



DEARBORN SCHOOLS EMPLOYEE
HEALTHCARE PROGRAM
DFT - DEARBORN FEDERATION OF TEACHERS
DSE - DEARBORN FEDERATION OF SCHOOL EMPLOYEES
ADSA - ASSOCIATION OF DEARBORN SCHOOL ADMINISTRATORS
DSOEA - DEARBORN SCHOOLS OPERATING ENGINEERS ASSOCIATION



2017-18

EMPLOYEE BENEFITS GUIDE

July 1, 2017 - June 30, 2018

Medicare Part D Prescription Drug Information

If you have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage.

Please see page 22 for more details.

Open Enrollment Process

Open Enrollment for making insurance benefit changes will be from May 1st through May 22nd.

All employees will be required to enroll in coverage by making an election for benefits. Your current Medical, Dental, Vision and FSA elections will **not** be rolled over into the new plan year and you must make an election during the Open Enrollment period in order for your benefits to continue to be effective for the new plan year. Your voluntary elections will rollover.

You have three different methods to enroll:

- Online
- Over the Phone
- Onsite Enrollment

Instructions for these three enrollment methods are on page 3 of this newsletter.

Remember that the choices you make now will be effective July 1, 2017 and will remain in effect until June 30, 2018 unless you experience a qualified special enrollment event.

If you do not make an election for benefits by May 22, 2017, your benefit coverage for Medical, Dental and Vision will be terminated effective June 30, 2017.

For those waiving coverage, you still need to make a benefit election indicating you are waiving coverage. Failure to make an election waiving coverage will make you ineligible for Cash in Lieu (if applicable).

Overview of Benefit Changes

The following changes will be effective July 1, 2017.

Medical

\$150/ \$300 Deductible / Rx Copay Changes
New employee contributions

Dental

No Change

Vision

No Change



Voluntary Offering—Current Elections will roll over!

Voluntary Term Life
Voluntary Accident coverage
Voluntary Critical Illness coverage
Voluntary Short Term Disability

Flexible Spending Account (FSA) - No change!

Eligibility

- Employee's spouse by legal marriage if recognized under the laws of the employee's state of domicile, including any same sex marriages.
- Dependent children are eligible for coverage until the end of the month in which they turn 26.

Inside this Issue.....

Open Enrollment Process.....	2-3	Guardian Voluntary Coverage.....	11-18
Employee Contributions.....	4	Your Rights Under Federal Law	19-21
Medical & RX Overview	4-5	Medicare Part D Notice.....	22
Dental Benefits.....	6-7	COBRA Notice.....	23-25
Vision Benefits.....	8	Appendix SBCs.....	26-34
Cash in Lieu	9	Benefit Resources	35
Flexible Spending Accounts.....	10		

Open Enrollment Process

Benefit Enrollment Instructions Effective Monday, May 1, 2017



ONLINE ENROLLMENT SYSTEM:

To access your benefits online, go to: www.nextgenerationenrollment.com/nge/login anytime.

Enter your username. Your username is the first initial of your first name, the first six characters of your last name, and the last four digits of your Social Security number. *For example, if your name is John Williams, and the last four digits of your Social Security number are 1234, your username will look like this: jwillia1234.*

Enter your password. Your password is your date of birth in a number format without any punctuation, starting with the year you were born, then the month and then the date (YYYYMMDD). *For example, if your date of birth is January 5, 1970, your password will look like this: 19700105.*

Once you have logged in, you will be prompted to change your password.

OVER THE PHONE:

If you prefer to speak directly to a representative in the Benefit Center who will assist you in making your elections and with technical support, please call the Benefit Center at **(888) 222-4309**. Representatives are available between the hours of 8 a.m. and 11 p.m. EST, Monday through Friday.

When you call, the Benefit Center will ask you to verify the last four digits of your Social Security number and your date of birth. From that point, the representative will walk you through your personal information on file to confirm its accuracy. Please be prepared to first provide verbal authorization if you would like your spouse to speak with a representative on your behalf.

ONSITE ENROLLMENT:

If you prefer to enroll online yourself but would like personal assistance using the new system, please call **888-222-4309** to make an appointment. The office is located at:

**15250 Mercantile Dr.
Dearborn, MI 48120**

Please remember that Open Enrollment will end at midnight on May 22, 2017.

**[If you do not make an election for benefits by May 22, 2017,
your benefit coverage for Medical, Dental and Vision will be terminated
effective June 30, 2017.](#)**

Medical & RX

Below is an overview of the copays effective July 1st. A full benefit summary is available on page 5 and a detailed Summary of Benefits and Coverage is available starting on page 24.

Benefit	Service Type	
Medical	Deductible	\$150 single / \$300 Family
	PHP/MHSA Visit	\$20
	Specialist	\$30
	Urgent Care	\$40
	Emergency Room	\$200
Prescription	Generic	\$15
	Preferred	\$30
	Non-Preferred	\$60



Employee Contributions

Below is your employee contribution towards the medical, dental and vision plans. Contributions are based on full time status. Additional cost share will apply for less than full time status.

Election	Medical	Dental	Vision	Cash in Lieu*
Single	\$21.00 Per 20 Pays \$35.00 Per Month	\$0.00	\$0.00	\$30.00 Per 20 Pays \$50.00 Per Month
Two Person	\$42.00 Per 20 Pays \$70.00 Per Month	\$0.00	\$0.00	\$57.00 Per 20 Pays \$95.00 Per Month
Family	\$63.00 Per 20 Pays \$105.00 Per Month	\$0.00	\$0.00	\$75.00 Per 20 Pays \$125.00 Per Month

* In order to receive Cash in Lieu you will be required to show proof of other coverage on an annual basis.



Medical & RX Summary



Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
 Summary of Benefits

AA000775 / XR000929 / ALT 5

Health Care Services	Coverage	Limitations*
Benefit Period, Annual Deductible, and Annual Co-insurance Maximum:		
Benefit Period:	Calendar Year	
Annual Deductible	\$150 Individual ; \$300 Family	
Co-insurance (amount member pays)	None	
Annual Co-insurance Maximum	N/A	
Annual Out-of-Pocket Maximum	\$6,600 Individual ; \$13,200 Family	These values do not accumulate. Premiums, balance-billed charges, health care this plan doesn't cover. All other cost-sharing accumulates.
Preventive Services:		
Preventive Office Visit / Physical Exam	Covered - Deductible does not apply	
Well Baby Office Visit	Covered - Deductible does not apply	
Routine Hearing Exam	Covered - Deductible does not apply	
Routine Eye Exam	Covered - Deductible does not apply	
Immunizations	Covered - Deductible does not apply	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	
Pap Smears and Mammograms	Covered - Deductible does not apply	
Outpatient & Physician Services:		
Personal Care Physician Office Visit	\$20 Copay - Deductible does not apply	Visits are face-to-face, telephonic, or through secure electronic portal
Specialty Physician Office Visit	\$30 Copay - Deductible does not apply	
Gynecology Office Visit	\$30 Copay - Deductible does not apply	
Audiology Office Visit	\$30 Copay - Deductible does not apply	
Eye Exam Office Visit	\$30 Copay - Deductible does not apply	
Allergy Treatment and Injections	Covered after Deductible	
Laboratory and Radiology Services	Covered after Deductible	
Dialysis	Covered after Deductible	
Chemotherapy	Covered after Deductible	
Radiation Therapy	Covered after Deductible	
Outpatient Surgery	Covered after Deductible	
Chiropractic Office Visit and Related Services	\$30 Copay - Deductible does not apply	Up to 35 visits per benefit period
Emergency/Urgent Care:		
Emergency Room Services	\$200 Copay - Deductible does not apply	Copay will be waived if admitted
Urgent Care Facility Services	\$40 Copay - Deductible does not apply	
Emergency Ambulance Services	Covered after Deductible	Emergency transport only
Inpatient Hospital Services:		
Hospital Inpatient Stay in Semi-Private Room, Specialty Units as medically necessary, Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after Deductible	
Bariatric Surgery & Related Services	\$1,000 Copay after Deductible	One procedure per lifetime
Maternity Services:		
Initial Prenatal Office Visit	Covered - Deductible does not apply	Covered under Preventive Services
Subsequent Prenatal Office Visits	Covered - Deductible does not apply	Covered under Preventive Services
Postnatal Office Visits	\$30 Copay - Deductible does not apply	
Labor, Delivery and Newborn Care	Covered after Deductible	
Mental /Behavioral Health:		
Inpatient Services	Covered after Deductible	
Outpatient Services	\$20 Copay - Deductible does not apply	
Substance Use Disorder:		
Inpatient Services	Covered after Deductible	
Outpatient Services	\$20 Copay - Deductible does not apply	
Other Services:		
Home Health Care	Covered after Deductible	Unlimited
Hospice Care	Covered after Deductible	Up to 210 days per lifetime
Skilled Nursing Care	Covered after Deductible	Covered for authorized services - Up to 100 days per benefit period
Durable Medical Equipment, Prosthetics & Orthotics	Covered after Deductible	Coverage provided for approved equipment based on HAP's guidelines
Hearing Aid Hardware	Covered after Deductible	Covered for authorized equipment
Vision Hardware	Not Covered	
Physical, Occupational, and Speech Therapy (PT/OT/ST)	Covered after Deductible	Up to 60 combined visits per benefit period - May be rendered at home
Voluntary Sterilizations	Women: Covered Men: Covered after Deductible	Adult sterilization procedures are limited to vasectomy and tubal ligation whose sole intent is to prevent conception. Women: Covered as Preventive Service
Voluntary Termination of Pregnancy	Not Covered	
Infertility Services	Plan Pays 50% after Deductible	Services for diagnosis, counseling, and treatment of anatomical disorders causing infertility in accordance with HAP's benefit, referral and practice policies
Assisted Reproductive Technologies	Not Covered	
Pharmacy:		
Generic / Preferred Brand / Non-Preferred Brand	\$15 / \$30 / \$60 Copay - Deductible does not apply	Retail: 30 day supply for non-maintenance drugs at 1 Copay; 90 day supply for eligible maintenance drugs at 2 Copays Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 Copays

Value Plus

Rev 05/2012

Benefit Riders: K60,J05,317,313,272,203,124,073,013,012,MHE,MHP,L05,496

- * Hospital admissions require that HAP be notified within 48 hours of admission. Failure to notify HAP within 48 hours could result in a reduction of benefits, or nonpayment.
- * Students away at school are covered for acute illness and injury related services according to HAP criteria. Students away at school are not covered for routine physicals, non-emergency psychiatric care, elective surgeries, obstetrical care, sports medicine and vision care services while at school.
- * In cases of conflict between this summary and your HMO Subscriber Contract, the terms and conditions of the HMO Subscriber Contract govern.
- * Your employer may have determined that your benefit plan may or may not be grandfathered under health care reform legislation. If you have questions regarding grandfathering, please check with your employer.

Dental Benefits

The dental plan is through Delta Dental. The dental plan and benefits are not changing. Please note that your dental enrollment election is separate from your medical enrollment election. Here's a summary of plan provisions:



**Delta Dental PPO (Standard)
Summary of Dental Plan Benefits
For Group# 2980-0001, 0002, 0003, 0004, 0005, 0006, 0007, 9991, 9992, 9993, 9994,
9995, 9996, 9997
Dearborn Schools Employee Healthcare Program (DSEHP)**

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays*	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	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			
Minor Restorative Services – fillings and crown repair	80%	80%	80%
Endodontic Services – root canals	80%	80%	80%
Periodontic Services – to treat gum disease	80%	80%	80%
Oral Surgery Services – extractions and dental surgery	80%	80%	80%
Other Basic Services – misc. services	80%	80%	80%
Relines and Repairs – to bridges, implants, and dentures	80%	80%	80%
Major Services			
Major Restorative Services – crowns	50%	50%	50%
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	Up to age 19	Up to age 19	Up to age 19

* When services are received from a Premier or Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's PPO Dentist Schedule (or the Nonparticipating Dentist Fee) that will be paid for those services. This amount may be less than what the dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Two prophylaxes (cleanings) are payable per calendar year. Two additional prophylaxes are payable per calendar year for individuals with a documented history of periodontal disease. Full mouth debridement is payable once in any seven-year period.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable once per calendar year for people up to age 19.

Dental Benefits

- Space maintainers are payable once per area per lifetime for people up to age 16.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any seven-year period.
- Sealants are payable once per tooth per three-year period for the occlusal surface of first and second permanent molars up to age 19. The surface must be free from decay and restorations.
- Crowns, onlays and substructures are payable once per tooth in any seven-year period.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Metallic inlays are Covered Services.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Certain oral surgery procedures including vestibuloplasty, frenulectomy, frenuloplasty, tooth transplantation, oroantral fistula closure and treatment of alveolus fractures are Covered Services.
- Full and partial dentures are payable once in any seven-year period.
- Bridges and substructures are payable once in any seven-year period.
- Implants and implant related services are payable once per tooth in any seven-year period.
- Occlusal guards are payable once in any five-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – \$1,000 per person total per Benefit Year on all services, except cephalometric film, photos, diagnostic casts, and orthodontics. \$1,000 per person total per lifetime on cephalometric film, photos, diagnostic casts, and orthodontic services.

Deductible – \$25 Deductible per person total per Benefit Year limited to a maximum Deductible of \$50 per family per Benefit Year. The Deductible does not apply to orthodontic services.

Waiting Period – Per Collective Bargaining Agreement.

Eligible People – Per Collective Bargaining Agreement. The Contractor pays the full cost of this plan.

Also eligible are your legal spouse and your children to the end of the month in which they turn 26, including your children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled.

If you and your spouse are both eligible under this Contract, you may be enrolled as both a Subscriber on your own application and as a dependent on your spouse's application. Your dependent children may be enrolled on both applications as well. Delta Dental will coordinate benefits.

Benefits will cease on the last day of the month in which the employee is terminated.



Customer Service Toll-Free Number: (800) 524-0149
www.DeltaDentalMI.com
July 1, 2015

Vision Benefits

The vision plan is with NVA. Please note that your vision enrollment election is separate from your medical enrollment election. Below is an overview of the schedule of benefits.



PROPOSED SCHEDULE OF BENEFITS – DEARBORN / MICHIGAN

FIXED RATE INSURED PLAN DESIGN – OPTION 1

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
EXAMINATION Once Every 12 Months	Covered 100% After \$6 Copay	(Reimbursed Amounts) Up to \$45
LENSES Once Every 12 Months	Standard Glass or Plastic Covered 100% After \$12 Copay	Single Vision Up to \$30 Bi-focal Up to \$50 Tri-focal Up to \$65 Lenticular Up to \$80
LENS OPTIONS		
Fashion Gradient Tint	Covered 100%	N/A
Solid Tints	Covered 100%	N/A
Glass Photogrey	Covered 100%	N/A
Polycarbonate - Under age 19	Covered 100%	N/A
Transitions	Covered 100%	N/A
FRAME Once Every 12 Months	Covered up to \$50 Retail Allowance ³ (20% discount off remaining balance over \$50 allowance) ⁴	Up to \$38
CONTACT LENSES Once Every 12 Months	(In lieu of Lenses)	(In lieu of Lenses)
ELECTIVE ¹	Covered up to \$90 Retail Allowance ⁵ (15% discount (Conventional) or 10% discount (Disposable) off remaining balance over \$90) ⁶	Up to \$75
MEDICALLY NECESSARY ²	Covered 100%	\$220

¹Fitting & Follow-Up Fees are deducted from the Contact Lens Allowance shown above unless otherwise specified.

²Prior Authorization required from NVA

³Includes frames up to \$16 Every Day Low Price-price point at Walmart/Sam's Club locations (if included in the network).

⁴Discount does not apply at Walmart/Sam's Club locations or for certain proprietary frame brands.

⁵\$63 Every Day Low Price-price point for contact lenses at Walmart/Sam's Club locations (if included in the network).

⁶Discount does not apply at Walmart/Sam's Club locations, Cole corporate locations (if applicable) or Contact Fill.

NOTE: If covered participants choose extra options, they are responsible for the additional cost of the options paid directly to the ECP

Cash in Lieu

If you chose to decline the medical plan offered by DSEHP, you may elect to receive a credit in lieu of coverage (see page 4 for payment schedule). In order to receive the cash in lieu credit, you must meet the credentials below. By electing into the cash in lieu option, you are acknowledging that you understand you will only be allowed to change your election during the next open enrollment period or during a qualified event.

This credit is earned monthly and paid each qualifying payroll, only if the following are true:

1. You are a full-time employee, as defined by the District, for the current school year
2. Your spouse is not employed by the District
3. You provide proof that you have medical coverage through another source

NOTE: You **MUST** provide proof of other coverage in order to receive the cash in lieu credit. You will need to provide this documentation to the DSEHP Benefit Center **within 30 days** of open enrollment closing or by July 1st. You can reach the DSEHP Benefit Center via phone by calling (888) 222-4309. Documentation can be submitted as follows:

1. Fax to (888) 277—4146
2. Email to dsehp@ngeinfo.com
3. In person at: 15250 Mercantile Drive, Dearborn MI 48120

You will NOT receive the opt out credit until documentation is received by the DSEHP Benefit Center.

If you have questions regarding the cash in lieu benefit, please contact the DSEHP Benefit Center at (888) 222-4309 Monday through Friday 8 am to 11 pm EST.



Flexible Spending Accounts (FSA)

As you know, health care and day care expenses can really add up. Flexible Spending Accounts give you a way to pay for these expenses with tax-free dollars. Because you bypass taxes, you save money.

There are two types of accounts:

- ◆ **Health Care Flexible Spending Account—Up to a \$2,550 annual election**
- ◆ **Dependent Care Flexible Spending Account—Up to a \$5,000 annual election**

You may choose to participate in one or both of these options, depending on your individual needs.

Flexible Spending Accounts allow you to save money because your contributions to the accounts are deducted from your pay before Federal and Social Security taxes are calculated. The amount of savings you will enjoy by participating in a Flexible Spending Account will depend on your individual tax bracket and the amount of money that is withheld from your paycheck on a tax-free basis.

The Health Care Flexible Spending Account is designed to help you pay for health expenses that are not covered by your basic health plans, including deductible amounts you have to pay and copays or co-insurance amounts required by your insurance plans. Eligible expenses also include many expenses that may not be covered by your vision or dental plan.

The Dependent Care Flexible Spending Account is similar to the Health Care Flexible Spending Account; it allows you to pay for eligible dependent day care expenses with pre-tax dollars. To decide whether a Dependent Care Flexible Spending Account is right for you, determine if you will incur eligible expenses. Generally, child and elder care companion services are eligible expenses, as are Social Security and other taxes you pay as a caregiver.

Detailed information can be found on the Next Generation website about both of these plan options.

Any question about these accounts can be directed to Next Generation Enrollment at:

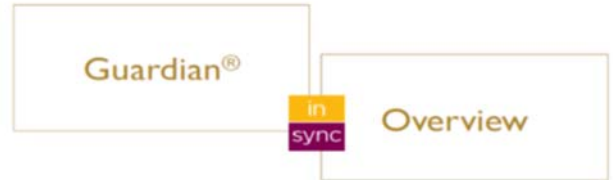
888-222-4309 or www.nextgenerationenrollment.com



Voluntary Options

Dearborn Schools Employee Healthcare Program

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer provided benefits or our Collective Bargaining Agreement.



Great News! Your benefits plan includes four products: Voluntary Life, Short Term Disability, Critical Illness, and Accident Insurance. Below is a brief description of the benefits these products can provide you and your family.

Voluntary Life Insurance: protect your family and finances

Guardian Life Insurance helps provide financial protection for your family and loved ones. If something were to happen to you, life insurance would provide money so that your family and your loved ones can continue to manage expenses if you were no longer around. Consider your living expenses such as mortgage payments, legal or medical fees, childcare, college education, and outstanding debts.



Short Term Disability Insurance: because illness and injury could leave you without a paycheck.

Although you may have life and medical insurance, neither one compensates you if you need to be out of work due to an illness or serious injury. That's why Guardian Short Term Disability Insurance adds value to any benefits package. It's the perfect complement to your existing benefits and can help cover expenses such as physical therapy, child care, spousal care giving, and travel to treatment centers.



Critical Illness Insurance: helping you focus on recovery — not your finances

Treatment of critical illnesses such as cancer, heart attack and stroke can lead to unexpected expenses that create an additional financial burden. Guardian Critical Illness Insurance can help you pay for travel to treatment centers, ongoing household bills, co-pays for experimental treatment, and everyday expenses like groceries, rent and mortgage.



Accidents happen. Fortunately, we can help with unexpected expenses

Guardian Accident Insurance helps offset the costs associated with both minor and major accidents. For every covered accident, Guardian can pay a benefit based on the injury you or your spouse/children sustain and the various treatments and/or services received, regardless of what is covered by medical insurance. Payments are made directly to you and can be used for any purpose — even your everyday expenses like food, rent and utilities.



If you waived these coverages when they were initially offered to you, you can elect them during this year's Annual Enrollment. You may be asked to satisfy Evidence of Insurability.



Products are underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Some products may not be available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Documents are the final arbiter of coverage. Accident Ins. Policy Form #GP-1-AC-IC-12, Critical Illness Ins. Policy Form #GC-CI-11, STD Ins. Policy Form # GP-1-STD07-1.0, Life Ins. Policy Form #GP-1-R-EPOPT-96.

File #2016-27779 Exp. 8/18

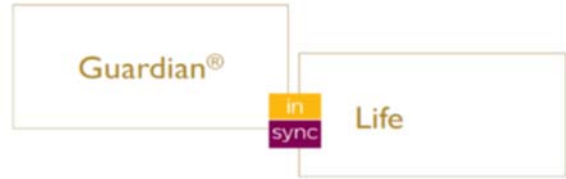
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Voluntary Life Insurance — Evidence of Insurability required if you previously waived coverage

VOLUNTARY LIFE INSURANCE Dearborn Schools Employee Healthcare Program

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer provided benefits or our Collective Bargaining Agreement.



Protect your family and finances with Voluntary Life Insurance

A good place to start is your workplace benefits

Life Insurance helps provide financial protection for your family and loved ones. If something were to happen to you, life insurance would provide money so that your family and your loved ones can continue to manage expenses if you were no longer around. Consider your living expenses such as mortgage payments, legal or medical fees, childcare, college education, and outstanding debts.



How it works

Choose the level of life insurance coverage that works for you, from \$5,000 - \$150,000. As an actively at work member who enrolls in the program, you may also cover your spouse and children.

Can you afford not to protect your family?

1/2 of all American households feel they're underinsured

7 to 10 times income is the general rule of thumb for recommended life insurance coverage

40% of adult Americans have no life insurance whatsoever

Provision	Schedule of Benefits
Employee Benefit	\$5,000; \$10,000; \$15,000; \$25,000; \$50,000; \$75,000; \$100,000; \$150,000
Spouse Benefit	50% of employee amount, Max: \$25,000
Child Benefit	10% of employee amount, Max: \$10,000
Accelerated Life	50% of the death benefit, Minimum: \$10,000, Maximum: \$250,000
Portability	Included, without Evidence of Insurability

Enroll today!

If you waived this coverage when it was initially offered to you, you can elect it during this year's Annual Enrollment. You may be asked to satisfy Evidence of Insurability.

Monthly Premiums

Payroll deduction amounts will be based on employer payroll frequency.

RATES per \$1,000										
Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Rates	\$0.042	\$0.05	\$0.079	\$0.14	\$0.216	\$0.325	\$0.509	\$0.825	\$1.357	\$2.612

The Spouse rate is based on the employee's age bracket. The Child rate is \$.0167 per thousand and covers all children.

Underwriting Requirements	Employee	Spouse	Child
Guarantee Issue (Initial Enrollment Only)	\$150,000	\$25,000	\$10,000



GuardianAnytime.com

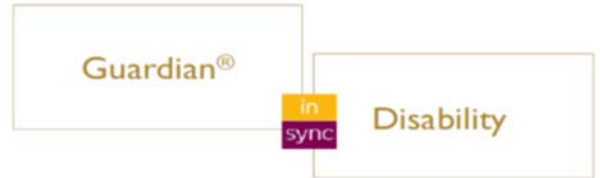
The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004. GUARDIAN® and the GUARDIAN G® logo are registered service marks of The Guardian Life Insurance Company of America and are used with express permission.

File #2015

Short Term Disability—Evidence of Insurability required if you previously waived

SHORT TERM DISABILITY Dearborn Schools Employee Healthcare Program

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer provided benefits or our Collective Bargaining Agreement.



Guardian is #1 in TOTAL inforce disability cases and in STD cases.*

*LIMRA, Year-End 2013 Report. Based on number of Group STD and LTD inforce - excludes reserve buy-outs.

If you waived this coverage when it was initially offered to you, you can elect it during this year's Annual Enrollment. You may be asked to satisfy Evidence of Insurability.

We are all vulnerable to illnesses and injuries that could leave us without a paycheck.

Although many employers offer life and medical insurance as part of their benefits package, neither one compensate when a member is out of work due to an illness or serious injury. That's why Guardian Short Term Disability Insurance adds value to your benefits package. It's the perfect complement to existing benefits, and helps ensure that you are covered in the event of a serious injury or illness.

Could your family live on \$1,065 a month?³

Most families would find it difficult to live on the maximum Social Security Disability income alone. Guardian Disability Insurance offers the financial protection members need when a wage earner is unable to work.

Consider all the additional expenses they may incur resulting from a serious injury or illness, such as physical therapy, child care, spousal care giving, and travel to treatment centers.

Benefits of group coverage include:

- Expert return to work and rehabilitative services to restore a productive lifestyle
- Affordable group rates
- Fast, fair and accurate claims administration

Short Term Disability Product Overview	
Duration of Benefits	26 Week Duration
Definition of Disability	Own Job
Coverage Type	Non-occupational
Integration Method	Benefits reduced by other group disability benefits, social security benefits not included
Pre-Existing Condition Limit	3 months prior/12 months insured, benefits limited to 2 weeks of payments, continuity of coverage
Minimum Weekly Benefit	None
Annual Re-Enrollment	On an annual basis, participating employees will be allowed to 'step-up' one eligible increment.
TeleGuard (Telephonic claims submission)	Included



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2015-3397 Exp. 6/18
Page 1 of 2

Short Term Disability—Evidence of Insurability required if you previously waived

SHORT TERM DISABILITY

Dearborn Schools Employee Healthcare Program

Monthly Premiums									
Payroll deduction amounts will be based on employer payroll frequency									
		Age							
Weekly Benefit	Min. Salary Required	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60+
\$200	\$17,333	\$17.96	\$24.08	\$17.44	\$12.92	\$12.86	\$14.58	\$16.96	\$20.12
\$250	\$21,667	\$22.45	\$30.10	\$21.80	\$16.15	\$16.08	\$18.23	\$21.20	\$25.15
\$375	\$32,500	\$33.68	\$45.15	\$32.70	\$24.23	\$24.11	\$27.34	\$31.80	\$37.73
\$500	\$43,333	\$44.90	\$60.20	\$43.60	\$32.30	\$32.15	\$36.45	\$42.40	\$50.30
\$750	\$65,000	\$67.35	\$90.30	\$65.40	\$48.45	\$48.23	\$54.68	\$63.60	\$75.45

DID YOU KNOW

- 36 million Americans are classified as disabled (about 12% of the population)¹
- There is a 25% chance for workers to become disabled for 3 months or more during their working career²
- 71% of workers would find it somewhat or very difficult to meet their current financial obligations if their next paycheck were delayed for just one week³

You choose a flat benefit amount based on your needs and budget

Premium varies based on your age and amount selected

Premium can be displayed to match your payroll deduction method to help simplify the enrollment process

Sample Monthly Premium

Age	\$200	\$250	\$375	\$500	\$750
25	\$17.96	\$22.45	\$33.68	\$44.90	\$67.35
35	\$17.44	\$21.80	\$32.70	\$43.60	\$65.40
45	\$12.86	\$16.08	\$24.11	\$32.15	\$48.23

¹ Social Security Administration Fact Sheet, 3/18/11, "1 in 4 of today's 20 year olds will become disabled before they retire."

² Council for Disability Awareness. Disability Statistics. http://www.disabilitycanhappen.org/chances_disability/disability_stats.asp

³ The average amount paid by Social Security Disability Insurance (SSDI) in June 2010

Critical Illness Insurance—Evidence of Insurability required if you previously waived

CRITICAL ILLNESS INSURANCE Dearborn Schools Employee Healthcare Program

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer provided benefits or our Collective Bargaining Agreement.



Helping you focus on recovery — not your finances

Treatment of critical illnesses such as cancer, heart attack and stroke can lead to unexpected expenses that create an additional financial burden. Critical Illness insurance can help you pay for travel to treatment centers, ongoing household bills, co-pays to experimental treatment, and everyday expenses like groceries, rent and mortgage.

See below for a schedule of paid benefits and monthly rates.

How it works

Choose the level of coverage – \$5,000 or \$10,000 that works best for you and your family. As an actively at work employee, you, your spouse and your children can be covered (spouses covered at 50% and children covered at 25%). These offered voluntary benefits are above and beyond what is provided by your employer and union.

Critical Illness insurance pays a lump-sum amount upon diagnosis of:

Conditions	1 st Occurrence	2 nd Occurrence
Cancer		
Invasive Cancer	100%	50%
Carcinoma In Situ	30%	0%
Benign Brain Tumor	75%	0%
Skin Cancer	\$250	Not included
Vascular		
Heart Attack	100%	50%
Stroke	100%	50%
Heart Failure	100%	50%
Arteriosclerosis	30%	0%
Other		
Organ Failure	100%	50%
Kidney Failure	100%	50%
Pre-Existing Condition Limitation: A pre-existing condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 month look back period, 12 month exclusion period 3 month look back period, 6 months treatment free, 12 month exclusion period (TX & VA)	
Other Covered Conditions: Addison's Disease (30%), ALS (Lou Gehrig's Disease) (100%) Alzheimer's Disease (50%), Coma (100%), Huntington's Disease (30%) Multiple Sclerosis (30%) Loss of Speech, Sight or Hearing (100%) Parkinson's Disease (100%) Permanent Paralysis (50% for 1 limb 100% for 2 limbs), Severe Burns (100%)		

This plan will also pay for additional occurrences*. The maximum benefit payable is 300% of the selected benefit amount. Benefits reduce by 50% at age 70. Guardian Critical Illness Insurance is underwritten by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. Critical Illness Policy Form #GC-CI-11 et al.



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Childhood Conditions Benefit For Employees

Your plan includes a 100% of Child Benefit for the first occurrence of several childhood conditions, including:

Cerebral Palsy, Cleft lip/palate, Club Foot, Cystic Fibrosis, Down's Syndrome, Muscular Dystrophy, Spina Bifida, and Type I Diabetes

ANNUAL WELLNESS BENEFIT For Employees & Covered Family Members

This plan pays you \$50 once per year per covered individual for receiving one or more approved covered wellness screenings or for an annual physical / well child visit. See schedule for list of covered procedures.

If you waived this coverage when it was initially offered to you, you can elect it during this year's Annual Enrollment. You may be asked to satisfy Evidence of Insurability.

File #2014-16033
Exp 6/18
Page 1 of 2

Critical Illness Insurance—Evidence of Insurability required if you previously waived

CRITICAL ILLNESS INSURANCE Dearborn Schools Employee Healthcare Program

Monthly Premiums

Payroll deduction amounts will be based on employer payroll frequency.

EMPLOYEE (Child cost included)							
Benefit Amounts	Age						
	< 30	30-39	40-49	50-59	60-69	70+	
\$5,000	\$5.50	\$7.07	\$11.60	\$19.45	\$28.76	\$53.60	
\$10,000	\$8.60	\$11.57	\$20.15	\$34.90	\$52.41	\$100.35	

SPOUSE							
Benefit Amounts	Age						
	< 30	30-39	40-49	50-59	60-69	70+	
\$2,500	\$2.97	\$3.84	\$6.35	\$10.74	\$15.95	\$29.25	
\$5,000	\$4.52	\$6.09	\$10.62	\$18.47	\$27.78	\$52.62	

Guaranteed Issue Amount – Initial Enrollment Opportunity

Employee <70	\$10,000	Employee 70+	Health questions required
Spouse <70	\$5,000	Spouse 70+	Health questions required
Child	All amounts Guaranteed		

If you waived this coverage when it was initially offered to you, you can elect it during this year's Annual Enrollment. You may be asked to satisfy Evidence of Insurability.

SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS

- The policy has exclusions and limitations that may impact the eligibility for or entitlement to benefits under each covered condition. There are limitations & special requirements for each condition. See the certificate of coverage or contact your sales representative for full details.
- We will not pay benefits for the First Occurrence of a Critical Illness if it occurs less than 3 months after the First Occurrence of a related Critical Illness for which this Plan paid benefits. By related we mean either: (a) both Critical Illnesses are contained within the Cancer Related Conditions category; or (b) both Critical Illnesses are contained within the Vascular Conditions category.
- We will not pay benefits for a Second occurrence (recurrence) of a Critical Illness unless the Covered Person has not exhibited symptoms or received care or treatment for that Critical Illness for at least 12 months in a row prior to the recurrence. For purposes of this exclusion, care or treatment does not include: (1) preventive medications in the absence of disease; and (2) routine scheduled follow-up visits to a Doctor.
- We do not pay benefits for a second ever occurrence of a critical illness if the insured has exhibited symptoms or received treatment for that critical illness within the past 12 months (care or treatment does not include: (a) preventive medications in the absence of disease; and (b) routine scheduled follow-up visits to a doctor.)
- First & second occurrence refers to the first & second time an insured experiences or is diagnosed with a covered critical illness while covered under Guardian Critical Illness Insurance.
- We do not pay benefits for a third or later occurrence of a Critical Illness. A pre-existing condition includes any condition for which an employee, in the three month period prior to coverage in this plan, consults with a physician, receives treatment, or takes prescribed drugs. Please refer to the plan documents for specific time periods. State variations may apply.
- If the plan is new (not transferred): During the exclusion period, this Critical Illness plan does not pay charges relating to a pre-existing condition. If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. Please refer to the plan details for specific time periods. State variations may apply.
- We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane.
- In order to be eligible for coverage: Employees must be legally working: (a) in the United States or (b) outside the United States, for a US based employer, in a country or region approved by Guardian. Subject to state specific variations. Employees must be working full-time on the effective date of coverage; otherwise, coverage becomes effective after the completion of the specific waiting period.
- Health questions are required on all late enrollees. Benefit increases may require underwriting.
- This coverage will not be effective until approved by a Guardian underwriter. This proposal is subject to a satisfactory financial evaluation. Please refer to certificate of coverage for full plan description; plan documents are the final arbiter of coverage.

Accident Insurance—Evidence of Insurability required if you previously waived

ACCIDENT INSURANCE Dearborn Schools Employee Healthcare Program

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer provided benefits or our Collective Bargaining Agreement.



Accidents happen

Fortunately, we can help with unexpected expenses

Guardian Accident Insurance helps offset the costs associated with both minor and major accidents:

- For every covered accident, Guardian can pay a benefit based on the injury you sustain and the various treatments and/or services received, regardless of what is covered by medical insurance.
- Special Feature: Guardian Accident Insurance will increase covered benefits by 20% for a child who has an accident while playing organized sports.*

See next page for a schedule of paid benefits and monthly rates.

A benefit when you need it

Consider some of the unexpected costs that may result from an accident such as travel to treatment centers, child care while recovering, household expenses while you can't work, or even modifications to a home or automobile.

Payments are made directly to you and can be used for any purpose — even everyday expenses like groceries, rent and mortgage.

Enroll today

During this enrollment, you and your family are guaranteed coverage:

- No health questions
- Family coverage available
- Convenient payroll deductions
- Portable



DID YOU KNOW?

1 out of 5 people receive emergency room treatment annually¹

\$17,749 is the average out-of-pocket medical bills and that's not including the loss of earnings of the injured and their spouses²

62% of bankruptcies are the result of medical causes despite 76% of those claiming bankruptcy had medical insurance³

*The child must be insured by the plan on date the accident occurred. The child must be 18 years of age or younger. 1. www.cdc.gov/nchs/data/nhis/earlyrelease/emergency_room_use_january-june_2011.pdf. 2. "Study Links Medical Costs and Personal Bankruptcy." Bloomberg BusinessWeek, June 4, 2009. 3. Duke University Medical Center, 2011 <http://clearhealthcosts.com/tag/duke-university-medical-center>. Guardian's Accident Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. This policy provides Accident insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. IMPORTANT NOTICE – THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS. Policy Form #GP-1-AC-IC-12.



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File #2014-16033
Exp 6/18
Page 1 of 2

Accident Insurance—Evidence of Insurability required if you previously waived

Accident Insurance

Covered Events	Benefits Paid
Initial Transportation & Treatment	
Air/Ground Ambulance (<50 miles away)	\$500/\$100
Transportation ¹	\$400 – 3 times per accident
Accident ER Treatment/Urgent Care/Office	\$150/\$50
Diagnostic Exam (Major)/X-ray	\$100/\$20
Injury Diagnosis	
Coma/Concussions	\$7,500/\$50
Burns (2nd Degree/3rd Degree)	9 sq in to 18 sq in: \$0/\$2,000 18 sq in to 35 sq in: \$1,000/\$4,000 Over 35 sq in: \$3,000/\$12,000
Burn – Skin Graft	50% or burn benefit
Dislocations	Schedule up to \$3,600
Eye Injury	\$200
Fractures (Bone)	Schedule up to \$4,500
Knee Cartilage	\$500
Laceration	Schedule up to \$300
Tendon/Ligament/Rotator Cuff	1: \$250 2 or more: \$500
Hospitalization	
Hospital Admission/ICU Admission	\$750/\$1,500
Hospital Confinement	\$175/day, up to 1 yr
ICU Confinement	\$350/day, up to 15 days
Treatments & Family Care	
Appliance ² , Blood/Plasma/Platelets, Emergency Dental Work, Epidural Anesthesia for Pain, Joint Replacement, Artificial Limb, Rehabilitation Unit Confinement, Ruptured Disc Surgical Repair, Surgeries	Additional Money paid for these treatments. Please refer to plan summary for details.
Family Care ³	\$20/day up to 30 days
Child Organized Sport ⁴	20% increase to child benefits
Lodging ⁵	\$100/day, up to 30 days for companion hotel stay
Follow-Up	
Accident Follow-Up Visits – Doctor	\$25 up to 6 treatments
Occupational or Physical Therapy	\$25/day up to 10 days

Off the Job Coverage	
Tier	Monthly Rates*
Employee	\$17.83
Employee and Spouse	\$30.40
Employee and Child	\$31.90
Family	\$44.47

*Payroll deduction amounts will be based on employer payroll deduction frequency

ANNUAL WELLNESS BENEFIT

For Employees & Covered Family Members

This plan pays you \$50 once per year per covered individual for receiving one or more approved covered wellness screenings or for an annual physical / well child visit. See schedule for list of covered procedures.

The benefits listed are payable if the service, treatment or procedure is due to injuries incurred in a covered accident. 1 Transportation – Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident. 2 Appliance – Benefit is paid if a wheelchair, leg or back brace, crutches, walker, walking boot that extends above the ankle or brace for the neck is prescribed by a physician as necessary due to an injury sustained as the result of a covered accident. 3 Family Care – Benefit is payable for each child attending a Child Care center while the insured is confined to the hospital, ICU or Alternate Care or Rehabilitative facility due to injuries sustained in a covered accident. 4 Child Organized Sport – Benefit is paid if the covered accident occurred while your covered child is anticipating in an organized sport that is governed by an organization and requires formal registration to participate. This benefit is only payable if child coverage is included on the plan. 5 Lodging – Benefit is paid for a companion's hotel stay while the insured is confined to the hospital as the result of a covered accident. The hospital must be more than 50 miles from the insured's residence.

Benefits Claim Example

Fractured arm and torn knee cartilage	
COVERED EVENTS	Benefit Paid
Ambulance	\$100
Emergency Room Visit	\$150
Medical Resonance Imaging (MRI)	\$100
X-Ray	\$20
Fractured arm (open)	\$4,500
Knee Cartilage Tear	\$500
Arthroscopic Surgery	\$150
Knee Brace (appliance)	\$100
Physical Therapy (10 visits)	\$250
Follow-up visits with doctor (6 visits)	\$150
TOTAL BENEFIT PAID UNDER POLICY	\$6,020

Summary of Plan Limitations and Exclusions

- Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.
- This proposal summarizes the major features of the Guardian Accident benefit plan. It is not intended to be a complete representation of the proposed plan. For full plan features, including exclusions and limitations, please refer to your Policy.
- This proposal is hedged subject to satisfactory financial evaluation.
- State variations may apply.
- This plan will not pay benefits for any injury caused by or related to:
 - Declared or undeclared war, act of war, or armed aggression; taking part in a riot or civil disorder; or commission of, or attempt to commit a felony, intentionally self inflicted injury, while sane or insane; suicide or attempted suicide, while sane or insane.
 - The covered person being legally intoxicated
 - Treatment rendered or hospital confinement outside the United States or Canada.
 - Travel or flight in any kind of aircraft, including any aircraft owned by or for the employer except as a fare-paying passenger on a common carrier.
 - Participation in any kind of sporting activity for compensation or profit, including coaching or officiating.
 - Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
 - Participation in hang gliding, bungee jumping, sail gliding, parasailing, parakiting, ballooning, parachuting, and/or skydiving.
 - Injuries to a dependent child received during the birth.
 - An accident that occurred before the covered person is covered by this plan.
 - Sickness, disease, mental infirmity or medical or surgical treatment.

File #2014-16033
Exp 6/18
Page 2 of 2



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Your Rights Under Federal Law

Change in Status or Special Enrollment -

You may qualify for a special enrollment if certain events occur in your life:

- If you decline coverage for yourself and/or your dependents (including your spouse) because you are covered under another health plan, you may be able to enroll yourself and/or your dependents in the plan if you experience an involuntary loss of that coverage (e.g., spouse loses his/her job, divorce).
- 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 dependents in the plan.

In either situation, you must request enrollment through the DSEHP Benefit Center within 30 days after the special enrollment event as described above. If you enroll as the result of a special enrollment event, coverage will be made effective on the date of the event.

Newborn and Mother's 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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).



Women's Health Cancer Rights Act Notice -

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
- Surgery/reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis;
- Physical complication during all stages of mastectomy, including lymph edemas.

The plan may not:

- Interfere with a woman's right under the plan to avoid these requirements;
- Offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles and co-insurance requirements consistent with other coverage provided under the plan.

Patient Protection Notice -

HAP generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in HAP's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of participating primary care providers, contact HAP at 877-427-3678. For children you may designate a pediatrician as the primary care provider.

You do not need prior authorization from HAP or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact HAP at 877-427-3678.

Your Rights Under Federal Law—Continued

CHIPRA MODEL NOTICE

Qualified group health plans in States that provide medical assistance through either Medicaid or a Children’s Health Insurance Program (CHIP or SCHIP) must provide a notice informing employees of the potential opportunity for state Medicaid or CHIP health care assistance for group health plan coverage. The notice must be provided to employees when initially eligible and during the annual enrollment. [Note: Health FSAs and qualified High Deductible Health Plans (HSA-compatible) are not qualified health plans.]

State-specific information must also be included in the notice. We have not included that information here because portions of the information such as phone numbers change. An updated model notice is available on the DOL’s Employee Benefits Security Administration’s (“EBSA”) website at: <http://www.dol.gov/ebsa>

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

DSEHP

Protecting Your Health Information Privacy Rights

May 1, 2017

DSEHP is committed to the privacy of your health information. The administrators of the DSEHP (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 DSEHP Benefit Center at 888-222-4309.

HIPAA SPECIAL ENROLLMENT RIGHTS

DSEHP Initial Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the DSEHP Group 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.

Your Rights Under Federal Law—Continued

Eligibility for 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.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1216-0149
(expires 4-30-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Medicare Part D

Important Notice from Dearborn Schools Employee Healthcare Program (DSEHP) About Your CREDITABLE 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 DSEHP 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. DSEHP has determined that the prescription drug coverage offered by the HAP 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 coverage will not be affected.

Summary of Options for Medicare Eligible Employees (and/or Dependents):

- Continue medical and prescription drug coverage and do not elect Medicare D coverage. **Impact** – your claims continue to be paid by DSEHP health plan.
- Continue medical and prescription drug coverage and elect Medicare D coverage. **Impact** - As an active employee (or dependent of an active employee) the DSEHP health plan continues to pay primary on your claims (pays before Medicare D).
- Drop the coverage and elect Medicare Part D coverage. **Impact** – Medicare is your primary coverage. You will not be able to rejoin the DSEHP health plan unless you experience a family circumstance change or until the next open enrollment period.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will not be able to get this coverage back unless you experience a family status change or until the next open enrollment period.

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 HAP 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 November to join.

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

Contact the person listed below for further information [or call Office Manager, NGE at [(313) 9823292]. **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 DSEHP 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: July 1, 2017

Name of Entity/Sender: DSEHP

Contact--Position/Office: Office Manager, NGE

Address: 15250 Mercantile Dr., Dearborn MI 48120

Phone Number: 888-222-4309

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

COBRA Notice

General Notice Of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA ****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

COBRA Notice

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: DSEHP Benefit Center, 15250 Mercantile Drive, Dearborn MI 48120 or call 888-222-4309

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Please call the DSEHP benefit center at 888-222-4309 if this occurs.

COBRA Notice

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

DSEHP Benefit Center
15250 Mercantile Drive
Dearborn, MI 48120
888-222-4309

Appendix - SBC



Coverage Period: 07/01/2017 - 06/30/2018

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual+Family | Plan Type: HVP

⚠ This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.hap.org or by calling 1-800-422-4641.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$150 person / \$300 family; doesn't apply to preventive care, office visits, urgent care, emergency care, or pharmacy.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$6,600 person / \$13,200 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, Balance Billed Charges, and Health Care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Does this plan use a network of providers?	Yes. See www.hap.org or call 1-800-422-4641 for a list of preferred providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	Yes.	Written referrals are not required for specialist visits within the member's assigned network for selected services. Referrals or oral approvals are required in other instances. Further information on the referral process can be found at www.hap.org .

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-800-422-4641 to request a copy.

1 of 9
QR-13583A5 Any

Appendix - SBC



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay per visit	Not Covered	Visits are face-to-face, telephonic, or through secure electronic portal
	Specialist visit	\$30 copay per visit	Not Covered	-----None-----
	Other practitioner office visit	\$20 PCP Other Practitioner copay per visit/ \$30 Specialist Other Practitioner copay per visit	Not Covered	Chiropractic manipulation of the spine for subluxation only - 35 visits per benefit year Acupuncture Not Covered
	Preventive care/screening/immunization	No Charge	Not Covered	Coverage information available at www.hap.org .
If you have a test	Diagnostic test (x-ray, blood work)	No Charge after deductible	Not Covered	Some services require prior authorization.
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	Not Covered	Services require prior authorization.

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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2 of 9
QR-13583A5 Any

Appendix - SBC

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.hap.org .	Generic Drugs	\$15 copay/prescription (retail).	Not Covered	Applies to all categories below. Retail: 30 day supply for non-maintenance drugs at 1 copay; 90 day supply for eligible maintenance drugs at 2 copays; Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 copays
	Preferred brand drugs	\$30 copay/prescription (retail).	Not Covered	
	Non-preferred brand drugs	\$60 copay/prescription (retail).	Not Covered	
	Specialty drugs	\$60 copay/prescription (retail).	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	Not Covered	Some services require prior authorization.
	Physician/surgeon fees	No Charge after deductible	Not Covered	-----None-----
If you need immediate medical attention	Emergency room services	\$200 copay per visit	\$200 copay per visit	Copay will be waived if admitted
	Emergency medical transportation	No Charge after deductible	No Charge after deductible	Emergency Transport Only
	Urgent care	\$40 copay per visit	\$40 copay per visit	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	Not Covered	Some services require prior authorization.
	Physician/surgeon fee	No Charge after deductible	Not Covered	-----None-----

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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Appendix - SBC

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Mental/Behavioral health inpatient services	No Charge after deductible	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder outpatient services	\$20 copay per visit	Not Covered	Some services require prior authorization. Services can be accessed by calling 1-800-444-5755
	Substance use disorder inpatient services	No Charge after deductible	Not Covered	Services require prior authorization. Services can be accessed by calling 1-800-444-5755
If you are pregnant	Prenatal and postnatal care	\$30 copay per visit	Not Covered	No Charge for Prenatal care
	Delivery and all inpatient services	No Charge after deductible	Not Covered	Some services require prior authorization.

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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4 of 9
QR-13583A5 Any

Appendix - SBC

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge after deductible	Not Covered	-----None-----
	Rehabilitation services	No Charge after deductible	Not Covered	Up to 60 combined visits per benefit period - May be rendered at home
	Habilitation services	No Charge after deductible	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Services require prior authorization. *See outpatient Mental Health for ABA cost share amount.
	Skilled nursing care	No Charge after deductible	Not Covered	Covered for authorized services - Up to 100 days per benefit period
	Durable medical equipment	No Charge after deductible	Not Covered	Coverage provided for approved equipment based on HAP's guidelines.
	Hospice service	No Charge after deductible	Not Covered	Up to 210 days per lifetime
If your child needs dental or eye care	Eye exam	\$30 copay per visit	Not Covered	No Charge for preventive eye exam
	Glasses	Not Covered	Not Covered	-----None-----
	Dental check up	Not Covered	Not Covered	-----None-----

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

• Acupuncture	• Long-Term Care	• Routine Foot Care (Only when meets Plan guidelines)
• Cosmetic Surgery	• Non-Emergency Care When Traveling Outside the U.S.	• Vision Hardware (Unless additional rider purchased)
• Dental Care (Adult)	• Private-Duty Nursing	

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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5 of 9
QR-13583A5 Any

Appendix - SBC

Excluded Services & Other Covered Services:

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---------------------|---|----------------------------|
| • Bariatric Surgery | • Hearing Aids | • Routine Eye Care (Adult) |
| • Chiropractic Care | • Infertility Treatment (Only when meets Plan guidelines) | • Weight Loss Programs |

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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6 of 9
QR-13583A5 Any

Appendix - SBC

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-422-4641. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccoio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact HAP at 1-800-422-4641 or visit us at www.hap.org

For more information regarding grievance and appeals, contact the plan at 1-800-422-4641. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccoio.cms.gov. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Financial and Insurance Regulation, P.O.Box 30220, Lansing, MI 48909, phone 1-877-999-6442, website: <http://michigan.gov/difs> or e-mail difs-HICAP@michigan.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

_____To see examples of how this plan might cover costs for a sample medical situation, see the next page._____

Questions: Call 1-800-422-4641 or visit us at www.hap.org.


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7 of 9
QR-13583A5 Any

Appendix - SBC

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,190
- Patient pays \$350

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$150
Co-pays	\$50
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$350

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,270
- Patient pays \$1,130

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$150
Co-pays	\$900
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$1,130

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Appendix - SBC



Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2017 - 06/30/2018

Coverage for: Individual+Family | Plan Type: HVP

Questions and answers about the Coverage Examples:

- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

Does the Coverage Example predict my own care needs?

- ✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Are there other costs I should consider when comparing plans?

- ✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-422-4641 or visit us at www.hap.org.

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9 of 9
QR-13583A5 Any

Your Benefit Resources



Medical & Prescription Drug	HAP	877-427-3678 www.hap.org
Dental	Delta Dental	800-524-0149 www.deltadentalmi.com
Vision	National Vision Administrators (NVA)	800-672-7723 www.e-nva.com
Voluntary Life Insurance Short Term Disability Critical Illness Accident Coverage	Guardian	888-600-1600 www.guardiananytime.com
Flexible Spending Accounts (FSA)	Next Generation Enrollment	888-222-4309 www.nextgenerationenrollment.com

Other Questions or Changes In Eligibility



Arthur J. Gallagher & Co.

888-222-4309

The contents of this booklet is intended for use as an easy to read summary only. It does not constitute a contract. Additional limitations and exclusions may apply. For an official description of benefits, please refer to each carrier's official certificate/benefit guide.