credit.

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Creative Foam Corporation is committed to the privacy of your health information. The administrators of the Creative Foam Corporation Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Melissa Baldwin - Benefits Manager at 810.936.2134 or mlbaldwin@creativefoam.com.

NOTICE OF CREDITABLE COVERAGE

Important Notice from Creative Foam Corporation

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Creative Foam Corporation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Creative Foam Corporation has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Plan coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current Plan coverage, be aware that you and your dependents will be able to get this coverage back at a future open enrollment.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Creative Foam Corporation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Creative Foam Corporation changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 1, 2025
Name of Entity/Sender:	Creative Foam Corporation
Contact—Position/Office:	Melissa Baldwin - Benefits Manager
Office Address:	300 N Alloy Dr Fenton, Michigan 48430-2648 United States
Phone Number:	810.936.2134

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Creative Foam – Dowagiac Union
Community Blue PPOSM ASC

Coverage for: Individual/Family | Plan Type: PPO



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

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

Important Questions	Answers		Why this Matters:
	In-Network	Out-of-Network	
What is the overall <u>deductible</u> ?	\$1,500 Individual/ \$3,000 Family	\$3,000 Individual/ \$6,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .		This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.		You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? (May include a <u>coinsurance</u> maximum)	\$3,000 Individual/ \$6,000 Family for medical coverage. \$2,000 Individual/ \$4,000 Family for prescription drug coverage	\$6,000 Individual/ \$12,000 Family for medical coverage. \$2,000 Individual/ \$4,000 Family for prescription drug coverage	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, any <u>pharmacy</u> penalty and health care this <u>plan</u> doesn't cover.		Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsm.com or call the number on the back of your BCBSM ID card for a list of <u>network providers</u> .		This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copay/office visit; deductible does not apply	40% coinsurance	None
	Specialist visit	\$50 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	May require preauthorization
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsm.com/druglists	Generic or select prescribed over-the-counter drugs	\$10 copay/prescription for retail 30-day supply; \$20 copay/prescription for mail order 90-day supply; deductible does not apply	In-Network copay; deductible does not apply	
	Preferred brand-name drugs	\$40 copay/prescription for retail 30-day supply; \$80 copay/prescription for mail order 90-day supply; deductible does not apply	In-Network copay; deductible does not apply	Preauthorization, step therapy and quantity limits may apply to select drugs. Preventive drugs covered in full. 90-day supply not covered out of network. Select diabetic supplies and devices may be covered under the prescription drug program.
	Nonpreferred brand-name drugs	\$80 copay/prescription for retail 30-day supply; \$160 copay/prescription for mail order 90-day supply; deductible does not apply	In-Network copay; deductible does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty Drugs	25% <u>coinsurance</u> of the approved amount, but no more than \$500 <u>copay</u> /prescription for retail 30-day supply; <u>deductible</u> does not apply	In-Network <u>copay</u> ; <u>deductible</u> does not apply	<u>Preauthorization</u> is required. <u>Specialty drugs</u> limited to a 15 or 30-day supply. Pharmacy <u>Specialty drugs</u> obtained from other than an <u>Exclusive Specialty Pharmacy Network provider</u> will not be covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay</u> /visit; <u>deductible</u> does not apply	\$250 <u>copay</u> /visit; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted or for an accidental injury.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Mileage limits apply
	<u>Urgent care</u>	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required
If you have a hospital stay	Physician/surgeon fee	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need behavioral health services (mental health and substance use disorder)	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u> for mental health; 40% <u>coinsurance</u> for substance use disorder	Your cost share may be different for services performed in an office setting
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	Prenatal: No Charge; <u>deductible</u> does not apply Postnatal: No Charge; <u>deductible</u> does not apply	Prenatal: 40% <u>coinsurance</u> Postnatal: 40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) and depending on the type of services <u>cost share</u> may apply. <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization is required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Habilitation services</u>	Not covered for Applied Behavioral Analysis; Not covered for Physical, Speech and Occupational Therapy	Not covered for Applied Behavioral Analysis; Not covered for Physical, Speech and Occupational Therapy	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization is required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Excludes bath, exercise and deluxe equipment and comfort and convenience items. Prescription required.
If your child needs dental or eye care For more information on pediatric vision or dental, contact your plan administrator	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Physician certification required. Visit limits apply.
	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)	
• Acupuncture treatment	• Infertility treatment
• Cosmetic surgery	• Long term care
• Dental care (Adult)	• Private-duty nursing
• Hearing aids	• Routine eye care (Adult)
	• Routine foot care
	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Bariatric surgery	• Coverage provided outside the United States. See http://provider.bcbs.com
• Chiropractic care	• Non-emergency care when traveling outside the U.S

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

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet Minimum Value Standards? Yes

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

Language Access Services: See Addendum

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

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

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost \$12,700

In this example, Peg would pay:

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

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

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

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost \$5,600

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

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

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic tests (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost \$2,800

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$70
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,670

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



This benefit summary prepared by



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