DSEHP

DEARBORN SCHOOLS EMPLOYEE HEALTHCARE PROGRAM

DFT - DEARBORN FEDERATION OF TEACHERS
DFSE - DEARBORN FEDERATION OF SCHOOL EMPLOYEES
ADSA - ASSOCIATION OF DEARBORN SCHOOL ADMINISTRATORS
DSOEA - DEARBORN SCHOOLS OPERATING ENGINEERS ASSOCIATION

July 1, 2020 - June 30, 2021

2020-2021
EMPLOYEE BENEFITS GUIDE
DFT

aft A Union of Professionals dearborn federation of teachers

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 26 for more details.

Open Enrollment Process

Open Enrollment for making insurance benefit changes will be from May 1st through May 15th.

All employees 2019 elections (except FSA) WILL ROLL OVER for the 2020 plan year unless you take action. Your current Medical, Dental, Vision and Voluntary elections will be rolled over into the new plan year. You must make an election during the Open Enrollment period in order for your FSA benefits to continue to be effective for the new plan year.

If you would like to make a change to your current elections and enroll in the FSA plan for 2020 you have two different methods to enroll:

- Online
- Over the Phone

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

Remember that the choices you make now will be effective July 1, 2020 and will remain in effect until June 30, 2021 unless you experience a qualified special enrollment event.

If you do not make changes to your current elections for benefits by May 15, 2020, your benefit coverage for Medical, Dental , Vision and Voluntary will be rolled over effective June 30, 2020.

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).

Eligibility

- An employee's FTE profile must be .5 or greater to be eligible for benefits.
- 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.
- The DSEHP plan does not allow dual coverage for Medical coverage, however dual coverage is ALLOWED for Dental and Vision.
- New hires are eligible 1st of the month following 28 days.

Inside this Issue…..

Open Enrollment Process

Benefit Enrollment Instructions
Effective Friday, May 1, 2020

Online Enrollment System:

To access your benefits online, go to: https://benefits.plansource.com/ 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.

Please remember that Open Enrollment will end at midnight on May 15, 2020.

If you do not make changes to your current elections for benefits by May 15, 2020, your benefit coverage for Medical, Dental, Vision and Voluntary will be rolled over effective June 30, 2020.

You MUST make an active election for the FSA plan in order to have that benefit for 2020!

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 30.

Benefit	Service Type	
Medical	Deductible	$150 single / $300 Family
	PHP/MHSA Visit	$20
	Telehealth visit	$0
	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	$37.20 Per 20 Pays $62.00 Per Month	$0.00	$0.00	$40.00 Per 20 Pays $66.67 Per Month
Two Person	$75.00 Per 20 Pays $125.00 Per Month	$0.00	$0.00	$80.00 Per 20 Pays $133.33 Per Month
Family	$100.80 Per 20 Pays $168.00 Per Month	$0.00	$0.00	$100.00 Per 20 Pays $166.67 Per Month

* In order to receive Cash in Lieu you will be required to show proof of other coverage on an annual basis and have an FTE profile of 1.0.

Important Information

Life changes that can qualify you for a Special Enrollment Period are listed below. You must notify the DSEHP benefit call center at 1-888-222-4309 within 30 days if you would like to exercise your special open enrollment period.

Changes in household

You may qualify for a Special Enrollment Period if you or anyone in your household **in the past 30 days**:

- **Got married.**
- **Had a baby, adopted a child, or placed a child for foster care.** Your coverage can start the day of the event
- **Got divorced or legally separated and lost health insurance. Note:** Divorce or legal separation without losing coverage doesn't qualify you for a Special Enrollment Period.
- **Death—**If you are covered under your spouses plan and they pass away you are eligible to join the DSEHP Health Plan

Changes in residence

Household moves that qualify you for a Special Enrollment Period:

- Moving to the U.S. from a foreign country or United States territory
- A student moving to or from the place they attend school

Note: Moving only for medical treatment or staying somewhere for vacation doesn't qualify you for an SEP.

Important: You must prove you had qualifying health coverage for one or more days during the 30 days before your move.

Loss of health insurance

You may qualify for a Special Enrollment Period if you or anyone in your household lost qualifying health coverage **in the past 30 days**

Coverage losses that may qualify you for a Special Enrollment Period:

- Losing job based coverage
- Losing eligibility for Medicaid or CHIP
- Losing eligibility for Medicare
- Losing coverage through a family member

Medical & RX Summary

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

HMO

AA000775 / XR000941 QR-27820

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$150 Individual; $300 Family	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	0%	N/A	
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$6,600 Individual; $13,200 Family	N/A	These values do not accumulate: premiums, balance-billed charges, health care this plan doesn't cover. All other cost sharing accumulates.
Preventive Services			
Office Visit / Physical Exam / Well Baby Exam	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$20 Copay - Deductible does not apply	N/A	
Telehealth Visit	Covered - Deductible does not apply	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	$30 Copay - Deductible does not apply	N/A	
Audiology Office Visit	$30 Copay - Deductible does not apply	N/A	One routine hearing exam per benefit period at no cost share
Eye Exam Office Visit	$30 Copay - Deductible does not apply	N/A	One routine eye exam per benefit period at no cost share
Allergy Treatment	Covered after deductible	N/A	
Allergy Injections	Covered after deductible	N/A	
Laboratory & Pathology	Covered after deductible	N/A	Some services require preauthorization
Imaging MRI, CT & PET Scans	Covered after deductible	N/A	Services require preauthorization
Radiology (X-ray)	Covered after deductible	N/A	Some services require preauthorization
Radiation Therapy & Chemotherapy	Covered after deductible	N/A	
Dialysis	Covered after deductible	N/A	
Chiropractic Services	$30 Copay - Deductible does not apply	N/A	Manipulation of the spine for subluxation only; Up to 35 visits per benefit period.
Outpatient Surgical Services			
Outpatient Surgery	Covered after deductible	N/A	
Ambulatory Surgical Center	Covered after deductible	N/A	
Professional Surgical and Related Services	Covered after deductible	N/A	
Emergency/Urgent Care			
Urgent Care	$40 Copay - Deductible does not apply		
Emergency Room Care	$200 Copay - Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	Covered after deductible		Emergency transport only
Inpatient Hospital Services			
Facility Fee	Covered after deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after deductible	N/A	
Bariatric Surgery and Related Services	$1,000 Copay after deductible	N/A	One procedure per lifetime
Maternity Services			
Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services.
Postnatal Office Visits	$30 Copay - Deductible does not apply	N/A	
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	

Medical & RX Summary

Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	$20 Copay - Deductible does not apply	N/A	
Other Services			
Home Health Care	Covered after deductible	N/A	Does not include Rehabilitation Services; Unlimited
Hospice Care	Covered after deductible	N/A	Up to 210 days per lifetime.
Skilled Nursing Care	Covered after deductible	N/A	Covered for authorized services; Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	Covered after deductible	N/A	Covered for approved equipment only
Hearing Aid Hardware	Covered after deductible	N/A	Covered for approved equipment only
Rehabilitation Services: Physical, Occupational, and Speech Therapy	Covered after deductible	N/A	May be rendered at home; Up to 60 combined visits per benefit period
Habilitation Services	Covered after deductible	N/A	Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only. See Outpatient Mental Health for ABA cost sharing amount.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy
Infertility Services	50% Coinsurance after deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	Covered after deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$15 Copay 30 day supply, $30 Copay 90 day supply		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply.
Non-Preferred Generic Drugs	$15 Copay 30 day supply, $30 Copay 90 day supply		
Preferred Brand Drugs	$30 Copay 30 day supply, $60 Copay 90 day supply		
Non-Preferred Brand Drugs	$60 Copay 30 day supply, $120 Copay 90 day supply		
Preferred Specialty Drugs	$60 Copay 30 day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	$60 Copay 30 day supply at specialty pharmacy only		

Value Plus
Benefit Riders: HMHE, HK60, HL05, HJ31, H317, H313, H272, H203, H124, H073, H013, H012, H496

- Elective hospital admissions require that HAP be notified prior to the admission. HAP must be notified within 48 hours of any emergency hospital admission. Failure to notify HAP 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.
- In case of conflict between this summary and your HMO Subscriber Contract and Riders, the terms and conditions of the HMO Subscriber Contract and Riders will govern.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.

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®

Delta Dental of Michigan, Ohio, Indiana QUALITY ISO 9001 CERTIFICATION

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	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays*	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.

Custom

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.

National Vision Administrators, L.L.C.

Your NVA Vision Benefit Summary

DSEHP

Schedule of Vision Benefits

Benefit Frequency	Participating Provider	Non-Participating Provider
Examination Once Every 12 Months	Covered 100%	Reimbursed Amount ▪ Up to $28 (OD) ▪ Up to $37 (MD)
Lenses Once Every 12 Months	Standard Glass or Plastic	
▪ Single Vision	Covered 100%	▪ Up to $35
▪ Bifocal		▪ Up to $50
▪ Trifocal		▪ Up to $60
▪ Lenticular		▪ Up to $95
▪ Polycarbonates (under age 19)	Covered 100%	▪ N/A
▪ Gradient Tints	Covered 100%	▪ N/A
▪ Solid Tints	Covered 100%	▪ N/A
▪ Glass Photogrey	Covered 100%	▪ N/A
▪ Transitions	Covered 100%	▪ N/A
Frame Once Every 12 Months	Retail Allowance Up to $75① (20% discount off balance)*	▪ Up to $40
Contact Lenses Once Every 12 Months	In lieu of Lenses & Frame	In lieu of Lenses & Frame
Elective Contact Lenses	Up to $100 Retail② (15% discount (Conventional) or 10% discount (Disposable) off balance)**	▪ Up to $100
Fit/Follow-Up***		
Standard Daily Wear	Covered 100%	▪ N/A
Standard Extended Wear	Covered 100%	▪ N/A
Specialty Wear	Covered 100%	▪ N/A
Medically Necessary****	Covered 100%	▪ Up to $210

*Does not apply to Wal-Mart / Sam's Club locations or for certain proprietary brands. **Does not apply to Wal-Mart/Sam's Club or Contact Fill (NVA Mail Order) and may be prohibited by some manufacturers. ***Only covered if you choose Contact Lenses. ****Pre-approval from NVA required.

① **Frames up to $27 EDLP price point at Wal-Mart/Sam's Club locations.**
② **Contact Lenses up to $70 EDLP price point at Wal-Mart/Sam's Club locations.**

Due to their everyday low prices (EDLP) the amounts listed below may not be applicable at Wal-Mart/Sam's Club.
Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- $75 Polarized
- $100 Progressive Lenses Premium*
- $10 Standard Scratch-Resistant Coating
- $12 Ultraviolet Coating
- $40 Standard Anti-Reflective
- $50 Progressive Lenses Standard*
- $30 Blended Bifocal (Segment)
- $55 High Index
- $25 Polycarbonate (Single Vision) 19 & over
- $30 Polycarbonate (Multi-Focal) 19 & over

*Fixed Pricing not available on certain brands
Options not listed will be priced by NVA providers at their R&C retail price less 20%.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Group Number# 8644

How Your Vision Care Program Works

Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses and a frame or contact lenses and contact lens evaluation/fitting once every 12 months from last date of service.

For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, simply present your NVA identification card to the provider or indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care provider, please visit our website at www.e-nva.com or contact NVA's Customer Service Department toll-free at 1.800.672.7723 (TDD line 1-888-820-2990) or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.
If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 8644000101 or the group number on the identification card and enter in your search parameters. It's that easy!

Get a Better View

www.e-nva.com

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Vision Benefits

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations: The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P. O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

Your NVA EyeEssential® Plan Discount – In Network Only		
Service	**Participating Provider**	**Lens Options**
	Member Cost:	
Eye Examination:	Retail Less $10	$12 Solid Tint/ Gradient Tint $50 Standard Progressive Lenses $75 Polarized Lenses $65 Transitions Single Vision Standard $70 Transitions Multi-Focal Standard $15 Standard Scratch Coating $12 UV Coating $35 Polycarbonate $45 Standard Anti-Reflective
Contact Lens Fitting:	Retail Less 10%	
Lenses:	Glass or Plastic	
Single Vision	$35.00	
Bifocal	$55.00	
Trifocal or Lenticular	$70.00	
Frame:	Retail Less 35%	
Contact Lenses*:	**Member Cost:**	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at their reasonable & customary retail price less 20%.

Wal-Mart / Sam's Club Stores: Due to their everyday low prices (EDLP) Wal-Mart / Sam's Club stores do not provide additional discounts.

At NVA, We Work Only for Our Clients.

Exclusions / Limitations: No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

National Vision Administrators, L.L.C. ▫ PO Box 2187 ▫ Clifton, NJ 07015
Web: www.e-nva.com ▫ Toll-Free: 1.800.672.7723

This document is intended as a program overview only and is not a certified document of the individual plan parameters.

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 (FTE profile 1.0), 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@plansource.com

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**
  - Active employees may roll over up to $500
- **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 form 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 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 a caregiver.

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

Any question about these accounts can be directed to PlanSource at:

888-222-4309
www.plansource.com

Voluntary Options

Dearborn Schools Employee Healthcare Program

Guardian

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.

Guardian Short Term Disability Insurance **is insurance for your paycheck** and can help you continue to cover living expenses for you or your family, or help with other 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.

Guardian Critical Illness Insurance pays you a cash benefit that you can spend any way you choose. Pay for your medical plan deductibles and 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.

Guardian pays you a cash benefit based on the injuries you or your spouse/children sustain and the various treatments and/or services you receive, regardless of what's covered by your medical plan.

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.

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.

Voluntary Life Insurance

Dearborn Schools Employee Healthcare Program
Voluntary Life Insurance

Keep your family and finances safe

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.

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.

Provision	Schedule of Benefits
Employee Benefit Options	$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

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

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

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

Guardian

Short Term Disability

Dearborn Schools Employee Healthcare Program
Short Term Disability Insurance

Provide a financial safety net for yourself and those who depend on you

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.

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

Life and medical insurance are essential parts of your benefits offering; however, they don't insure your paycheck.

Guardian Short Term Disability Insurance helps you protect your paycheck when you can't work, either due to an illness or serious injury.

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.

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.

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 included.
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 is included.

Guardian®

Short Term Disability

Dearborn Schools Employee Healthcare Program
Short Term Disability Insurance

Monthly Premiums
Payroll deduction amounts will be based on employer payroll frequency

		Age							
Weekly Benefit	Minimum 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

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

Premium varies based on your age & amount selected

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.

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

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 career[2]
- 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 week[3]

[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

Guardian Disability Insurance is underwritten by The Guardian Life Insurance Company of America, New York, NY. Product 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. Note: Plan design availability may vary by state and/or employer industry. Short Term Disability Policy Form #GP-1-STD07-1.0, et al.

Guardian®

Critical Illness Insurance

Dearborn Schools Employee Healthcare Program
Critical Illness Insurance

Financial protection to help you focus on what matters most

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	1st Occurrence	2nd 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	
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.

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 1 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.

Guardian

Critical Illness Insurance

Dearborn Schools Employee Healthcare Program
Critical Illness Insurance

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

New Hire & Annual Enrollment			
Employees & Spouses Under Age 70	All Amounts Guarantee Issue	Employees & Spouses Age 70+	Health questions required
Children	All Amounts Guaranteed		

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.

Guardian®

Accident Insurance

Dearborn Schools Employee Healthcare Program Accident Insurance

Accidents Happen. Guardian can help.

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

- Guardian pays a cash benefit directly to you based on the injuries you sustain and the various treatments and/or services you receive after you've had an accident, regardless of what is covered by your medical insurance.
- **Special Feature**: Guardian Accident Insurance will increase covered benefits by 20% for a child who has an accident while playing organized sports.*

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.

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 to Enroll
- No Waiting Periods
- Affordable, Convenient Payroll Deductions
- Portable – You can take this coverage with you if your employment ends.

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

*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.

DID YOU KNOW?

1 out of 5 people receive emergency room treatment annually[1]

$17,749 is the average out-of-pocket medical bills and that's not including the loss of earnings of the injured and their spouses[2]

62% of bankruptcies are the result of medical causes despite 76% of those claiming bankruptcy had medical insurance[3]

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.

Guardian®

Accident Insurance

Dearborn Schools Employee Healthcare Program 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	
Additional Money paid for these treatments. Please refer to plan summary for details.	Appliance2, Blood/Plasma/Platelets, Emergency Dental Work, Epidural Anesthesia for Pain, Joint Replacement, Artificial Limb, Rehabilitation Unit Confinement, Ruptured Disc Surgical Repair, Surgeries
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 Accident Coverage Plan

Tier	Monthly Rates*
Employee	$17.83
Employee and Spouse	$30.40
Employee and Child	$31.90
Family	$44.47

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.

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

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.

Guardian®

EAP

Ulliance

Enhancing People. Improving Business.

No cost and completely confidential

LIFE ADVISOR EAP®

The Ulliance Life Advisor EAP® is a benefit that employers can sponsor and offer total well-being services to their employees, spouse/live-in partner and dependents under the age of 27 at no cost to the employee.

Counseling

Counseling is available in-person or telephonically with a counselor close to work, home or school. Individual, family and couples counseling are all included. Short-term, solution focused support for work-life issues such as stress, major life transitions, relationship issues, substance use, grief/loss and overwhelming emotions.

Coaching

Life Advisor Coaches offer telephonic support for individual life enhancement goals, such as education, career advancement, financial or self improvement goals.

Crisis Support

Mental health professionals are available by phone 24/7/365.

Referrals

Consultants provide recommendations for resources within the community.

Work-life Materials

Information on a wide range of work-life balance topics are easily accessed through the EAP portal. A work-life library of related books are available by calling Ulliance and as always, are free of charge.

Legal & Financial Consultations

Ulliance professionals can connect employees with resources to assist individuals regarding legal and financial issues.

Connect with us 800.448.8326 LifeAdvisorEAP.com

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 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, 2019

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.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact DSEHP Benefit Center at 888-222-4309

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(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, PlanSource 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, 2019
Name of Entity/Sender: DSEHP
Contact--Position/Office: Office Manager, PlanSource
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 2 1244-1850

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

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage period: 7/1/2019—6/30/2020

Health Alliance Plan

Coverage for: Individual+Family | **Plan Type: HVP**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-422-4641 or visit www.hap.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-422-4641 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$150** person / **$300** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, urgent care, office visits, emergency care and pharmacy are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
What is the out-of-pocket limit for this plan?	**$6,600** individual/ **$13,200** family	The out of pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out of pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, Balance billing 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.
Will you pay less if you use a network provider?	Yes. See **www.hap.org or call 1-800-422-4641** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out of network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out of network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

DSEHP VEBA

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

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

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hap.org	Generic drugs	$15 copay/prescription (retail); deductible does not apply.	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 copay; Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 copay
	Preferred brand drugs	$30 copay/prescription (retail); deductible does not apply.	Not Covered	
	Non-preferred brand drugs	$60 copay/prescription (retail); deductible does not apply.	Not Covered	
	Specialty drugs	$60 copay/prescription (retail); deductible does not apply.	Not Covered	Specialty drugs are not available at 90 day or mail order
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	No Charge after deductible	Not Covered	----------None----------
If you need immediate medical attention	Emergency room care	$200 copay per visit; deductible does not apply.	$200 copay per visit; deductible does not apply.	Copay will be waived if admitted
	Emergency medical transportation	No Charge after deductible	No Charge after deductible	Emergency medical transportation Only
	Urgent care	$40 copay per visit; deductible does not apply.	$40 copay per visit; deductible does not apply.	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	No Charge after deductible	Not Covered	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay per visit; deductible does not apply.	Not Covered	Some services require preauthorization. Services can be accessed by calling 1-800-444-5755
	Inpatient services	No Charge after deductible	Not Covered	Services require preauthorization. Services can be accessed by calling 1-800-444-5755

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$30 copay per visit; deductible does not apply.	Not Covered	No Charge for Prenatal care
	Childbirth/delivery professional services	No Charge after deductible	Not Covered	----------None----------
	Childbirth/delivery facility services	No Charge after deductible	Not Covered	**Some services require preauthorization.
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 preauthorization. *See outpatient Mental Health for ABA cost sharing 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 services	No Charge after deductible	Not Covered	Up to 210 days per lifetime
If your child needs dental or eye care	Children's eye exam	$30 copay per visit; deductible does not apply.	Not Covered	No Charge for routine eye exam
	Children's glasses	Not Covered	Not Covered	----------None----------
	Children's dental check-up	Not Covered	Not Covered	----------None----------

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Excluded Services & Other Covered Services:

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery	• Hearing Aids	• Routine Eye Care (Adult)
• Chiropractic Care	• Infertility Treatment (Only when meets plan guidelines)	• Weight Loss Programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue coverage after it ends. For more information on you 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/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.Healthcare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact the plan at 1-800-422-4641; you may also contact the Department of Insurance and Financial Services, Healthcare Appeals Section, Office of General Counsel, 611 Ottawa, 3rd Floor, P.O. Box 30220, Lansing, MI 48909-7720, http://michigan.gov/difs; call 1-877-999-6442 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum essential coverage for a month, you'll have to pay when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum value standards, you may be eligible for premium tax credits to help you pay for a plan through the Marketplace.

Language Access Services:
Please see a full list of Language Access Services following the Coverage Examples at the end of the Summary of Benefits of Coverage.

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

Appendix - SBC

About these Coverage Examples:

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

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
The plan's overall deductible	$150
Specialist copayment	$30
Hospital (facility) copayment	$0
Other coinsurance	0%

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

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$150
Copayments	$610
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$820

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The plan's overall deductible	$150
Specialist copayment	$30
Hospital (facility) copayment	$0
Other coinsurance	0%

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

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$150
Copayments	$1,075
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,280

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible	$150
Specialist copayment	$30
Hospital (facility) copayment	$0
Other coinsurance	0%

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

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$150
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$240

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

Appendix - SBC

Language Access Services

VINI RE: Nëse flisni shqip, ju ofrohen shërbime ndihme gjuhësore falas. Telefononi numrin (800) 422-4641 ose TTY: 711.

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية مجانًا. اتصل بالرقم 4641-422 (800) أو خدمة الهاتف النصي:711.

নজর দিন: আপনি বাংলা ভাষায় কথা বললে, ভাষা সহায়তার পরিষেবা বিনামূল্যে আপনার জন্য উপলব্ধ। (800) 422-4641 বা TTY: 711 নম্বরে কল করুন।

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 422-4641 或 TTY 用户請致電 711。

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufnummer: (800) 422-4641 oder TTY: 711.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (800) 422-4641 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(800) 422-4641 まで、お電話にてご連絡ください。TTY ユーザーは 711 までご連絡ください。

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-422-4641 번 또는 TTY: 711 번으로 연락해 주십시오.

UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 422-4641 lub TTY: 711.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь по номеру (800) 422-4641 (телетайп: 711).

NAPOMENA: Ako govorite hrvatski/srpski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte (800) 422-4641 ili tekstualni telefon za osobe oštećena sluha: 711.

ATENCIÓN: si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Llame al (800) 422-4641, los usuarios TTY deben llamar al 711.

ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ/ܐܪܡܝܐ، ܟܐ ܡܫܬܟܚܝ ܠܟܘܢ ܬܫܡܫܝܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘ ܥܠ ܡܢܝܢܐ (800) 422-4641 ܐܘ ܥܠ TTY: 711.

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Tumawag sa (800) 422-4641 o TTY: 711.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi (800) 422-4641 hoặc TTY: 711.

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)	**Plan Source**	**888-222-4309** **www.plansource.com**
EAP	**Ulliance**	**800-448-8326** **www.lifeadvisorEAP.com**

Other Questions or Changes In Eligibility
888-222-4309

Arthur J. Gallagher & Co.

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.