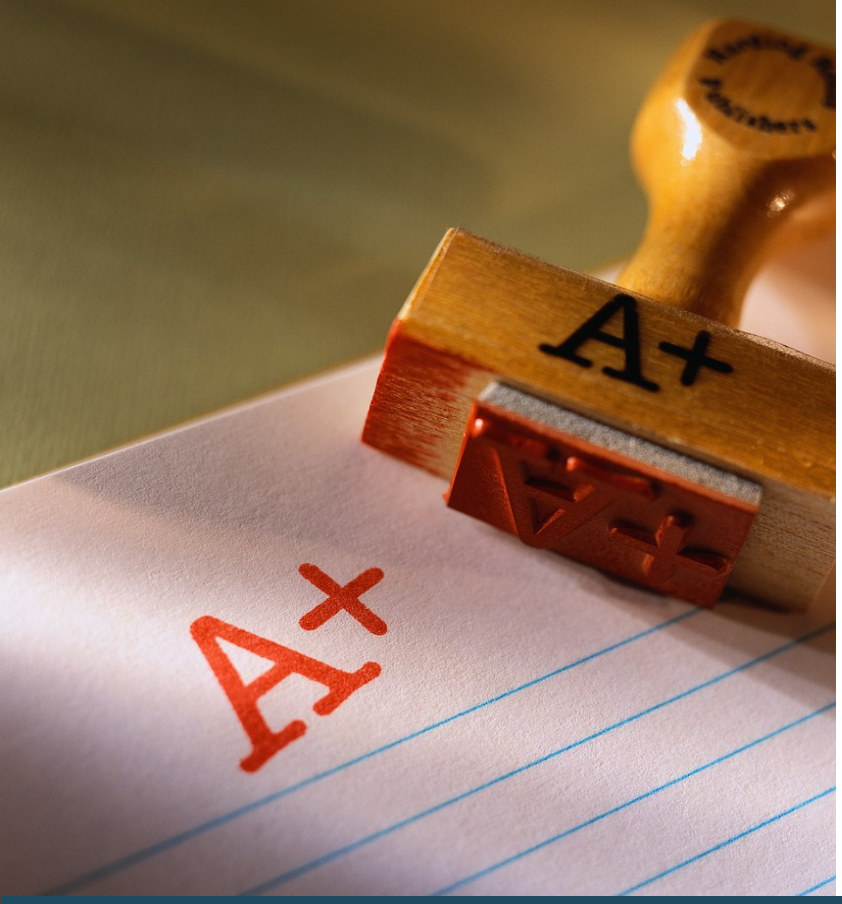
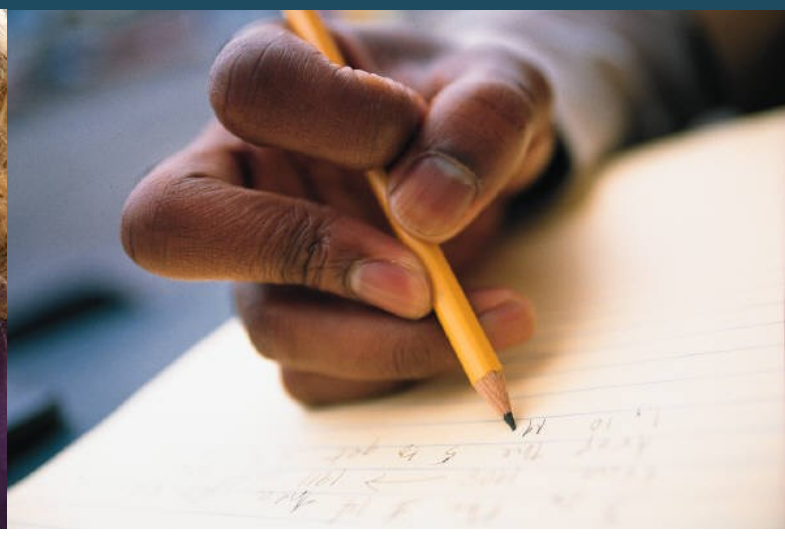


Bloomfield Hills Schools

2018 Workbook

Educated Choices

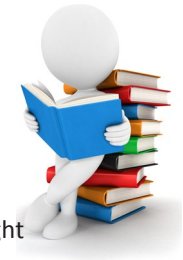


Medicare Part D - Prescription Drug Information

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 pages 53-54 for more details. Not all medical plans are considered creditable with Medicare and may require you to take action or pay a penalty in the future.

Table of Contents

Welcome to your 2018 *Educated Choices* Annual Enrollment!



Educated Choices is an innovative, progressive flexible benefit plan that gives you the choice to select your benefits from a menu of options, based on your employment agreement. Each year, you have the opportunity to select the right benefit combination for you and your family.

2018 UPDATES

- **Open enrollment runs from November 1—8 ONLY—the system will not be re-opened for a confirmation period.**
- BCBSM vision network has been expanded to include the VSP network. (Your new Vision ID cards will arrive prior to 1/1/18)
- Next Generation Enrollment (NGE) is now known as Plan Source.
- Reliance Standard will replace Lincoln Financial as the Life and Disability carrier.
- HSA contribution eligibility will cease in the month in which you turn 65 AND enroll in Medicare, unless BHS is informed in writing 30 days prior to the contrary. See reimbursement account section for more details.

2018 IRS REQUIRED CHANGES TO HIGH DEDUCTIBLE HEALTH PLANS

The IRS has raised the minimum deductible requirement of High Deductible Health Plans to $1,350/$2,700 for 2018. Our $1,300/$2,600 PPO plan will be modified to reflect this new requirement.

Additionally, the IRS will allow you to deposit up to $3,450/ $6,900 into your Health Savings Account.

The $1,000 catch up provision still applies for those turning age 55, in the 2018 plan year, or those who are already age 55 or older.

Using Your Benefit Education Materials

This workbook contains information you need to know about ***Educated Choices***. It provides an informative overview of your benefit options and is designed to help you in selecting your benefits. In addition to this workbook, several other benefit education resources are included with your enrollment email. Please review these materials carefully so your choice in benefits will be an ***Educated Choice***.

- Pre-Enrollment Email – outlines Open Enrollment details, including how and when to enroll
- Summary of Benefits – details benefit options available to you, based on your employment agreement
- Frequently Asked Questions (FAQs) – provides answers to commonly asked questions about the ***Educated Choices*** enrollment process
- HSA FAQs – provides answers to commonly asked questions about the Health Savings Account enrollment process
- Married Couples Health Risk Assessment
- Open Enrollment Event FSA Reminder

Educated Choices Glossary

It may be helpful for you to review some of the common terms used throughout this workbook to increase your understanding of the ***Educated Choices*** program.

- **Approved Amount** – The fee that BCBSM approves as the "reasonable and customary" fee for a specific service in a particular geographic location.
- **Benefits-At-A-Glance/Summary of Benefits** – An easy to read summary of in-network and out-of-network deductibles, co-pays and dollar maximums for certain covered services under the plan. It is a summary, not an all-inclusive list of the benefit plan. A complete description of benefits can be found in the certificates and riders for each plan.
- **Benefit Dollars** – The credits available to an employee which are used to purchase benefit options offered

Educated Choices Glossary

through ***Educated Choices***.

- **Brand-name drugs** – Prescription drugs that are patent protected. When the patent expires, other manufacturers can produce the generic equivalent of the brand and sell it under a generic name. See Tier 2 and Tier 3 descriptions on each Medical/Rx plan Benefit Summary.

- **Coinsurance** – The fixed percentage of expenses you share with the insurance carrier. The coinsurance begins after the deductible has been satisfied.
- **Co-payment** – The fixed dollar amount you pay for certain services. **Coverage Status** – This is the number of individuals eligible to be covered under your health plan (single, two-person or family).
- **Deductible** – The expense you incur before the plan or insurance carrier begins paying your covered expenses. The deductibles are met each calendar year for medical. Vision deductibles will vary according to your employment agreement (outlined in your Summary of Benefits).
- **Effective Date** – All ***Educated Choices*** benefits will be effective on January 1st for the full calendar year.
- **Eligible Dependent** – This includes your spouse and eligible dependents between the ages of 1 day-26 years, regardless of marital, student and financial status.
- **Formulary** – A regularly updated list of medications reviewed by the Blues' Pharmacy and Therapeutics Committee that represents the clinical judgment of Michigan Physicians, pharmacists and other health care experts in the diagnosis and treatment of disease and preservation of health.
- **Full Scope Flexible Spending Account (FSA)**– a saving option for employees who are at least age 65 and enrolled in Medicare, or not enrolled in a Health Savings Account (HSA). The Full Scope FSA permits reimbursement for expenses associated with medical, dental and vision services.
- **Generic drugs** – Non-brand name drugs that produce the same effects in the body as the equivalent brand-name drugs. The Food and Drug Administration requires that generic drugs have the same active ingredients as the equivalent brand-name drugs. They may differ from brand-name drugs in color and shape. Since the major difference between brand-name and generic drugs is price, your prescription will be filled with the generic equivalent when medically appropriate. See Tier 1 description on the Benefit Summaries.
- **Health Savings Account (HSA)** – A tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high-deductible health plan (HDHP). This money remains the property of the subscriber even if employment is terminated. **This is not an option for someone who is not enrolled with a High Deductible Health Plan or someone who is age 65 or over AND enrolled in Medicare.**
- **Health Equity is the provider for the Health Savings Account. You can access these funds using your benefit debit VISA or through the online banking system. This is your personal bank account. Your employer has no access to these funds.**
- **High Deductible Health Plan (HDHP)** – a health insurance plan with lower premiums and higher deductibles than a traditional health plan.
- **In-Network** – This means your doctor or facility participates in and accepts the High Deductible Health Plan and has agreed to a reduced fee schedule.
- **Life Status Change** – If you have a life status change (e.g., your spouse's employment changes or is terminated involuntarily, or you have a birth, marriage, death of a dependent or spouse, or divorce in your family), you may be able to add or drop certain types of coverage for dependents. If you have any questions as to what is considered an acceptable status change, please contact your Benefits Coordinator within thirty (30) days of the life status event. **Mid-plan year life status changes require a meeting with the Benefits Coordinator. Please contact her within 30 days of the life event to schedule an appointment. Health Savings Account Changes may be made every 30 days and also require a meeting with the Benefits Coordinator. A life status event does not need to occur to make this type of change to payroll deductions.**

  Note: Mid-plan year changes cannot be made via online enrollment systems, email or through voice message systems.
- **Out-of-Network** – This means your doctor or facility is **not** part of and does not accept the Simply Blue PPO HSA plan. Out-of-network services will be covered at a lower percentage, you will be responsible for the difference. BCN DOES NOT COVER ANY SERVICES IF YOU GO OUT-OF-NETWORK!

Open Enrollment Updates

Educated Choices Plan Provisions

Other benefits based on your salary, such as the 403(b) and Michigan Public Schools Retirement Service Credit, will not be affected if you convert your salary to purchase additional benefits. Converting your salary to purchase benefits may have a slight effect on the benefits you and your family will receive from Social Security since these benefits are based on your FICA taxable income.

Medical Plan Deductible

IRS regulations state, High Deductible Health Plans (HDHP) must have minimum deductible amounts of $1,350 for single coverage and $2,700 for family coverage. Bloomfield Hills Schools offers three High Deductible Health Plans. Two PPO plans through BCBSM and one HMO through BCN. Health Equity will service any health savings accounts (HSA) associated with any of these medical plans.

Waiver of Medical Insurance Forms

If you choose to decline the medical coverage offered by Bloomfield Hills Schools, you will be able to waive coverage during the online enrollment process if you decline to enroll into a medical option.

Health Risk Assessment Credit

Bloomfield Hills Schools will continue to offer a credit to employees and spouses (if applicable), who participate in the annual Health Risk Assessment. In order to be eligible to receive the Health Risk Assessment credit for the upcoming plan year, the completed form must be submitted to the Benefits Coordinator no later than September 15th annually. Forms received after the due date will not qualify for any credit. There will be no exceptions. These forms are available on the Bloomfield Hills Schools Intranet under Human Resources, Benefits. If you are unable to locate the form please contact the Benefits Coordinator at sdare@bloomfield.org.

Please note that, for all employees who turned in a Health Risk Assessment form, you will not be able to view this credit in the online enrollment system, however it will be detailed on your online confirmation statement.

Your Choices

Bloomfield Hills Schools understands that the benefit decisions you make today may not be right for you in future years. Therefore, you have an opportunity each year in the fall to make changes in benefits for the upcoming calendar year. **The available choices, as outlined in your employment agreement, are displayed on your Summary of Benefits. The funding of options by Bloomfield Hills Schools can be viewed on the online enrollment system.** If you have any questions regarding your enrollment, benefit coverage or options described herein, please contact:

Sarah Dare, Benefits Coordinator
sdare@bloomfield.org
(248) 341-5431

Karen Healy, Director
Human Resources and Payroll
khealy@bloomfield.org
(248) 341-5432

Public Act 152

State Legislature changed the funding of benefits for public school employees. Bloomfield Schools elected to comply with the law with the "hard cap".

Governor Snyder signed a new law that limits public employer contributions to employee health insurance, effective with each collective bargaining agreement that expires on or after January 1, 2012. This law will apply to all public schools in the state. The "Publicly Funded Health Insurance Contribution Act" provides two mechanisms that limit employer contributions to healthcare: a "hard cap" and an optional "80/20" plan. The Act applies to "medical benefit plans" that provide payment of medical benefits, including, but not limited to, hospital and physician services, prescription drugs, and related benefits. The Act does not apply to dental or vision care plans.

The Default Limit: The Hard Cap

The Act is drafted to apply a maximum that a public employer may pay towards public employee health care costs. The limit on a public employer's total contribution for employee health insurance for the upcoming plan year is equivalent to:

- $6,560.52 times the number of employees and elected public officials with single-person coverage
- $13,720.07 times the number of employees and elected public officials with individual-and-spouse coverage or individual-plus-1-nonspouse-dependent coverage
- $17,892.36 times the number of employees and elected public officials with family coverage

The State of Michigan releases the annual Hard Cap each year, so the new information on these limits will be included online during the annual open enrollment process.

The amount necessary to purchase health insurance for employees that exceeds this "cap" must be paid by employees.

Q: What employers are affected by the Act?

The new law applies broadly to "public employers." The Act applies to local units of government, political subdivisions of the state, and "any intergovernmental, metropolitan, or local department, agency, or authority, or other local political subdivisions." Also included are school districts, community or junior colleges, and certain other institutions of higher education.

Q: What employer costs count toward the cap?

The annual premium or illustrative rate and any payments for reimbursements of co-pays, deductibles, or payments into Health Savings Accounts, Flexible Spending Accounts, or similar accounts used for health care are included as employer costs.

Q: Will the caps ever change?

Yes. The State Treasurer will adjust the caps each October 1 based on the change in the medical care component of the U.S. Consumer Price Index. The newly adjusted caps will be effective January 1 of each year.

Educated Choices Online Enrollment Instructions

The ***Educated Choices*** Online enrollment system is an easy, convenient way to enroll in your benefits using your computer. **Please note, enrollment is mandatory.**

Enrollment System

The ***Educated Choices*** Online enrollment system is available 24 hours a day, seven days a week during the enrollment period. Open Enrollment will be held:

- **November 1, 2017 through November 8, 2017 for an effective date of January 1 through December 31, 2018.**

It is very important for you to note these dates. Please plan to enroll during the designated enrollment period.

Once you have enrolled using the Web site, you have almost completed the enrollment process. **Dependents not newly enrolled but between the ages of 20 and 26 will require each employee to provide an electronic acknowledgement while enrolling. Documentation for newly enrolled dependents (copy of marriage license/birth certificate/ Social Security card) is required before the dependent(s) can be added to your insurance benefits. Failure to provide adequate documentation by December 1, 2017 will result in your dependent(s) being removed from coverage effective January 1 of the new plan year.**

Process for Life Insurance Beneficiaries

It is extremely important to declare one or more beneficiaries for the life insurance benefits you receive as an employee of Bloomfield Hills Schools. Your beneficiary information is being stored online in the enrollment system. During the enrollment process, you will be asked to enter beneficiary information for your employee life insurance policies. **Note that you must go online during the annual enrollment period and designate or confirm a beneficiary.**

Preparing for Enrollment

Please review your ***Educated Choices*** newsletter, workbook, and Summary of Benefits.

When you have decided on each of your ***Educated Choices*** benefit options, gather dependent information, including Social Security numbers and dates of birth. You are now ready to enroll!

Completing Your Enrollment

- To enroll, logon to the ***Educated Choices*** Web site at https://benefits.plansource.com. Instructions on how to login, including your "Username" and "Password", can be found on your pre-enrollment email included with your enrollment materials.
- The system will ask you to verify your email address(es). Please be sure to include your email address; this is required for you to receive a confirmation email once your enrollment is complete.

- You will be able to review, update, add or delete your dependent information. This information determines your coverage status (single, two-person, or family) for your medical, dental and vision choices. Review this information carefully.
- Continue to the benefit election screen where you will make your election choices. The online enrollment system will show your payroll deductions per pay period. Deductions are taken over a 20 pay cycle for the Plan Year January 1 through December 31, no deductions are taken in July or August.

Educated Choices Online Enrollment Instructions

- Once you have confirmed your elections in the online system, your enrollment is complete! You will be offered the opportunity to receive an email confirmation and receive a congratulatory message. **Be sure to turn in any required documentation and print your confirmation statement.**
- If you need to make changes to your benefit selections, you may return to the ***Educated Choices*** online enrollment system as many times as you wish within the annual enrollment period.

Confirmation Statement Process

At the end of the enrollment period, a confirmation email will be sent to your email address on file in the enrollment system. It will provide a link for you to click and review your confirmation statement online.

Please review your confirmation statement carefully to ensure that your selections were recorded correctly. The dependents listed on your confirmation statement will dictate to the insurance providers the covered participants under your plan.

While online….

You will receive a Personal Health Statement (PHS) if you made change(s) to your voluntary life election over the guaranteed issue amount. You will need to complete this medical questionnaire and return the fully completed form to the life insurance carrier. Please do not send a fully completed Personal Health Statement to the Human Resources Department. Also, please note, increased life insurance amounts remain pending until written approval is received from the carrier. You have until January 1st of the plan year to submit the PHS to the carrier. Failure to do so will result in your request being closed.

Insurance Carrier Contact Information

If you need to contact the carriers directly, customer service phone numbers and Web site addresses are listed below.

Medical, Prescription, Dental and Vision Coverage

Blue Cross/Blue Shield of Michigan
BCBS PPO HSA Plan
Customer Service: 1-800-637-2227
Website: www.bcbsm.com

Blue Care Network
Customer Service: 1-800-662-6667
Website: www.bcbsm.com

Health Savings Account (HSA)

Health Equity
Customer Service: 1-866-346-5800 Hours of Operation: 24/7 365 days per year
Website: www.healthequity.com

Health and Dependent Care Reimbursement Accounts

NGE
Phone: 1-866-369-1387
Fax: 1-888-267-0839
Website: www.nextgenerationenrollment.com

Employee and Dependent Life Insurance Protection, AD & D, and Short and Long Term Disability

Reliance Standard
Customer Service Phone: 1-800-351-7500
Customer Service Email: customer.service@rsli.com
Website: www.reliancestandard.com

Eligibility and Additional Resources for your *Educated Choices*

BCBSM Secure Member Services and BCN Secure Member Services

The online Secure Member Services will help you learn more about:

- Managing Your Health
- Personalized Health Care
- Managing Your Claims
- Medication Guides and Brochures
- Helping Members Save Money
- Establishing an Advance Directive
- Member Publications
- Member Forms
- Member FAQs

http://www.bcbsm.com/member

Additional BCBSM and BCN Member Services

Blue Cross Blue Shield of Michigan also offers a variety of in-store discounts such as Weight Watchers, Jenny Craig, Dunham's and more. See flyer included with your enrollment materials.

You can contact Blue Cross Blue Shield by calling Customer Service at 1-877-790-2583 or BCN Customer Service at 800-662-6667 or logging online at www.bcbsm.com

Eligible Dependent Requirements

Coverage in the ***Educated Choices*** medical, dental and vision plans is for you, your spouse and your eligible dependents. Due to Health Care Reform regulations, children are eligible until the end of the month that they reach age 26.

During the enrollment process, you will need to enter your eligible dependent's Social Security number (SSN) and date of birth. **Note that all insurance carriers must have an accurate SSN on file for your dependents in order to process claims**. Eligible dependents between the ages of 19 and 26 must meet the requirements listed below and can be covered through the end of the month in which they turn 26. This is regardless of student, financial, marital or dependency status.

Dependent children of the subscriber or the subscriber's spouse are eligible provided such children are:

- Between 19-26 years old
- Related by blood, marriage or legal adoption

Please note: Coverage provisions for dependent children may vary based on insurance carrier.

Medical and Prescription Drug Benefits

Your Medical Plan Choices

The available choices, as outlined in your employment agreement, are displayed on your Summary of Benefits. Your cost and the employer cost/credits are displayed as you online enroll.

Medical Plans

This section outlines the medical plans offered through ***Educated Choices***.

The BCBS HDHP plan has an in-network option that gives you access to quality medical services. Obtaining services from an in-network provider reduces the cost as these doctors and hospitals have agreed to provide medical services at reduced rates. You decide whom you want to see at the time of service. If you select an in-network doctor or hospital from the online directory, your covered benefits are typically greater and your cost is usually less. However, the in-network deductible is higher than traditional health plans and there is a deductible for out-of-network services that must be met each calendar year. After the deductible is satisfied, Prescription Drugs (including contraceptives) have a co-pay. Prescription Drugs have a mail order and retail, 90-day supply option with a reduced co-pay (after deductible).

Services provided by an out-of-network provider may not be covered. **You are responsible for deductible fees incurred for services provided.**

Being covered by this HDHP may allow you to contribute to a **Health Savings Account (HSA)**. An **HSA** is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high-deductible health plan (HDHP). The funds contributed to an HSA are not subject to federal income tax at the time of deposit. Unlike a flexible spending account (FSA), HSA funds roll over and accumulate year to year if not spent. HSAs are owned by the individual, which differentiates them from company-owned Health Reimbursement Arrangements (HRA) that are an alternate tax-deductible source of funds paired with either HDHPs or standard health plans. HSA funds may currently be used to pay for qualified medical expenses at any time without federal tax liability or penalty. Withdrawals for non-medical expenses are treated very similarly to those in an individual retirement account (IRA) in that they may provide tax advantages if taken after retirement age, but they incur penalties if taken earlier. More information on HSAs can be found on the FAQ sheet included in your enrollment materials.
The IRS regulates the maximum contribution limits for HSA accounts. Below are the details for the plan year.

HSA Contribution Limits (January 1 through December 31, 2018)

- **For Single Coverage – $3,450**
- **For Family Coverage - $6,900**

HSA participants between age 55 and 64 who are not enrolled in Medicare, have the option to **contribute an additional $1,000 annually.**

In order to be eligible for a health savings account, you must be able to answer no to all of the following questions:

1. Are you currently enrolled in Medicare?
2. Are you or your spouse enrolled in another medical plan that is not a high-deductible health plan?
3. Per IRS regulations, one cannot be enrolled into a Health Savings Account (HSA) and a Health Care Flexible Spending Account (FSA) at the same time. On January 1, will you or your spouse be enrolled in an FSA or have money left in an FSA?
4. Will you be claimed as a dependent on another person's tax return this year?
5. Do you receive health benefits under TRICARE (healthcare program for active duty and retired members of the uniformed services, their families and survivors)?
6. Are you or your spouse receiving VA Benefits that are not connected to a service-related disability?

Medicare Enrolled Staff or Family Members

If you or a family member are enrolled with Medicare, a copy of the enrollment card must be forwarded to the Benefits Coordinator during annual open enrollment. BCBS and the Center for Medicare/ Medicare Services (CMMS) coordinate benefits with Bloomfield Hills School District being the primary payee. It is critical that we have the correct information to submit to these servicing agencies in order for claims to be properly paid. If you or a family member become enrolled with Medicare during the plan year, a copy of the enrollment card must be forwarded to the Benefits Coordinator at

Medical and Prescription Drug Benefits

Prescription Drugs

BCBSM and BCN have different formularies and different copay tiers. (Formulary is a list of covered medicines) What you pay depends on what tier your drug is in and whether you are enrolled in the PPO or HMO plan.

BCBSM Copays

Tier 1 – Generic—$5 copay applies after deductible is met

Tier 1 drugs are generic drugs. They require the **lowest co-payment**, making them the most cost effective option for treatment. Many prescription drugs are available as generics.

Tier 2 – Formulary Brand—$25 copay applies after deductible is met

Tier 2 drugs are brand-name drugs. Tier 2 drugs are also safe and effective but require a **higher co-payment** than Tier 1 drugs.

Tier 3 – Non-formulary Brand—$50 copay applies after deductible is met

Tier 3 drugs are brand-name drugs not included in Tier 2. These drugs require the highest co-payment. You may also have to pay the difference between the cost of the Tier 3 non-formulary brand-name drug and the generic if a generic equivalent is available but the brand is dispensed.

BCN Copays

Tier 1A – Preferred Generic - $10 copay applies after deductible is met.
Tier 1A drugs are cost effective generic drugs. They require the lowest co-payment, making them the most cost effective option for treatment.

Tier 1B – Generic - $30 copay applies after deductible is met.
Tier 1B drugs are generic medications but have a higher cost associated with them than the preferred generics.

Tier 3 – Formulary Brand - $60 copay applies after deductible is satisfied.
Tier 3 drugs are cost effective name brand drugs and require a higher copayment than generics.

Tier 4 – Non Formulary Brand - $80 copay applies after deductible is met.
Tier 4 drugs are brand name drugs not included in Tier 3 and require a higher copayment than generics or Formulary Brand.

Tier 5 – Formulary Specialty – 20% coinsurance applies after deductible is met (maximum cost to member is limited to $200 per refill)
Tier 5 drugs are specialty medications that can be used to treat chronic and/or severe medical conditions but are considered more cost effective than other specialty medications.

Tier 6 – Non Formulary Specialty – 20% coinsurance applies after deductible is met (maximum cost to member is limited to $300 per refill)

that time.

Generic equivalents or formulary brand-name alternatives are available for many of these Tier 3 drugs. Similar drugs with generic equivalents may also be available. If you want to know if you can have your prescription changed to a Tier 1 or Tier 2 medication, speak with your physician to see if a change is appropriate for you.

BCBSM and BCN's *Custom Formulary Quick Guide for Members* lists commonly prescribed medications available under each tier. You can find the *Custom Formulary Quick Guide for Members* at **www.bcbsm.com**.From the Member Page:

- Click on Prescription Drugs
- Click on Approved Drug Lists (Formularies)
- Click on Custom Formulary
- Click on Download the Custom Formulary Quick Guide (PDF)

Medical and Prescription Drug Benefits

A drug you are taking may not be covered under this prescription drug plan. You should check the *Custom Formulary Quick Guide for Members* prior to your new plan's effective date to see if your medication is covered. If it isn't covered, contact your physician to have your prescription changed, if determined appropriate, to a covered drug.

Duplication of Coverage/Dual Medical Coverage

You have the ability to enroll with **Dual Medical Coverage**. However, if you are enrolled with the District's High Deductible Health Plan with a Health Savings Account you are not eligible to be enrolled through a Non-High Deductible Health Plan with your spouse or parent. If you are enrolled with a Non-High Deductible Health Plan, you are eligible to enroll in the BHSD medical coverage in addition to enrolling in the medical coverage provided through the medical plan provided by your spouse's employer. (However, you will not be eligible to enroll with the health savings account).

Medical Opt-Out

You can opt-out of medical coverage for yourself and your dependents as indicated in your employment agreement. If you involuntarily lose your other medical coverage, this plan allows you to select a Bloomfield Hills Schools' medical plan. **However, you must notify the Benefits Coordinator within 30 days of your loss of coverage in order to opt back into a medical plan.**

Mid-plan year life status changes require a meeting with the Benefits Coordinator. Please contact the Benefits Coordinator within 30 days of the life event to schedule an appointment. Voluntary changes can only be made once per year during the *Educated Choices* open enrollment.

If you choose to decline the medical coverage offered by Bloomfield Hills Schools, you will not need to complete a waiver form. Instead, you will be able to waive coverage during the online enrollment process if you decline to enroll into a medical option.

To enroll in the Medical Opt-Out plan online, you will first need to decline the Medical options. If you qualify for the opt-out credit, you will be directed to the Medical Opt-Out plan page where you will need to enroll into the opt-out plan. Make sure to check the box next to each of your dependents. This information is used to determine who would be eligible for medical coverage and the value of your opt-out amount (single, two-person or family). Bloomfield Hills Schools will add the cash

Dental and Vision Coverage

Dental Plan Coverage

Dental plans encourage you and your eligible dependents to seek quality dental care on a regular, preventive basis as part of a total health care program. When participating in the dental plan, you have the flexibility to select your own dentist.

Covered Services

Dental services are divided into categories and reimbursements are based on "reasonable and customary" charges.

- **Class I Preventive** – Benefits include examinations, cleanings and periodic X-rays
- **Class II Basic Services** – Benefits include fillings, root canal therapy, extractions, oral surgery, repair of dentures and bridges and periodontal services
- **Class III Major Services** – Benefits include inlays, crowns, bridges and dentures
- **Class IV Orthodontia Services** – Benefits, if applicable to your employment agreement, may include services, treatment and procedures for the alignment or correction of teeth, up to age 19

Your Dental Plan Choices

The available choices, as outlined in your employment agreement, are displayed on your Summary of Benefits which follow. Your cost and the employer cost/credits are displayed as you online enroll.

Vision Plan Coverage

Eyesight is important to your well being. Your current vision plan helps you maintain quality eye care. When participating in the vision plan, you have the flexibility to select your own optometrist or ophthalmologist, however you will pay less out of your pocket when using a VSP provider. Locate participating VSP providers at https://vsp.com

Covered Services

The vision plan offers you the following benefits:

- Eye exam screening and analysis
- Corrective lenses or contact lenses
- Frames

A co-pay is required for each eye exam and for new lenses and frames (combined).

Limitations

The following expenses are **not covered**:

- Surgical or medical care for treatment of eye disease and/or injury
- Sunglasses (plain or prescription); photo-sensitive, anti-reflective or aniseikonic glasses; or other tinted glasses of any kind to the extent that the charges exceed the charge for clear lenses or safety lenses or goggles
- Additional cost for progressive lenses
- Expenses incurred for cosmetic or fashion reasons
- Replacement of lost, stolen or broken lenses or frames

Your Vision Plan Choices

The available choices, as outlined in your employment agreement, are displayed on your Summary of Benefits included in your Open Enrollment Packet. Your cost and the employer cost/credits are displayed as you online enroll.

Membership has its benefits

Blue Cross Blue Shield of Michigan and Blue Care Network members can score big savings on a variety of healthy products and services from businesses in Michigan and across the United States.

We've got plenty of deals to keep you and your family healthy.

Member discounts with Blue365 offers exclusive deals on things like:

- **Fitness and wellness:** Health magazines, fitness gear and gym memberships
- **Healthy eating:** Cookbooks, cooking classes and weight-loss programs
- **Lifestyle:** Travel and recreation
- **Personal care:** Lasik and eye care services, dental care and hearing aids

Cash in on discounts

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

Blue Cross Blue Shield Blue Care Network of Michigan | Blue365® Because health is a big deal™

Member discounts with Blue365

Take advantage of discounts from the businesses listed below and many more.

Get monthly updates and details about new offers delivered directly to your email inbox. Just log in to your member account at bcbsm.com and opt-in to receive emails through *Paperless Options* under *Account Settings*.

You can conveniently access discounts from any device — anytime, anywhere.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Program information valid as of January 2017.

The Blue365 program is brought to you by the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association is an association of independent, locally operated Blue Cross and Blue Shield plans. Blue365 offers access to savings on items that members may purchase directly from independent vendors, which are different from items that are covered under health care plan policies with Blue Cross Blue Shield of Michigan or Blue Care Network, its contracts with Medicare or any other applicable federal health care program. Neither Blue Cross Blue Shield of Michigan, Blue Care Network nor the Blue Cross and Blue Shield Association recommends, endorses, warrants or guarantees any specific vendor or item.

CF 12374 JAN 17 R064814

BLUE CROSS/BLUE SHIELD

MEDICAL

PPO $1,350/$2,700

Blue Cross Blue Shield of Michigan

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

BLOOMFIELD HILLS BOARD OF ED
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Simply Blue PPO HSA℠ ASC with Rx
Effective Date: On or after January 2018
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible, copay and/or coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Preauthorization for Specialty Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when require, are preauthorized or approved by BCBSM except in an emergency

Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo**. Select **Approving covered services.**

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility**.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

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

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "lowaccess area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

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

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Benefits	In-network	Out-of-network
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage. **Note:** The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	$1,350 for a one-person contract $2,700 for a family contract (2 or more members) each calendar year **(no 4th quarter carry-over)** Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Deductibles may increase each calendar year. Please call your customer service center for an annual update.	$2,700 for a one-person contract $5,400 for a family contract (2 or more members) each calendar year **(no 4th quarter carry-over)**
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	None	20% of approved amount for most covered services
Annual out-of-pocket maximums-applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	$2,250 for a one-person contract $4,500 for a family contract (2 or more members) each calendar year	$4,500 for a one-person contract $9,000 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam-includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening- laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices-includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

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Benefits	In-network	Out-of-network
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the **same** calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy **Note:** Medically necessary colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Online visits - by physician must be medically necessary **Note:** Online visits by a vendor are not covered.	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

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Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services - must be medically necessary	100% after in-network deductible	100% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care	100% after in-network deductible	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% after in-network deductible Unlimited days	80% after out-of-network deductible
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care- must be in a **participating** skilled nursing facility	100% after in-network deductible Limited to a maximum of 120 days per member per calendar year	100% after in-network deductible
Hospice care	100% after in-network deductible Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods-provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% after in-network deductible
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	100% after in-network deductible	100% after in-network deductible

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Benefits	In-network	Out-of-network
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization-consult with your doctor	100% after in-network deductible	100% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery-includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	100% after in-network deductible	80% after out-of-network deductible
Voluntary abortions	100% after in-network deductible	80% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% after in-network deductible -in designated facilities **only**
Bone marrow transplants-must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials **Note**: BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

Mental health care and substance use disorder treatment

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility • covered mental health services **must** be performed in a residential psychiatric treatment facility • Treatment must be preauthorized • subject to medical criteria	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible in participating facilities **only**
• Online visits **Note:** Online visits by a vendor are not covered.	100% after in-network deductible	80% after out-of-network deductible
• Physician's office	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance use disorder treatment-in approved facilities **only**	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

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Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment-when rendered by an approved board-certified behavioral analyst-is covered through age 18, subject to preauthorization **Note**: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not covered	Not covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	100% after in-network deductible	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible	80% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy-provided for rehabilitation	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member, per calendar year	
Durable medical equipment **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	100% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing care	100% after in-network deductible	100% after in-network deductible

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Simply Blue HSA with Prescription Drugs
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Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are require to pay applicable prescription drug copays and coinsurance amounts which are subject to your annual out-of-pocket maximums.

Note: The following prescription drug expenses will not apply to your Simply Blue HAS deductible or annual out-of-pocket maximum

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- the 20% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay plus an additional 20% of the BCBSM approved amount

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
	31 to 83-day period	No coverage	After deductible is met, you pay $10 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $50 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $100 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $100 copay	After deductible is met, you pay $100 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs * BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Prescribed over-the-counter drugs - when covered by BCBSM	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	Not covered	100% of approved amount	80% of approved amount
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/ coinsurance.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty for insulin or other covered injectable legend drug

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Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.

Features of your prescription drug plan	
Drug interchange and generic copay/ coinsurance waiver	BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, You pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

BLUE CROSS/BLUE SHIELD

Medical

PPO $2,000/$4,000

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Note: A list of services that require approval **before** they are provided is available online at **bcbsm.com/importantinfo**. Select **Approving covered services.**

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. **If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility**.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other disease as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

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

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "lowaccess area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

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Eligibility Information

Member	Eligibility Criteria
Dependents	• Subscriber's legal spouse • **Dependent children:** related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26
Sponsored dependents	• Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.

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

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Benefits	In-network	Out-of-network
Deductibles **Note:** Your deductible **combines** deductible amounts paid under your Simply Blue HSA medical coverage **and** your Simply Blue prescription drug coverage. **Note:** The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract.	$2,000 for a one-person contract $4,000 for a family contract (2 or more members) each calendar year **(no 4th quarter carry-over)**	$4,000 for a one-person contract $8,000 for a family contract (2 or more members) each calendar year **(no 4th quarter carry-over)**
Flat-dollar copays	See "Prescription Drugs" section	See "Prescription Drugs" section
Coinsurance amounts (percent copays) **Note:** Coinsurance amounts apply once the deductible has been met.	None	20% of approved amount for most covered services
Annual out-of-pocket maximums-applies to deductibles and coinsurance amounts for all covered services - including prescription drug cost-sharing amounts	$3,000 for a one-person contract $6,000 for a family contract (2 or more members) each calendar year	$6,000 for a one-person contract $12,000 for a family contract (2 or more members) each calendar year
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam-includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year **Note:** Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening- laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices-includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's

Benefits	In-network	Out-of-network
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) **Note:** Subsequent medically necessary mammograms performed during the **same** calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible **Note:** Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
	One per member per calendar year	
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy **Note:** Medically necessary colonoscopies performed during the **same** calendar year are subject to your deductible and coinsurance.	80% after out-of-network deductible
	One routine colonoscopy per member per calendar year	

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Online visits - by physician must be medically necessary **Note:** Online visits by a vendor are not covered.	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's

Benefits	In-network	Out-of-network
Urgent care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services - must be medically necessary	100% after in-network deductible	100% after in-network deductible

Diagnostic services

Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Postnatal care	100% after in-network deductible	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies **Note:** Nonemergency services must be rendered in a **participating** hospital.	100% after in-network deductible Unlimited days	80% after out-of-network deductible
Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care- must be in a **participating** skilled nursing facility	100% after in-network deductible Limited to a maximum of 120 days per member per calendar year	100% after in-network deductible
Hospice care	100% after in-network deductible Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods-provided through a **participating** hospice program **only**; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	100% after in-network deductible

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's

Benefits	In-network	Out-of-network
Home health care: • must be medically necessary • must be provided by a **participating** home health care agency	100% after in-network deductible	100% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a **participating** Home Infusion Therapy (HIT) provider or in a **participating** freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization-consult with your doctor	100% after in-network deductible	100% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery-includes related surgical services and medically necessary facility services by a **participating** ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males **Note:** For voluntary sterilizations for females, see **"Preventive care services."**	100% after in-network deductible	80% after out-of-network deductible
Voluntary abortions	100% after in-network deductible	80% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a **designated** facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% after in-network deductible -in designated facilities **only**
Bone marrow transplants-must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials **Note**: BCBSM covers clinical trials in compliance with PPACA.	100% after in-network deductible	80% after out-of-network deductible
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

Mental health care and substance use disorder treatment

Benefits	In-network	Out-of-network
Inpatient mental health care and **inpatient** substance treatment	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	
Residential psychiatric treatment facility • covered mental health services **must** be performed in a residential psychiatric treatment facility • Treatment must be preauthorized • subject to medical criteria	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: • Facility and clinic	100% after in-network deductible	100% after in-network deductible in participating facilities **only**
• Physician's office	100% after in-network deductible	80% after out-of-network deductible

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's

Benefits	In-network	Out-of-network
Outpatient substance use disorder treatment-in approved facilities **only**	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment-when rendered by an approved board-certified behavioral analyst-is covered through age 18, subject to preauthorization **Note**: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.	Not covered	Not covered
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) **Note:** Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. **Note:** When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	100% after in-network deductible	80% after out-of-network deductible
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible	80% after out-of-network deductible
	Limited to a **combined** 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy-provided for rehabilitation	100% after in-network deductible	80% after out-of-network deductible **Note:** Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a **combined** 60-visit maximum per member, per calendar year	
Durable medical equipment **Note:** DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.	100% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing care	100% after in-network deductible	100% after in-network deductible

Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's

Simply Blue HSA with Prescription Drugs

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay/coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at **bcbsm.com/pharmacy**. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Your Simply Blue HSA prescription drug benefits, including mail order drugs, are subject to the same deductible and same annual out-of-pocket maximum required under your Simply Blue HSA medical coverage. Benefits are not payable until you have met the Simply Blue HSA annual deductible. After you have satisfied the deductible you are require to pay applicable prescription drug copays and coinsurance amounts which are subject to your annual out-of-pocket maximums.

Note: The following prescription drug expenses will not apply to your Simply Blue HAS deductible or annual out-of-pocket maximum

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- the 20% member liability for covered drugs obtained from an out-of-network pharmacy

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic or select prescribed over-the-counter drugs	1 to 30-day period	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay	After deductible is met, you pay $5 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $10 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $10 copay	After deductible is met, you pay $10 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay	After deductible is met, you pay $25 copay plus an additional 20% of the BCBSM approved amount
	31 to 83-day period	No coverage	After deductible is met, you pay $50 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay	After deductible is met, you pay $50 copay plus an additional 20% of the BCBSM approved amount

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
	31 to 83-day period	No coverage	After deductible is met, you pay $100 copay	No coverage	No coverage
	84 to 90-day period	After deductible is met, you pay $100 copay	After deductible is met, you pay $100 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law. They are identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs * BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Prescribed over-the-counter drugs - when covered by BCBSM	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
State-controlled drugs	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
FDA-approved **generic** and **select brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand-name** prescription preventive drugs, supplements and vitamins as required by PPACA	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	Not covered	100% of approved amount	80% of approved amount

Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved **generic** and **select brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	80% of approved amount
Other FDA-approved **brand name** prescription contraceptive medication (non-self-administered drugs are not covered)	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs **Note:** Needles and syringes have no copay/ coinsurance.	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance for the insulin or other covered injectable legend drug	Subject to Simply Blue HSA medical deductible and prescription drug copay/coinsurance plus an additional 20% prescription drug out-of-network penalty for insulin or other covered injectable legend drug

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Features of your prescription drug plan

Custom Drug List	A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost. • **Tier 1 (generic)** - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. • **Tier 2 (preferred brand)** - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. • **Tier 3 (nonpreferred brand)** - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Prior authorization/step therapy	A process that requires a physician to obtain approval from BCBSM **before** select prescription drugs (drugs identified by BCBSM as requiring preauthorization) will be covered. **Step Therapy**, an initial step in the "Prior Authorization" process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require preauthorization. Details about which drugs require preauthorization or step therapy are available online site at **bcbsm.com/pharmacy**.
Drug interchange and generic copay/ coinsurance waiver	BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Mandatory maximum allowable cost drugs	If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the **difference** in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug ***plus*** your applicable copay regardless of whether you or your physician requests the brand name drug. **Exception:** If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, You pay only your applicable copay. **Note:** This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits.

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BLUE CARE NETWORK

Medical

HMO $1,350/$2,700

Blue Care Network of Michigan

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

Client: Bloomfield Hills Schools

BCN HSA℠ HMO $1,350 High Deductible Health Plan for Medical and Prescription Drug Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract**. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Member's Responsibility: Deductible, Copays, Coinsurance and Dollar Maximums

Note: The **Deductible** will apply to certain services as defined below.

Deductible **Note:** deductible is combined for both medical and prescription drug coverage. The full family deductible **must** be met under a two-person or family contract before benefits are paid for any person on the contract	$1,350 per member, $2,700 per contract per calendar year
Fixed Dollar Copay **Note:** Copay amounts apply once the deductible has been met	None
Coinsurance **Note:** Coinsurance amounts apply once the deductible has been met	0% and 50% for select services as noted below
Out of Pocket Maximum – total amount paid toward medical and pharmacy services including deductible, copays and coinsurance.	$2,350 per member, $4,700 per contract per calendar year
Lifetime dollar maximum	None

Preventive Services

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%
Routine colonoscopy	Covered – 100%
Mammography Screening	Covered – 100%
Voluntary Female Sterilization	Covered – 100%
Breast Pumps	Covered – 100%
Maternity Pre-Natal Care	Covered – 100%

Physician Office Services

PCP Office Visits	Covered – 100% after deductible
Consulting Specialist Care – when referred	Covered – 100% after deductible

Emergency Medical Care

Hospital Emergency Room	Covered – 100% after deductible
Urgent Care Center	Covered – 100% after deductible
Ambulance Services – medically necessary	Covered – 100% after deductible

Diagnostic Services

Laboratory and Pathology Tests	Covered – 100% after deductible
Diagnostic Tests and X-rays	Covered – 100% after deductible
Radiation Therapy	Covered – 100% after deductible

Maternity Services Provided by a Physician

Post-Natal Care. See Preventive Services section for Pre-Natal Care	Covered – 100%
Delivery and Nursery Care	Covered – 100% after deductible

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 100% after deductible
Outpatient Surgery – see member certificate for specific surgical coinsurance	Covered – 100% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 100% after deductible up to 45 days per calendar year
Hospice Care	Covered – 100% after deductible
Home Health Care	Covered – 100% after deductible

Surgical Services

Surgery – includes all related surgical services and anesthesia.	Covered – 100% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	Covered – Male - 50% after deductible
Elective Abortion (One procedure per two year period of membership)	Covered - 50% after deductible
Human Organ Transplants (subject to medical criteria)	Covered – 100% after deductible
Reduction Mammoplasty (subject to medical criteria)	Covered – 50% after deductible
Male Mastectomy (subject to medical criteria)	Covered – 50% after deductible
Temporomandibular Joint Syndrome (subject to medical criteria)	Covered – 50% after deductible
Orthognathic Surgery (subject to medical criteria)	Covered – 50% after deductible
Weight Reduction Procedures (subject to medical criteria) – Limited to one procedure per lifetime	Covered – 50% after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care	Covered – 100% after deductible
Inpatient Substance Abuse Care	Covered – 100% after deductible
Outpatient Mental Health Care	Covered – 100% after deductible
Outpatient Substance Abuse Care	Covered – 100% after deductible

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	Covered – 100% after deductible
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder through age 18 Physical, speech and occupational therapy for autism spectrum disorder is unlimited.	Covered – 100% after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health benefit and medical office visit benefit

Other Services

Allergy Testing and Therapy	Covered – 100% after deductible
Allergy office visits	Covered – 100% after deductible
Allergy Injections	Covered – 100% after deductible
Chiropractic Spinal Manipulation – when referred	Covered – 100% after deductible; up to 30 visits per calendar year
Outpatient Therapy/Rehabilitation – subject to meaningful improvement within 60 days	Covered – 100% after deductible; limited to a benefit maximum of 60 consecutive days per calendar year
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% after deductible
Durable Medical Equipment	Covered – 50% after deductible
Prosthetic and Orthotic Appliances	Covered – 50% after deductible
Diabetic Supplies	Covered – 100% after deductible

HDHPLG, 1350HD, 2350OM, VACR50

Blue Care Network of Michigan

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

High Deductible Health Plan
Custom Drug List℠ $10/$30/$60/$80/20%/20%
Prescription Drug Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. Services must be provided or arranged by member's primary care physician or health plan.

Prescription Drugs

Deductible	The Deductible is combined for both medical and prescription drug coverage. The Deductible amount is listed with your medical benefits.
Tier 1A – Value Generics	$10 Copayment after Deductible
Tier 1B - Generics	$30 Copayment after Deductible
Tier 2 – Preferred Brand Drugs	$60 Copayment after Deductible
Tier 3 – Non-Preferred Drugs	$80 Copayment after Deductible
Tier 4 – Preferred Specialty	20% Coinsurance of the BCN Approved Amount after Deductible (Maximum Copayment $200)
Tier 5 Non-Preferred Specialty	20% Coinsurance of the BCN Approved Amount after Deductible (Maximum Copayment $300)
Sexual Dysfunction Drugs	50% Coinsurance of the BCN Approved Amount after Deductible
Contraceptives **Note:** Your cost sharing may be waived for Tier 1B, Tier 2 or Tier 3 contraceptive drugs if there are no appropriate generic products or preferred drugs available.	• Tier 1A – Covered in Full • Tier 1B – $30 Copay after Deductible • Tier 2 - $60 Copay after Deductible • Tier 3 - $80 Copay after Deductible
Preventive Medications	• Tier 1A – Covered in Full • Tier 1B Generic – Covered in Full • Tier 2 Preferred Brand – Covered in Full • Tier 3 Non-Preferred Drugs – Covered in Full
31-90 day supply for Mail-Order Pharmacy	Three times applicable copay minus $10 after Deductible
84-90 day supply for Retail Pharmacy	Three times applicable copay minus $10 after Deductible
Out-of-Pocket Maximum	Your medical out-of-pocket maximum is integrated with your BCN covered Prescription Drugs. The out-of-pocket maximum amount is listed with your medical benefits.

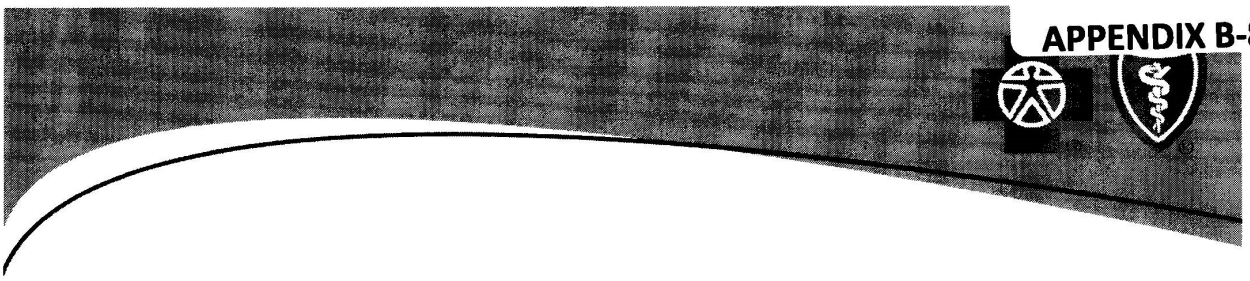
Definitions

Brand Name Drug	Manufactured and marketed under a registered trade name and trademark. • Multi-source Brand Name Drug: a drug that is available from a brand name manufacturer and also has a generic version. • Single Source Brand Name Drug: the drug can only be produced by the company holding the patent; no generics are available.
Generic Drugs	Prescription drugs that have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Non-Preferred Drugs	Prescription drugs that may not have a proven record for safety or their clinical record may not be as high as the BCN preferred alternatives.
Non-Preferred Specialty Drugs	Specialty drugs that may not have a proven record for safety or their clinical value may not be as high as the Specialty Drugs.
Out-of-Pocket Maximum	The highest amount of money you have to pay for covered services during the Calendar Year.
Preferred Brand Drugs	Prescription drugs that are Single Source Brand drugs that have a proven record for safety and effectiveness.
Preferred Specialty Drugs	Generic or Single Source Brand Specialty drugs that have a proven record for safety and effectiveness and offer the best value to our members.
Value Generic Drugs	Prescription drugs that have a proven clinical value essential for treatment of chronic conditions.

P136DL, 90D3X

BLUE DENTAL

...Plans are displayed by bargaining group



Traditional Plus Dental Coverage
Benefits-at-a-Glance for Bloomfield Hills Board of Education

Group: 007002956 BPID: 0000 TEACHER STAFF

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Network access information

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  ** A dentist access point is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two locations would be two access points.*

- **Blue Par Select**[SM] – Most dentists participate with the Blues on a "per claim" basis, so you should ask your dentist if he or she participates before every procedure. These dentists accept payment in full from BCBSM for covered services and you pay the dentist only applicable copays and deductibles, and any fees for noncovered services. You won't be balanced billed for any difference between our approved amount and the dentist's charge. We call this arrangement "Blue Par Select." To find a dentist who may participate with BCBSM, go to **bcbsm.com**. Select the **Dental Professionals** subsection of **"Where You Can Go for Care"** page.

Note: If you receive care from a nonparticipating dentist, you may be billed for the difference between our approved amount and the dentist's charge.

Member's responsibility (copays and dollar maximums)

Copays	30% for Class III services and 40% for Class IV services
Dollar maximums	
• Annual maximum (for Class I, II and III services)	$1,250 per member
• Lifetime maximum (for Class IV services)	$1,000 per member

Class I services

Oral exams	Covered – 100%, twice per calendar year
A set (up to 4) of bitewing x-rays	Covered – 100%, twice per calendar year
Full-mouth and panoramic x-rays	Covered – 100%, once every 60 months
Prophylaxis (teeth cleaning)	Covered – 100%, twice per calendar year
Pit and fissure sealants – for members age 19 or under	Covered – 100%, once per tooth every 36 months when applied to the first and second permanent molars
Palliative (emergency) treatment	Covered – 100%
Fluoride treatment	Covered – 100%, two per calendar year
Space maintainers – missing posterior (back) primary teeth	Covered – 100%, once per quadrant per lifetime, for members under age 19

Class II services

Fillings – permanent teeth	Covered – 100%, replacement fillings covered after 24 months or more after initial filling
Fillings – primary teeth	Covered – 100%, replacement fillings covered after 12 months or more after initial filling
Onlays, crowns and veneer fillings – permanent teeth	Covered – 100%, once every 60 months per tooth, payable for members age 12 and older
Recementing of crowns, veneers, inlays, onlays and bridges	Covered – 100%, three times per tooth per calendar year after six months from original restoration

Class II services, *continued*

Oral surgery including extractions	Covered – 100%
Root canal treatment – permanent tooth	Covered – 100%, once every 12 months for tooth with one or more canals
Scaling and root planing	Covered – 100%, once every 24 months per quadrant
Limited occlusal adjustments	Covered – 100%, **limited** occlusal adjustments covered up to five times in a 60-month period
Occlusal biteguards	Covered – 100%, once every 12 months
General anesthesia or IV sedation	Covered – 100%, when medically necessary and performed with oral or dental surgery
Adjustment of dentures	Covered – 100%, six months or more after it is delivered
Relining or rebasing of partials or complete dentures	Covered – 100%, once every 36 months per arch
Tissue conditioning	Covered – 100%, once every 36 months per arch
Repair and adjustments of partial or complete dentures	Covered – 100%

Class III services

Removable dentures (complete and partial)	Covered – 70%
Bridges (fixed partial dentures) – for members age 16 or older	Covered – 70%, once every 60 months after original was delivered
Endosteal implants – for members age 16 or older who are covered at the time of the actual implant placement	Covered – 70%, once per tooth in a member lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	Covered – 60%
Minor treatment to control harmful habits	Covered – 60%
Interceptive and comprehensive orthodontic treatment	Covered – 60%
Post-treatment stabilization	Covered – 60%
Cephalometric film (skull) and diagnostic photos	Covered – 60%

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

Traditional Plus Dental Coverage
Benefits-at-a-Glance for Bloomfield Hills Board of Education

Group: 007002956 BPID: 0002 ADMIN STAFF

This is intended as an easy-to-read summary. **It is not a contract**. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

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  ** A dentist access point is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two locations would be two access points.*

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Note: If you receive care from a nonparticipating dentist, you may be billed for the difference between our approved amount and the dentist's charge.

Member's responsibility (copays and dollar maximums)

Copays	30% for Class III services and 40% for Class IV services
Dollar maximums	
• Annual maximum (for Class I, II and III services)	$1,500 per member
• Lifetime maximum (for Class IV services)	$1,000 per member

Class I services

Oral exams	Covered – 100%, twice per calendar year
A set (up to 4) of bitewing x-rays	Covered – 100%, twice per calendar year
Full-mouth and panoramic x-rays	Covered – 100%, once every 60 months
Prophylaxis (teeth cleaning)	Covered – 100%, twice per calendar year
Pit and fissure sealants – for members age 19 or under	Covered – 100%, once per tooth every 36 months when applied to the first and second permanent molars
Palliative (emergency) treatment	Covered – 100%
Fluoride treatment	Covered – 100%, two per calendar year
Space maintainers – missing posterior (back) primary teeth	Covered – 100%, once per quadrant per lifetime, for members under age 19

Class II services

Fillings – permanent teeth	Covered – 100%, replacement fillings covered after 24 months or more after initial filling
Fillings – primary teeth	Covered – 100%, replacement fillings covered after 12 months or more after initial filling
Onlays, crowns and veneer fillings – permanent teeth	Covered – 100%, once every 60 months per tooth, payable for members age 12 and older
Recementing of crowns, veneers, inlays, onlays and bridges	Covered – 100%, three times per tooth per calendar year after six months from original restoration

Class II services, *continued*

Oral surgery including extractions	Covered – 100%
Root canal treatment – permanent tooth	Covered – 100%, once every 12 months for tooth with one or more canals
Scaling and root planing	Covered – 100%, once every 24 months per quadrant
Limited occlusal adjustments	Covered – 100%, **limited** occlusal adjustments covered up to five times in a 60-month period
Occlusal biteguards	Covered – 100%, once every 12 months
General anesthesia or IV sedation	Covered – 100%, when medically necessary and performed with oral or dental surgery
Adjustment of dentures	Covered – 100%, six months or more after it is delivered
Relining or rebasing of partials or complete dentures	Covered – 100%, once every 36 months per arch
Tissue conditioning	Covered – 100%, once every 36 months per arch
Repair and adjustments of partial or complete dentures	Covered – 100%

Class III services

Removable dentures (complete and partial)	Covered – 70%
Bridges (fixed partial dentures) – for members age 16 or older	Covered – 70%, once every 60 months after original was delivered
Endosteal implants – for members age 16 or older who are covered at the time of the actual implant placement	Covered – 70%, once per tooth in a member lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	Covered – 60%
Minor treatment to control harmful habits	Covered – 60%
Interceptive and comprehensive orthodontic treatment	Covered – 60%
Post-treatment stabilization	Covered – 60%
Cephalometric film (skull) and diagnostic photos	Covered – 60%

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

Custom Series PK-016 Dental Coverage
Benefits-at-a-Glance – Bloomfield Board of Education
Group: 67201-661, 666 Interpreters-Interveners, Technicians, Paras, Job Coach

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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

Deductible for Class II and Class III services only		None
Copays	Class I services	10% of approved amount
	Class II services	25% of approved amount
	Class III services	40% of approved amount
	Class IV services	Not covered
Dollar maximums	Annual maximum (for Class I, II and III services)	$1,000 per member for covered class I, II and III services
	Lifetime maximum (for Class IV services)	Not covered

Class I services

Oral exams – once every six consecutive months	90% of approved amount
Teeth cleaning – once every six consecutive months	90% of approved amount
Bitewing x-rays – once every six consecutive months	90% of approved amount
Full-mouth x-rays – once every 36 consecutive months	90% of approved amount
Palliative (emergency) treatment	90% of approved amount
Fluoride treatments	90% of approved amount
Space maintainers	90% of approved amount, up to age 19

Class II services

Fillings (amalgam, acrylic or silicate)	75% of approved amount after deductible
Inlays, onlays, crowns, and veneers	75% of approved amount after deductible
Root canal therapy	75% of approved amount after deductible
Periodontic treatments	75% of approved amount after deductible
General anesthesia	75% of approved amount after deductible
Oral surgery including extractions	75% of approved amount after deductible
Repairs to existing dentures	75% of approved amount after deductible

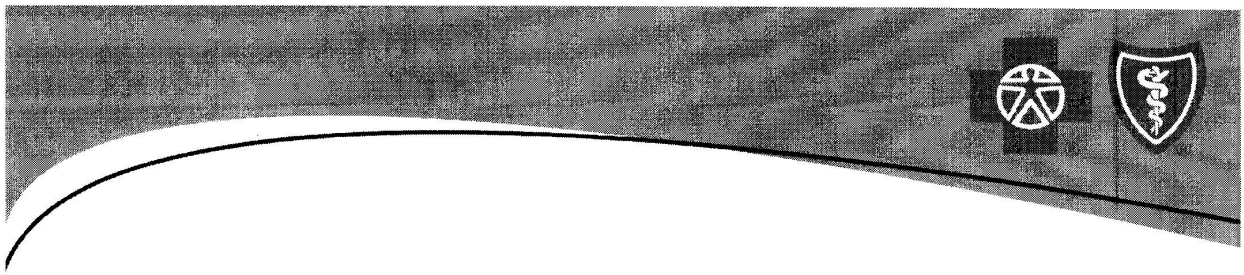
Class III services

Removable dentures	60% of approved amount after deductible
Fixed bridges	60% of approved amount after deductible

Class IV services – Orthodontic services for dependents under age 19

Habit breaking appliances	Not covered
Minor tooth guidance appliances	Not covered
Full-banding treatment	Not covered
Monthly, active treatment visits	Not covered

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins. If you receive care from a nonparticipating dentist, you may be billed for the difference between our approved amount and the dentist's charge.



Traditional Plus Dental Coverage
Benefits-at-a-Glance for Bloomfield Hills Board of Education
67201/669 AFSCME

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Network access information

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Note: If you receive care from a nonparticipating dentist, you may be billed for the difference between our approved amount and the dentist's charge.

Member's responsibility (copays and dollar maximums)

Copays	25% for Class II and III services and 50% for Class IV services
Dollar maximums	
• Annual maximum (for Class I, II and III services)	$1,000 per member
• Lifetime maximum (for Class IV services)	$1,200 per member

Class I services

Oral exams	Covered – 100%, twice per calendar year
A set (up to 4) of bitewing x-rays	Covered – 100%, twice per calendar year
Full-mouth and panoramic x-rays	Covered – 100%, once every 60 months
Prophylaxis (teeth cleaning)	Covered – 100%, twice per calendar year
Pit and fissure sealants – for members age 19 or under	Covered – 100%, once per tooth every 36 months when applied to the first and second permanent molars
Palliative (emergency) treatment	Covered – 100%
Fluoride treatment	Covered – 100%, two per calendar year
Space maintainers – missing posterior (back) primary teeth	Covered – 100%, once per quadrant per lifetime, for members under age 19

Class II services

Fillings – permanent teeth	Covered – 75%, replacement fillings covered after 24 months or more after initial filling
Fillings – primary teeth	Covered – 75%, replacement fillings covered after 12 months or more after initial filling
Onlays, crowns and veneer fillings – permanent teeth	Covered – 75%, once every 60 months per tooth, payable for members age 12 and older
Recementing of crowns, veneers, inlays, onlays and bridges	Covered – 75%, three times per tooth per calendar year after six months from original restoration

Class II services, *continued*

Oral surgery including extractions	Covered – 75%
Root canal treatment – permanent tooth	Covered – 75%, once every 12 months for tooth with one or more canals
Scaling and root planing	Covered – 75%, once every 24 months per quadrant
Limited occlusal adjustments	Covered – 75%, **limited** occlusal adjustments covered up to five times in a 60-month period
Occlusal biteguards	Covered – 75%, once every 12 months
General anesthesia or IV sedation	Covered – 75%, when medically necessary and performed with oral or dental surgery
Adjustment of dentures	Covered – 75%, six months or more after it is delivered
Relining or rebasing of partials or complete dentures	Covered – 75%, once every 36 months per arch
Tissue conditioning	Covered – 75%, once every 36 months per arch
Repair and adjustments of partial or complete dentures	Covered – 75%

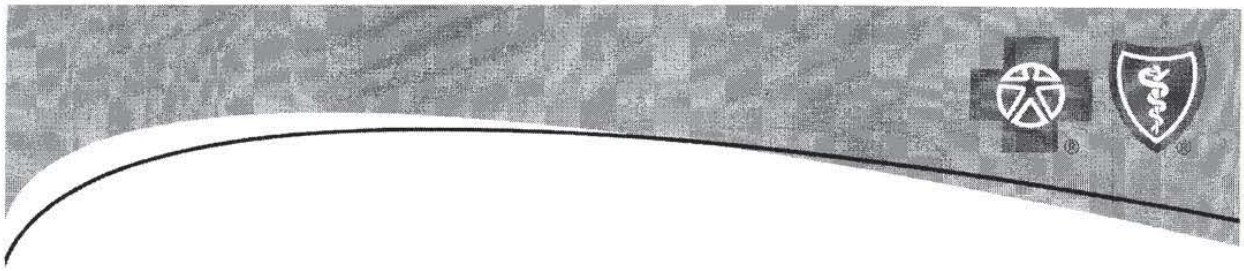
Class III services

Removable dentures (complete and partial)	Covered – 75%
Bridges (fixed partial dentures) – for members age 16 or older	Covered – 75%, once every 60 months after original was delivered
Endosteal implants – for members age 16 or older who are covered at the time of the actual implant placement	Covered – 75%, once per tooth in a member lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	Covered – 50%
Minor treatment to control harmful habits	Covered – 50%
Interceptive and comprehensive orthodontic treatment	Covered – 50%
Post-treatment stabilization	Covered – 50%
Cephalometric film (skull) and diagnostic photos	Covered – 50%

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.



Traditional Plus Dental Coverage
Benefits-at-a-Glance for Bloomfield Hills Board of Education
67201/664 11_01_10 Clerical

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Member's responsibility (copays and dollar maximums)

Copays	30% for Class III services and 40% for Class IV services
Dollar maximums	
• Annual maximum (for Class I, II and III services)	$1,250 per member
• Lifetime maximum (for Class IV services)	$1,000 per member

Class I services

Oral exams	Covered – 100%, twice per calendar year
A set (up to 4) of bitewing x-rays	Covered – 100%, twice per calendar year
Full-mouth and panoramic x-rays	Covered – 100%, once every 60 months
Prophylaxis (teeth cleaning)	Covered – 100%, twice per calendar year
Pit and fissure sealants – for members age 19 or under	Covered – 100%, once per tooth every 36 months when applied to the first and second permanent molars
Palliative (emergency) treatment	Covered – 100%
Fluoride treatment	Covered – 100%, two per calendar year
Space maintainers – missing posterior (back) primary teeth	Covered – 100%, once per quadrant per lifetime, for members under age 19

Class II services

Fillings – permanent teeth	Covered – 100%, replacement fillings covered after 24 months or more after initial filling
Fillings – primary teeth	Covered – 100%, replacement fillings covered after 12 months or more after initial filling
Onlays, crowns and veneer fillings – permanent teeth	Covered – 100%, once every 60 months per tooth, payable for members age 12 and older
Recementing of crowns, veneers, inlays, onlays and bridges	Covered – 100%, three times per tooth per calendar year after six months from original restoration

Class II services, *continued*

Oral surgery including extractions	Covered – 100%
Root canal treatment – permanent tooth	Covered – 100%, once every 12 months for tooth with one or more canals
Scaling and root planing	Covered – 100%, once every 24 months per quadrant
Limited occlusal adjustments	Covered – 100%, **limited** occlusal adjustments covered up to five times in a 60-month period
Occlusal biteguards	Covered – 100%, once every 12 months
General anesthesia or IV sedation	Covered – 100%, when medically necessary and performed with oral or dental surgery
Adjustment of dentures	Covered – 100%, six months or more after it is delivered
Relining or rebasing of partials or complete dentures	Covered – 100%, once every 36 months per arch
Tissue conditioning	Covered – 100%, once every 36 months per arch
Repair and adjustments of partial or complete dentures	Covered – 100%

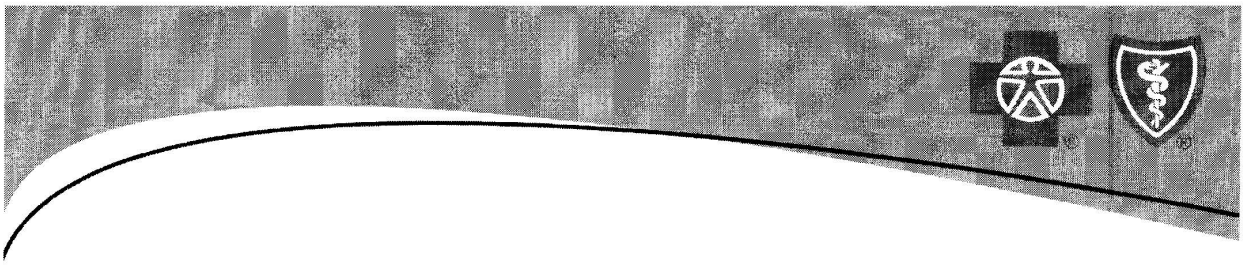
Class III services

Removable dentures (complete and partial)	Covered – 70%
Bridges (fixed partial dentures) – for members age 16 or older	Covered – 70%, once every 60 months after original was delivered
Endosteal implants – for members age 16 or older who are covered at the time of the actual implant placement	Covered – 70%, once per tooth in a member lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	Covered – 60%
Minor treatment to control harmful habits	Covered – 60%
Interceptive and comprehensive orthodontic treatment	Covered – 60%
Post-treatment stabilization	Covered – 60%
Cephalometric film (skull) and diagnostic photos	Covered – 60%

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.



Traditional Plus Dental Coverage
Benefits-at-a-Glance for Bloomfield Hills Board of Education
67201/665 Instructional Assistant

This is intended as an easy-to-read summary. **It is not a contract**. Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Network access information

- **DenteMax PPO network** – DenteMax PPO dentists agree to accept our approved amount as payment in full and participate on all claims. DenteMax is an independent company that leases its network to BCBSM to provide access to Blues members. You'll also receive discounts on noncovered services when you use PPO dentists. You can choose from more than 83,000 dentist access points* nationwide where dental services are available through our partnership with the **DenteMax** PPO network. To find a **DenteMax** dentist, please call 800-752-1547 or go to the DenteMax Web site at **dentemax.com.**

  ** A dentist access point is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two locations would be two access points.*

- **Blue Par Select℠** – Most dentists participate with the Blues on a "per claim" basis, so you should ask your dentist if he or she participates before every procedure. These dentists accept payment in full from BCBSM for covered services and you pay the dentist only applicable copays and deductibles, and any fees for noncovered services. You won't be balanced billed for any difference between our approved amount and the dentist's charge. We call this arrangement "Blue Par Select." To find a dentist who may participate with BCBSM, go to **bcbsm.com**. Select the **Dental Professionals** subsection of **"Where You Can Go for Care"** page.

Note: If you receive care from a nonparticipating dentist, you may be billed for the difference between our approved amount and the dentist's charge.

Member's responsibility (copays and dollar maximums)

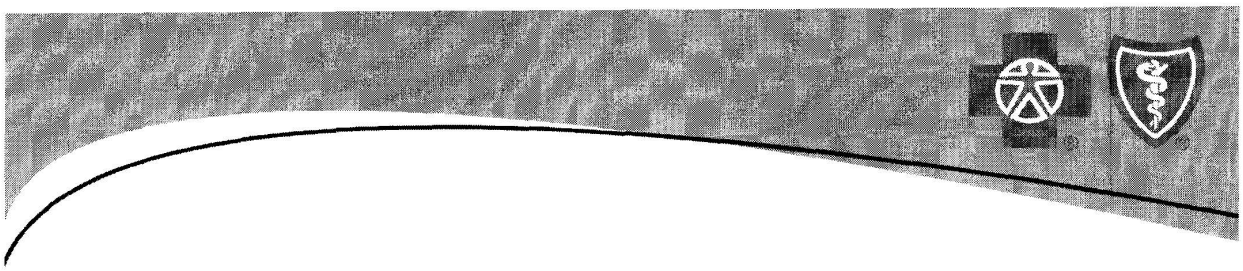
Copays	30% for Class II and III services
Dollar maximums	
• Annual maximum (for Class I, II and III services)	$1,000 per member
• Lifetime maximum (for Class IV services)	N/A

Class I services

Oral exams	Covered – 100%, twice per calendar year
A set (up to 4) of bitewing x-rays	Covered – 100%, twice per calendar year
Full-mouth and panoramic x-rays	Covered – 100%, once every 60 months
Prophylaxis (teeth cleaning)	Covered – 100%, twice per calendar year
Pit and fissure sealants – for members age 19 or under	Covered – 100%, once per tooth every 36 months when applied to the first and second permanent molars
Palliative (emergency) treatment	Covered – 100%
Fluoride treatment	Covered – 100%, two per calendar year
Space maintainers – missing posterior (back) primary teeth	Covered – 100%, once per quadrant per lifetime, for members under age 19

Class II services

Fillings – permanent teeth	Covered – 70%, replacement fillings covered after 24 months or more after initial filling
Fillings – primary teeth	Covered – 70%, replacement fillings covered after 12 months or more after initial filling
Onlays, crowns and veneer fillings – permanent teeth	Covered – 70%, once every 60 months per tooth, payable for members age 12 and older
Recementing of crowns, veneers, inlays, onlays and bridges	Covered – 70%, three times per tooth per calendar year after six months from original restoration



Class II services, *continued*

Oral surgery including extractions	Covered – 70%
Root canal treatment – permanent tooth	Covered – 70%, once every 12 months for tooth with one or more canals
Scaling and root planing	Covered – 70%, once every 24 months per quadrant
Limited occlusal adjustments	Covered – 70%, **limited** occlusal adjustments covered up to five times in a 60-month period
Occlusal biteguards	Covered – 70%, once every 12 months
General anesthesia or IV sedation	Covered – 70%, when medically necessary and performed with oral or dental surgery
Adjustment of dentures	Covered – 70%, six months or more after it is delivered
Relining or rebasing of partials or complete dentures	Covered – 70%, once every 36 months per arch
Tissue conditioning	Covered – 70%, once every 36 months per arch
Repair and adjustments of partial or complete dentures	Covered – 70%

Class III services

Removable dentures (complete and partial)	Covered – 70%
Bridges (fixed partial dentures) – for members age 16 or older	Covered – 70%, once every 60 months after original was delivered
Endosteal implants – for members age 16 or older who are covered at the time of the actual implant placement	Covered – 70%, once per tooth in a member lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	Not covered
Minor treatment to control harmful habits	Not covered
Interceptive and comprehensive orthodontic treatment	Not covered
Post-treatment stabilization	Not covered
Cephalometric film (skull) and diagnostic photos	Not covered

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination ***before*** treatment begins.

BLUE VISION

...Plans are displayed by bargaining group

Blue Cross Blue Shield of Michigan

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

BLOOMFIELD HILLS BD OF ED
A0TDZ7
67201683
0070029560015
Vision Coverage
Effective Date: On or after January 2018
Benefits-at-a-glance: Teachers, Admin., Clerical, Instructional Asst., Paras, Job Coach

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blues members. To find a VSP doctor, call **1-800-877-7195** or log on to the VSP Web site at **vsp.com.**

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Note: Discounts up to 20% for additional prescription glasses and any amount over the allowance ***plus*** savings on non-covered lens extras (up to 25%) when obtained from a VSP provider

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	$7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $45 less $5 copay (member responsible for any difference)
	One eye exam in any period of 12 **consecutive** months	

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	$7.50 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $7.50 copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 12 **consecutive** months	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$50 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less less $7.50 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $50 less $10 copay (member responsible for any difference)
	One frame in any period of 12 **consecutive** months	

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$7.50 copay	Reimbursement up to $210 less $7.50 copay (member responsible for any difference)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$35 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses per pair (member responsible for any cost exceeding the allowance)	$35 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses per pair (member responsible for any cost exceeding the allowance)
	Contact lenses up to the allowance in any period of 12 **consecutive** months	

Blue Cross Blue Shield of Michigan

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

BLOOMFIELD HILLS BD OF ED
A0TDN2
67201691
0070029560022
Vision Coverage
Effective Date: On or after January 2018
Benefits-at-a-glance : Technicians, Interpreters/Interveners, AFSCME

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

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Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both

Note: Discounts up to 20% for additional prescription glasses and any amount over the allowance ***plus*** savings on non-covered lens extras (up to 25%) when obtained from a VSP provider

Member's responsibility (copays)

Benefits	VSP network doctor	Non-VSP provider
Eye exam	$5 copay	$5 copay applies to charge
Prescription glasses (lenses and/or frames)	**Combined** $7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay
Medically necessary contact lenses **Note:** No copay is required for prescribed contact lenses that are not medically necessary.	$7.50 copay	Member responsible for difference between approved amount and provider's charge, after $7.50 copay

Eye exam

Benefits	VSP network doctor	Non-VSP provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $45 less $5 copay (member responsible for any difference)
	One eye exam in any period of 24 **consecutive** months	

Lenses and frames

Benefits	VSP network doctor	Non-VSP provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	$7.50 copay (one copay applies to **both** lenses and frames)	Reimbursement up to approved amount based on lens type less $7.50 copay (member responsible for any difference)
	One pair of lenses, with or without frames, in any period of 24 **consecutive** months	
Standard frames **Note:** All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$50 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less less $7.50 copay (one copay applies to **both** frames and lenses)	Reimbursement up to $50 less $10 copay (member responsible for any difference)
	One frame in any period of 24 **consecutive** months	

Contact Lenses

Benefits	VSP network doctor	Non-VSP provider
Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	$7.50 copay	Reimbursement up to $210 less $7.50 copay (member responsible for any difference)
	Contact lenses up to the allowance in any period of 24 **consecutive** months	
Elective contact lenses that **improve** vision (prescribed, but do not meet criteria of medically necessary)	$35 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses per pair (member responsible for any cost exceeding the allowance)	$35 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses per pair (member responsible for any cost exceeding the allowance)
	Contact lenses up to the allowance in any period of 24 **consecutive** months	

Life Insurance and Disability Protection

Life Insurance Protection

Bloomfield Hills Schools offers Life Insurance, AD&D and Optional Life through Reliance Standard. Please refer to your work agreement to determine if you are eligible for District provided employee life insurance.

Employee Life Insurance

This benefit provides protection for your family in the event of your death. Through the ***Educated Choices*** program, you may be eligible to receive basic Employee Life Insurance coverage based on your employment agreement (shown on your Summary of Benefits). You may also elect any level of additional insurance as outlined below:

Choices

Your choices for additional coverage may include:

$ 5,000	$ 75,000	$175,000
$10,000	$100,000	$200,000
$25,000	$125,000	$225,000
$50,000	$150,000	$255,000
		$275,000

Detailed Information Regarding Personal Health Statements (Evidence of Insurability-EOI)

Personal Health Statements (Evidence of Insurability-EOI) may be required, based on your additional Employee Life Insurance election. You will have until January 1 of the new plan year to submit your Evidence of Insurability to Reliance Standard, or your request will be declined. If you elect an additional Employee Life Insurance option requiring completion of a Personal Health Statement, the coverage and associated payroll deduction will not begin until your request for coverage is approved or denied by the carrier. If you do not submit an EOI form by January 1 of the new plan year, your request for the additional coverage will be terminated.

Please note: If you elect an additional Employee Life Insurance option requiring a Personal Health Statement to be completed, the coverage and associated payroll deduction will not begin until your request for coverage is approved or denied by the life insurance carrier. You will have until January 1 of each year to complete and submit your Personal Health Statement.

Imputed Income

When you purchase insurance in excess of $50,000, you are subject to the IRS' imputed income rules. Imputed income is the value of your life insurance over $50,000. You are required to pay federal and state income taxes and Social Security tax on this "excess" amount. The amount of tax you pay is based on your age. The value of the life insurance in excess of $50,000 will be reported on your W-2.

Considerations for Enrollment

When choosing the level of life insurance that is right for you, consider your family situation.

- How many people depend on your income?
- In your household, is your income primary or secondary?
- If you died, what major expenses would continue, such as a mortgage on your home or tuition for your children's college education?
- Do you have any other sources of income, such as personal life insurance benefits, Social Security or pension benefits?
- How long would your basic employee life policy sustain your family?

Accidental Death and Dismemberment (AD&D)

AD&D coverage is provided to protect you or your family in case of your accidental death or the loss of a limb or your eyesight.

Benefits

In the event of your accidental death, your beneficiary would receive 100 percent of your basic coverage. In the event of a loss resulting from an injury, you would be entitled to payment based on the following schedule:

Life Insurance and Disability Protection

Schedule of Benefits

Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
One Hand or One Foot	50%
Sight of One Eye	50%

Limitations

Benefits will not be paid for a loss:

- caused by suicide or self-inflicted injuries
- caused by or resulting from war or any act of war, declared or undeclared
- to which sickness, disease or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor
- sustained during the Insured's commission or attempted commission or an assault or felony
- to which the Insured's acute or chronic alcoholic intoxication is a contributing factor

Dependent Life Insurance

Dependent Life Insurance is a voluntary benefit offered through ***Educated Choices*** on an after-tax basis. This insurance is designed to assist you financially in the event that your spouse or child(ren) dies.

Choices

You can choose from the following options for your spouse and eligible child(ren):

- No coverage, $5,000 or $10,000

Limitations

All employees must be actively at work to be eligible for the life insurance plan.

Accelerated Death Benefit

The accelerated death benefit allows an employee to elect 75% of their life insurance benefit up to a maximum of $500,000; the payout will be made in a lump sum. This benefit is payable to the Insured one time only and permanently reduces the Insured's death benefit, including any amount of eligible benefit under the waiver of premium and/or conversion provisions, if applicable.

In order to qualify for this benefit, the Insured must have been covered under this Rider for a minimum of 60 days and certified as terminally ill. Terminally ill refers to an illness or physical condition, when certified by a duly licensed physician acting within the scope of his license, is reasonably expected to result in death in less than 12 months. The application for this benefit must be made in writing (the Accelerated Benefit form) and include the beneficiary's signed acknowledgment and agreement to the payment of this benefit.

Dependent child life insurance limitations

If a child dies from the 1st day of birth through six months of age, the life insurance benefit will be limited to $1,000. Children who have reached the age of six months through the end of the month in which they turn 26, are eligible for the full benefit that is elected by the employee ($5,000 or $10,000).

The tax laws require that this benefit be deducted from your salary on an **after-tax** basis.

Detailed Information Regarding Personal Health Statements (Evidence of Insurability-EOI)

Personal Health Statements (Evidence of Insurability-EOI) may be required, based on your Dependent Life Insurance election. If you elect a Dependent Life Insurance option requiring completion of a Personal Health Statement, the coverage and associated payroll deduction will not begin until your request for coverage is approved or denied by the carrier.

Personal Health Statements are not required for children.

Life Insurance and Disability Protection

Considerations for Enrollment

- Do you have a working spouse?
- If your spouse is employed, does he or she have any life insurance protection through his or her employer?
- Do you currently have life insurance coverage for your children?
- How would you handle burial expenses in the event of the death of a family member?

Short-Term Disability

Bloomfield Hills Schools may provide Short-Term Disability coverage to you at no cost.

The specific features of your Short-Term Disability plan (as defined in your employment agreement) are outlined in your Summary of Benefits.

Long-Term Disability

Bloomfield Hills Schools may provide Long-Term Disability coverage through Reliance Standard to you at no cost.

The specific features of your Long-Term Disability plan (as defined in your employment agreement) are outlined in your Summary of Benefits.

Bloomfield Hills Schools will provide you (if eligible) with a disability benefit equal to a percentage of your basic monthly earnings, not to exceed your maximum monthly benefit as outlined in your employment agreement.

The minimum monthly benefit is the greater of $100, or 10 percent of employee's gross disability payment.

Upon approval from the carrier, payments begin after you satisfy a "waiting period" following the onset of your disability. If you become disabled prior to age 60, payments continue until you die, recover or reach age 65. Disabilities beginning after age 60 are paid by a schedule based on your age when the disability began.

Social Security and other income benefits paid to you and your family are included in the percentage amount. This disability plan makes up the difference between these amounts and the guaranteed percent of pay.

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

Bereavement Support Services
Comfort and Guidance for Challenging Times

Bereavement Support Services provide confidential and professional support services to all covered employees and family members to cope with the loss of a loved one—at no extra cost.

Your Reliance Standard Life Insurance Policy offers access to unlimited and confidential telephonic grief counseling, legal and financial consultation when you need it most. Professional clinicians, who are experienced in dealing with grief, are available to discuss any concerns and offer comfort to those in need of support.

Grief Counseling

- ***Unlimited*** Telephonic Assessment and Referral
- Global Network of 52,000+ Licensed Providers

Legal and Financial Services

- ***Unlimited*** Phone Consultation for Any Financial Issue
- ***Unlimited*** Phone Consultation for Any Legal Issue
- Online Legal and Financial Resource Center Including Document Preparation

Program Access

- All Covered Employees and Family Members Eligible, Regardless of Location or Relationship
- 24/7, 365 Days-a-year Dedicated Toll-Free Line, Always Live Answer

Questions or to Access Services

Contact ACI Specialty Benefits toll-free at

855-RSL-HELP

(855-775-4357)

rsli@acieap.com

Bereavement Benefit services are provided by ACI Specialty Benefits, under agreement with Reliance Standard Life Insurance Company.

Reliance Standard Life Insurance Company is licensed in all states (except New York), the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam. In New York, insurance products and services are provided through First Reliance Standard Life Insurance Company, Home Office: New York, NY. Product availability and features may vary by state.

Powered by ACI SPECIALTY BENEFITS

RS-1948 (07/2016)

Identity Theft Full Remediation Services

Identity Theft is the fastest growing crime in the United States. The statistics are staggering and getting worse. In 2013 Identity theft was the number one consumer reported crime with 13.1 million victims, spending on average 58 to 165 hours to regain pre-theft status.[1,2,3]

How it impacts business

A national consultant confirmed 48 percent of a company's employees on average experience business or personal legal-related issues each year, spending about 51 hours away from work to resolve them.[2] Studies show employees with legal problems usually:

- Are absent five times more than average
- Use their medical benefits four times more than average
- Use their sick leave twice as often as the average employee
- Experience a substantial reduction in their productivity

This startling productivity loss is often undocumented but far from invisible.

Employers who provide identity protection and restoration services for their employees can expect a triple-digit return on investment (ROI) based on the estimated number of victims in the workforce, the corresponding potential loss of productivity, and the cost of providing identity protection and restoration services.

Both you and your employees have access to this valuable service through your Reliance Standard insurance coverage.

1 - Federal Trade Commission, "Consumer Sentinel Network Data Book 2013, February 2014"
2 - Javelin Strategy and Research: 2014 Identity Fraud Report
3 - ITRC "Identity Theft: The Aftermath" 2008

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

www.reliancestandard.com

Full Identity Theft Remediation Services

Should an employee or anyone in their family fall victim to identity theft, InfoArmor® Identity Protection Experts will provide restoration services including:

- Dedicated InfoArmor Privacy Advocates® to act on their behalf
- Identity restoration experts trained by the Identity Theft Resource Center
- Investigation and confirmation of fraudulent activity including known, unknown, and potentially complicated sources of identity theft
- Resolution of key issues by maintaining and explaining the victim's rights
- Placing phone calls and preparing appropriate documentation on the victim's behalf including anything from dispute letters to defensible complaints
- Assist in issuing fraud alerts and victim's statements when necessary, with the three consumer credit reporting agencies, Federal Trade Commission, Social Security Administration and the U.S. Postal Service
- Completing and providing copies of all documentation, correspondence, forms and letters for recordkeeping
- Contacting, following up and escalating issues with affected agencies and institutions
- Providing restoration beyond just credit, including criminal, DMV, medical records, etc.
- Real time access to public records such as DMV, criminal, address changes, liens, judgments and more

WalletArmor®

WalletArmor® provides 24/7 Online Credential Monitoring on the Internet's Underground economy. We'll know quickly if there is fraudulent activity. An employee will receive a call from our Privacy Advocates® letting them know their personal information has been compromised. We work with businesses to identify and replace essential cards and documents, and we contact the authorities. WalletArmor stores and secures valuable information for easy retrieval.

The WalletArmor® encrypted vault secures and monitors:

- User IDs & Passwords
- ATM Cards
- Credit Cards
- Checking Accounts
- Driver's Licenses
- Health Insurance Cards
- Vehicle Insurance Cards records, etc.

About InfoArmor®

InfoArmor was established in Scottsdale, Arizona, in 2007 to help one of the largest US banks protect the identities of its 10 million credit card holders. Today it partners with businesses and organizations to help their employees, members, and customers gain control of their personal information and protect and recover their identities.

InfoArmor employs a dedicated team of professionals that provide world class service and expertise in identity theft restoration. In the event of identity theft, the victim will be assigned a dedicated Privacy Advocate that will act on behalf of the customer to completely restore their identity. The victim will know their Privacy Advocate by name and will be able to have a personal proponent for their identity restoration.

InfoArmor's Privacy Advocates have been trained by and receive continued support from the Identity Theft Resource Center, the primary national non-profit that focuses on identity theft. Privacy Advocates are also Certified Identity Theft Risk Management Specialists by the Institute of Fraud Risk Management.

How to begin

InfoArmor Identity Theft Remediation with WalletArmor® is an optional service available with Reliance Standard's group Long Term Disability (LTD) coverage. Interested in a full comprehensive identity protection service? We alsooffer the option to purchase the market's most comprehensive identity theft defense program, PrivacyArmor®, either proactively or following a data breach. Ask your broker or Reliance Standard Sales Representative or Account Manager to see a quote with this service included.

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

INFOARMOR
IDENTITY PROTECTION EXPERTS

www.reliancestandard.com

RS-2421 (1/15)

24-Hour Travel Assistance Services

Through your group coverage with Reliance Standard, you automatically receive travel assistance services provided by On Call International (On Call), pursuant to an agreement between Reliance Standard and On Call. On Call is a 24-hour, toll-free service that provides a comprehensive range of information, referral, coordination and arrangement services designed to respond to most medical care situations and many other emergencies you may encounter when you travel. On Call also offers pre-trip assistance including passport/visa requirements, foreign currency and weather information. The following is an outline of the On Call emergency travel assistance service program. For a complete description of all services and the program terms and limitations, please request a Description of Covered Services from your employer.

Covered Services

When traveling more than 100 miles from home or in a foreign country, On Call offers you and your dependents the following services:

Pre-Trip Assistance

- Inoculation requirements information
- Passport/visa requirements
- Currency exchange rates
- Consulate/embassy referral
- Health hazard advisory
- Weather information

Emergency Medical Transportation*

- Emergency evacuation
- Medically necessary repatriation
- Visit by family member or friend
- Return of traveling companion
- Return of dependent children
- Return of vehicle
- Return of mortal remains

Emergency Personal Services

- Urgent message relay
- Interpretation/translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage/personal possessions
- Legal assistance and/or bail bond

Medical Services Include:

- Medical referrals for local physicians/dentists
- Medical case monitoring
- Prescription assistance and eyeglasses replacement
- Convalescence arrangements

*The services listed above are subject to a maximum combined single limit of $250,000. Return of vehicle is subject to $2,500 maximum limit.

How It Works

At any time before or during a trip, you may contact On Call for emergency assistance services. It is recommended that you keep a copy of this summary with your travel documents. Simply detach the wallet card below to ensure convenient access to the On Call phone numbers.

TO REACH ON CALL VIA INTERNATIONAL CALLING: Go to http://www.att.com/esupport/traveler.jsp?group=tips for complete dialing instructions. It is recommended that you do this prior to departing the US, find the access code from the country you will be visiting, and note it on the cut-out card below so you will have the information readily available in case of an emergency. (AT&T provides English-speaking operators and the ability to place collect calls to On Call, whereas local providers may encounter difficulty placing collect calls to the US.)

Administered by

ON CALL INTERNATIONAL
It could happen to you!™

Provided with your benefits coverage through

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

24-HOUR TRAVEL ASSISTANCE

ON CALL INTERNATIONAL

provided through

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

For emergency medical, legal and travel assistance information and referral service 24 hours a day, 365 days a year, call the numbers below. To place a collect call, dial the INTERNATIONAL COUNTRY CODE: _____ followed by On Call's collect call number.

In the U.S., toll free	Worldwide, collect
(800) 456-3893	(603) 328-1966

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Reliance Standard is not responsible for the content of the On Call travel assistance services, and is not responsible for, and cannot be held liable for, any services provided or not provided by On Call.

Reliance Standard Life Insurance Company is licensed in all states (except New York), the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands. In New York State, benefits are underwritten by First Reliance Standard Life Insurance Company, Home Office: New York, NY.

On Call is not responsible for the unavailability or results of any medical, legal or transportation services. You are responsible for obtaining all services not directly provided by On Call and for the expenses associated with them.

RS-2110 (8/12)

Extended Disability: Providing Assistance When Assistance Runs Out

A Disability Doesn't End Just Because Your Benefits Did

Until now, there hasn't been a financial safety net for employees who have reached the end of their Long Term Disability (LTD) benefits. Traditional LTD policies are designed to partially replace the income employees would have earned had they been able to continue working, so they stop paying benefits when the employee reaches normal retirement age.

Reliance Standard Life (RSL) now offers the Extended Disability Benefit — five additional years of benefits for your disabled employees who have reached the maximum duration of benefits under your LTD policy and who meet the qualifications listed on the next page. This extended benefit pays 85% of the net monthly benefit that the employee received until reaching the maximum duration of benefits. It pays up to $5,000 per month for up to five years.

The Extended Disability Benefit is not a separate policy. It's a benefit included in your RSL Group policy, making it easy to add this valuable benefit to your LTD coverage.

Up to Five More Years of Benefits for Your Disabled Employees

At a time when the average person has adjusted to living on a fixed income, the loss of an LTD benefit can be disastrous. The Extended Disability Benefit adds a continuing source of income for those who need it most—employees who are still totally disabled when they reach the end of their LTD benefits. If you have the Extended Disability Benefit and they have already been receiving benefits under your Reliance Standard Life LTD policy, they will continue to receive 85% of those benefits.

By having a benefit for five more years, a family will be able to relieve some of the stress of adjusting to a reduced income. The income can be used for any purpose.

Help For Those Who Need It Most

To qualify for extended benefits, the employee must qualify as totally disabled under your LTD policy, be receiving disability benefits AND be unable to safely and completely perform two or more of the Activities of Daily Living as listed below without assistance.

- eating/feeding
- dressing
- bathing
- transferring (moving in and out of a bed or chair)
- toileting;

OR

Be cognitively impaired and need another person's direct assistance or verbal direction to function;

AND

Be confined as an inpatient in a skilled nursing home, rehabilitation facility or rehabilitation hospital;

OR

Be receiving home health care or hospice care.

Benefits will continue up to five years, as long as these requirements are met.

Five Years of Precious Time

During the five years of extended benefits, families have less financial burden to distract them from the care of a disabled loved one. By helping to meet ongoing expenses, this benefit may help defer difficult financial decisions.

There's No Alternative to Peace of Mind

The Extended Disability Benefit can provide significant emotional and financial benefits. To understand how vital this coverage is, ask yourself what happens without it.

Social Security and Medicare may not provide adequate assistance, and many people do not purchase long-term care insurance.

For more information about the Extended Disability Benefit or any of Reliance Standard's other coverages, talk with your RSL sales representative.

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

www.reliancestandard.com

RS-2035 (4/13)

Reimbursement Account Services

At A Glance - Reimbursement Accounts

How to Enroll with FSA and HSA Accounts

Enrollment in the Reimbursement Account(s) is part of your annual ***Educated Choices*** online enrollment process outlined on pages 6-7 of this workbook.

Planning Carefully

The following IRS regulations apply to Reimbursement Accounts:

- Once you decide to participate in the Health Care and/ or the Dependent Care Reimbursement Account(s), your enrollment must remain in effect until the end of the plan year. Each year you will have an opportunity to enroll again.
- **The "Use it or Lose It" rule applies to both Health Care and Dependent Care Reimbursement Account(s). Any balance in the Reimbursement Account(s) that is not used for eligible expenses must be forfeited. You will have 60 days after the end of the plan year or the date you are no longer enrolled in the plan (whichever comes first) to submit eligible expenses incurred during that same year for reimbursement.**
- You may change your payroll deduction amount for your Health Care and/or Dependent Care Reimbursement Account(s) during the plan year, only if you have a life status change. **IRS-approved changes include a change in marital status, death of spouse or child, birth or adoption of a child and termination of employee's or spouse's employment.**
- As you know, the benefit you may receive from the Social Security program is based in part on the amount of Social Security tax you pay. With any Reimbursement Account, you will pay slightly lower Social Security taxes. The effect on the benefits you or your family may receive from Social Security should be minimal.

Bloomfield Hills Schools offers you the opportunity to participate in Health Care and Dependent Care Reimbursement Accounts, and Health Savings Accounts. A Reimbursement Account is a tax-free way of paying for eligible out-of-pocket health care and dependent care expenses. By participating in these accounts you have the opportunity to pay for these expenses using **pretax** dollars — you do not pay federal, state or Social Security taxes on the dollars you contribute. As a reimbursement participant, you will have access to a reimbursement administration system. The NGE and Health Equity systems will provide services to help you manage your reimbursement account(s).

- Review election information and manage your account using the Benefit Center. Representatives will be able to assist you with your Reimbursement Account questions. For FSA call toll free at 1-866- 369 -1387.For HSA call toll free 1-866-346-5800.
- Access detailed FSA account information online at

www.nextgenerationenrollment.com. Once there, Click on "Participants" and then click on "FSA/HRA/ HSA Plan Participants". Finally, click on "FSA/HRA/ HSA System Login". **Your Employer Registration ID is NGE4965.**
- Print your personalized FSA Health Care or Dependent Care Flexible Spending Reimbursement Form and link to contribution and reimbursement schedules.
- View a detailed Explanation of Benefits for FSA reimbursements, including line-by-line detail of each claim submitted, status of each claim processed, and denial information.
- Access detailed HSA account information at www.healthequity.com. Once there, select Log Into Your Account or Create New User Name and Password and follow the prompts. If you have questions related to your HSA account, including how to log on and how to best use your accounts, please contact Health Equity at (877) 284-9840.

Reimbursement Account Services

Health Savings Accounts

How Does It Work?

Step 1: Enroll in an HSA-eligible health plan – Your Employer will offer you an HSA-eligible health plan. This is a health care plan that does not pay for health care expenses until you pay a set amount as a deductible. Your plan will cover you after you meet your deductible.

Step 2: Access your HSA – Once you've selected your health plan, you will receive a welcome kit with information on how to access and use your Healthy Blue HSA.

Step 3: Contribute to your HSA – Contributions to your HSA can be made by you, your employer or both. Relatives and friends can also contribute to your HSA. The maximum HSA contribution allowed for 2018 is $3,450 for single coverage and $6,900 for family coverage. These dollar amounts are adjusted annually by the federal government. If you are 55 or older, you are eligible for an additional $1,000 catch-up contribution each year until you enroll in Medicare. The money in your account will automatically roll-over from year to year and remain in your account until you use it. Those staff age 65 or older and enrolled with Medicare are not eligible for participation in a health savings account.

Step 4: Use your money – You control how the money in your HSA is spent. You may use the money to cover your copayment and deductible requirements for services covered through your health plan or to pay for qualified medical expenses not covered by your health plan. It's important to know what is considered a qualified medical expense. It's also important to keep your receipts, in case you need to defend your spending for a tax audit. If you use money in your HSA for something other than a qualified medical expense, you'll have to pay income taxes on that amount. You'll also have to pay a 20 percent tax penalty (unless you are disabled or have attained age 65). If you are age 65 or older and enrolled in Medicare, you are not eligible to participate in the HSA.

Step 5: Invest your money – You may invest the money in your account if you choose. The same types of investments permitted for an individual retirement account are allowed for an HSA. You can grow your savings by investing in a wide variety of mutual funds.

How Do Flexible Spending Reimbursement Accounts Work?

- *You* determine the amount you want to contribute to each account for the plan year on an annual basis. A minimum contribution of $150 is required. Contributions for the plan year are limited to a maximum of $2,650 for the Health Care Reimbursement Account and a maximum of $5,000 for the Dependent Care Reimbursement Account.
- Your per-pay deposit/contribution is withheld from each paycheck before taxes are calculated.
- You pay expenses at the time of purchase with your Benefits MasterCard; or
- You incur and submit expenses for reimbursement via fax or mail. The reimbursement is tax free.

Flexible Spending Account (FSA)

Employees who enroll into the HDHP and the HSA are not eligible to enroll into the FSA plan.

NOTE: Employees age 65 or older (and are enrolled in Medicare) that enroll into the HDHP are not eligible to enroll into the HSA. However they may enroll into the FSA Plan.

REMINDER: You must re-enroll annually for your Health Care Reimbursement and Dependent Care Reimbursement account(s); elections do not automatically rollover.

IMPORTANT INFORMATION ABOUT TURNING AGE 65 AND YOUR HEALTH SAVINGS ACCOUNT

Beginning in 2018, BHS will presume that all employees have enrolled in Medicare during the month in which they turn 65. Contributions into the HSA will cease in the month in which you turn 65 unless you have informed BHS in writing 30 days prior that you have waived completely out of all Medicare coverage. An employee who has delayed Medicare enrollment is required to inform BHS when enrollment into Medicare occurs. Always seek guidance from your tax advisor.

Reimbursement Account Services

FSA Plan Year

Our FSA plan year is January 1 through December 31.

Retirement, Leave of Absence and Termination — Based upon IRS rulings, should your employment terminate mid-plan year, you have 60 days from your date of termination to submit eligible expenses. These claims must be incurred prior to your termination date, for both health care and dependent care reimbursement. Claims received after the 60-day period will be denied. The current plan year ends December 31, 2017. If you have not terminated employment, you have 60 days (until March 1, 2018) to submit eligible expenses for the current plan year.

Mid-plan year life status changes require a meeting with the Benefits Coordinator. Please contact the Benefits Coordinator within 30 days of the life event to schedule an appointment.

Benefits MasterCard

The Benefits MasterCard works like a debit card against your Flexible Spending Account and streamlines the reimbursement process so you do not have to wait to be reimbursed. It is accepted at most large retailers. You will not be required to submit receipts when using the Benefits MasterCard but for recordkeeping purposes you should retain all receipts.

If you are currently enrolled into the flexible spending account and already have a debit MasterCard, please retain your current card for use during the new plan year. Your new election will be loaded onto that card. If your current card is expiring this year, you will receive a new card in the mail prior to the start of the plan year. If you are new to the flexible spending account this year, a card will be ordered for you and will arrive at your home shortly before the start of the plan year, however please be aware that it will not be effective until the start of the plan year. Your Benefits MasterCard will arrive at your home address in a plain white envelope. Also, you will not have to activate your card, it will automatically activate on the first swipe.

NOTE: Your FSA Benefits MasterCard is not the same as the HealthyBlueHSA Visa® Debit card. If you enroll into the Flexible Spending Account you will receive a Benefits MasterCard, if you enroll into the Health Savings Account you will receive the HealthyBlueHSA Visa® Debit card.

How to Receive Reimbursement

1. Use your Benefits MasterCard to pay for eligible expenses at the time of purchase; no receipt submission for reimbursement is required at the time of purchase.
2. If you do not use your Benefits MasterCard, once you pay an expense for health care or dependent care services you may request reimbursement.
3. To submit manual claims for reimbursement you may use the online system. You will complete and print the online form to include with your receipts.
4. Access the PlanSource online system at: https://www.mywealthcareonline.com/PlanSource. Once there, Click on "Participants" and then click on "FSA/ HRA/ HSA Plan Participants". Finally, click on "Submitting For Reimbursements".
5. You may also submit expenses for reimbursement via fax, mail or by email; log in at https://www.mywealthcareonline.com/PlanSource/ for directions .
6. After your request is processed a reimbursement check will be mailed to your home. If you are enrolled for direct deposit, the reimbursement will be deposited to your bank account.
7. Each participant is responsible for keeping records to support these expenses, including those purchased with the Benefits MasterCard. You may be asked to substantiate Benefits MasterCard purchases with receipts. If you fail to do so upon request please note your account may be inactivated until such time you supply PlanSource with the required claim documentation.

Reimbursement Account Services

Dependent Care Reimbursement Account

This account will reimburse you for childcare or dependent care expenses to enable you and your spouse to work outside the home. This includes the cost of a childcare center, a babysitter or a person to care for a disabled dependent, spouse or parent. You can pay a relative to take care of your child(ren) or to care for a disabled spouse or parent. However, you cannot pay a dependent (a teenage daughter, for example) to take care of another dependent.

If you decide to utilize the Dependent Care Reimbursement Account, you cannot use the Federal Tax Credit for the same expenses.

Estimating Dependent Care Expenses

If you are or will be incurring Dependent Care expenses, the following examples may help to show you how the Dependent Care Reimbursement Account can save you tax dollars. **Please note the maximum amount you may contribute on an annual basis to the Dependent Care Reimbursement Account is $5,000 per household ($2,500 for married couples filing separately).**

Remember you may need to reduce the number of weeks you use day care by the number of holidays, vacation days and unscheduled days you have allotted each year.

Eligibility Requirements

A key criteria for eligibility is that you are employed and covered under this plan at the time your eligible dependent receives care.

You must also meet one of the following requirements for eligibility:

- Your spouse is working or looking for employment.
- You are a single parent or guardian.
- At a time when you are employed, your spouse is a full-time student at least five months during the year.
- Your spouse is mentally or physically disabled and unable to provide for his/her own care.
- You are legally separated or divorced and have custody of your child even though you may not be able to consider your child a dependent. For the period that the child resides with you, this Dependent Care Reimbursement plan can be used to pay for child-care services.

An Eligible Dependent is a qualifying individual spending at least eight hours a day in your home and is one of the following:

- Your dependent under age 13 for whom you claim an exemption on your income taxes. (If your dependent turns 13 during the plan year, expenses are no longer eligible for reimbursement). A child under the age of 13 for whom you have custody if divorced or legally separated.
- Your spouse if mentally or physically unable to provide self care.
- Your dependent, regardless of age, who is mentally or physically unable to provide self care even if you cannot claim an exemption for this dependent on your

Eligible expenses for reimbursement include:

- Care received inside or outside your home by someone other than your spouse, a person listed as a dependent on your income tax return, or one of your children under age 19. The child-care provider must claim the payments they receive as income.
- Care received from a qualifying child day-care center or adult or dependent care center.
- Care provided by a housekeeper as long as the services provided, in part, are the care of a qualified dependent.
- Care provided through nursery, preschool, after-school, or summer day camp programs. Taxes for wages spent on eligible dependent care can also be submitted for reimbursement.

Ineligible Expenses

- Dependent care for a child age 13 or over.
- Non work-related babysitting.
- Schooling in kindergarten and beyond.
- Overnight camp.

All submitted receipts are processed and reviewed prior to reimbursement per the Internal Revenue Code Sections 125 and 129.

Federal Notices

Newborn's 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 normal 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 physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, health plan providers may not require that a provider obtain authorization for prescribing a hospital length of stay of less than 48 hours (or 96 hours).

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits under this plan. If you would like further information about the Women's Health & Cancer Rights Act, please contact your medical carrier or your employer.

Special Enrollment Events/Changes in Family Status

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.

If you decline coverage for yourself and/or your dependents (including your spouse) now because you are covered by another health insurance plan, you may be able to enroll yourself or your dependents in this plan in the future. If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your dependents provided that you request enrollment within 30 days after the event. These events are referred to as changes in "family status." In addition, if you were to lose coverage, you must request enrollment within 30 days after the coverage ends and if the event qualifies as a "family status" change. When you become enrolled as the result of a Special Enrollment Event, coverage will be made effective on the date of the event.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact [

Michelle's Law

"Michelle's Law" applies to our benefit plan and requires all group health plans to provide continued coverage for a dependent child covered under the employer's group health plan if the child loses their benefit eligibility because of loss of student status resulting from a medically necessary leave of absence from a post-secondary educational institution.

If your child is covered under your employer's group health plan, but will lose eligibility because of a loss of student status caused by a medically necessary leave of absence, your child may be able to continue coverage under our plan for up to one year during the medically necessary leave of absence. This coverage continuation may be available if on the day before the medically necessary leave of absence begins your child is covered under your employer's group health plan and was enrolled as a student at a post-secondary educational institution.

Federal Notices

For purposes of this continued coverage, a “medically necessary leave of absence” means a leave of absence from a post-secondary educational institution, or any change in enrollment of the dependent at the institution, that: (1) begins while the dependent is suffering from a serious illness or injury, (2) is medically necessary, and (3) causes the dependent to lose student status for purposes of coverage under the plan.

The coverage continuation is available for up to one year after the first day of the medically necessary leave of absence and is the same coverage your child would have had if your child had continued to be a covered student and not needed to take a medical leave of absence. Coverage continuation may end before the end of one year if your child would otherwise lose eligibility under the plan.

If your child is eligible for this coverage continuation and loses coverage under the plan at the end of the continuation period, COBRA continuation may be available at the end of the Michelle’s Law coverage continuation period.

If you have any questions concerning this notice or your child’s right to continued coverage under Michelle’s law, please contact your Human Resource Manager at your employer.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility.

ALABAMA	ALASKA
Medicaid Website: myalhipp.com Phone: 855.692.5447	The AK Health Insurance Premium Payment Program Website: myakhipp.com Phone: 866.251.4861 Email: CustomerService@myakhipp.com Medicaid Website: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS	**COLORADO**
Medicaid Website: myarhipp.com Phone: 855.MYARHIPP (855.692.7447)	Child Health Plan Plus Website: Colorado.gov/HCPF/Child-Health-Plan-Plus Phone: 800.359.1991 / State Relay 711 Health First Colorado (Medicaid Program) Website: healthfirstcolorado.com Phone: 800.221.3943 / State Relay 711
FLORIDA	**GEORGIA**
Medicaid Website: FLmedicaidtplrecovery.com/hipp/ Phone: 877.357.3268	Medicaid Website: dch.georgia.gov/Medicaid *- Click on Health Insurance Premium Payment (HIPP)* Phone: 404.656.4507

INDIANA	IOWA
Healthy Indiana Plan for Low-Income Adults 19-64 Website: in.gov/fssa/hip Phone: 877.438.4479 All other Indiana Medicaid Website: indianamedicaid.com Phone: 800.403.0864	Medicaid Website: dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 888.346.9562

KANSAS	KENTUCKY
Medicaid Website: kdheks.gov/hcf/ Phone: 785.296.3512	Medicaid Website: chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
LOUISIANA	**MAINE**
Medicaid Website: dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 888.695.2447	Medicaid Website: maine.gov/dhhs/ofi/public-assistance/index.html Phone: 800.442.6003 TTY Maine relay 711
MASSACHUSETTS	**MINNESOTA**
CHIP & Medicaid Programs Website: mass.gov/eohhs/gov/departments/MassHealth Phone: 800.862.4840	Medicaid Website: mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 800.657.3739
MISSOURI	**MONTANA**
Medicaid Website: dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573.751.2005	Medicaid Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 800.694.3084
NEBRASKA	**NEVADA**
Medicaid Website: ACCESSNebraska.ne.gov Phone: 855.632.7633 OR LINCOLN: 402.473.7000 OMAHA: 402.595.1178	Medicaid Website: dwss.nv.gov/ Phone: 800.992.0900
NEW HAMPSHIRE	**NEW JERSEY**
Medicaid Website: dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603.271.5218	CHIP Website: njfamilycare.org/index.html Phone: 800.701.0710 Medicaid Website: state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 609.631.2392
NEW YORK	**NORTH CAROLINA**
Medicaid Website: health.NY.gov/health_care/medicaid/ Phone: 800.541.2831	Medicaid Website: dma.ncdhhs.gov/ Phone: 919.855.4100
NORTH DAKOTA	**OKLAHOMA**
Medicaid Website: nd.gov/dhs/services/medicalserv/medicaid/ Phone: 844.854.4825	CHIP & Medicaid Programs Website: insureoklahoma.org Phone: 1-888-365-3742

OREGON	PENNSYLVANIA
Medicaid Website: healthcare.oregon.gov/Pages/index.aspx OR visit : oregonhealthcare.gov/index-es.html Phone: 800.699.9075	Medicaid Website: dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 800.692.7462
RHODE ISLAND	**SOUTH CAROLINA**
Medicaid Website: eohhs.ri.gov Phone: 855.697.4347	Medicaid Website: scdhhs.gov Phone: 888.549.0820
SOUTH DAKOTA	**TEXAS**
Medicaid Website: dss.sd.gov Phone: 888.828.0059	Medicaid Website: gethipptexas.com/ Phone: 800.440.0493
UTAH	**VERMONT**
CHIP Website: health.utah.gov/chip Phone: 877.KIDS.NOW (877.543.7669) Medicaid Website: medicaid.utah.gov Phone: 1-866-435-7414	Medicaid Website: greenmountaincare.org/ Phone: 800.250.8427
VIRGINIA	**WASHINGTON**
CHIP Website: coverva.org/programs_premium_assistance.cfm Phone: 855-242-8282 Medicaid Website: coverva.org/programs_premium_assistance.cfm Phone: 800.432.5924	Medicaid Website: hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 800.562.3022 ext. 15473
WEST VIRGINIA	**WISCONSIN**
Medicaid Website: mywvhipp.com Phone: 855.MyWV.HIPP (855.699.8447)	CHIP & Medicaid Website: dhs.wisconsin.gov/health-care-coverage/index.htm Phone: 800.362.3002 *See also: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf*
WYOMING	
Medicaid Website: wyequalitycare.acs-inc.com Phone: 307.777.7531	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless it displays a valid Office of Management

Important Notice from Bloomfield Hills Schools 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 BCBSM and BCN 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:

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.

Bloomfield Hills Schools has determined that the prescription drug coverage offered by the Bloomfield Hills Schools health plans are, 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 may 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 Bloomfield Hills Schools 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 Bloomfield Hills Schools health plan continues to pay primary on your claims (pays before Medicare D).
- Drop the coverage (including medical as they cannot be elected independently) and elect Medicare Part D coverage. Impact – Medicare is your primary coverage. You will not be able to rejoin the Bloomfield Hills Schools 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 may 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 ABC COMPANY and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Bloomfield Hills Schools 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).

9/1/17

Name of Entity/Sender:	**Bloomfield Hills Public Schools**
Contact--Position/Office:	**Karen Healy Director of Human Resources and Payroll**
Address:	**7273 Wing Lake Road Bloomfield Hills MI 48304**
Phone Number:	**(248) 341-5432**

Please contact us for more information:

Privacy Officer
Karen Healy - Director, Human Resources and Payroll
Bloomfield Hills Public Schools
7273 Wing Lake Road
Bloomfield Hills, MI 48304
(248) 341-5432

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

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.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include case management.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing a provider for an office visit.

Health care operations include the business aspects of running our health plan, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of non-routine disclosures of protected health information.

- We have the obligation to provide and you have the right to obtain a paper copy of this notice from us at least every three years.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 6, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office for Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Privacy Officer

Karen Healy—Director, Human Resource and Payroll

Bloomfield Hill Schools

7273 Wing Lake Road

Bloomfield Hills, MI 48304

(248) 341-5432

For more information about HIPAA

or to file a complaint:

The U.S. Department of Health & Human Services

Office for Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

(202) 619-0257

Toll Free: 1-877-696-6775

Annual Open Enrollment

Annual Open Enrollment

Please be sure to check these points:

- Have you reviewed your medical benefit plan options carefully? Please review the **Considerations for Enrollment** in the **Medical** section of this workbook.
- Have you thought about purchasing Additional Employee Life Insurance or Optional Dependent Life Insurance? Please review the **Considerations for Enrollment** in the **Employee Life Insurance and Dependent Life Insurance** sections of this workbook.
- Is your annual deposit for the Health Care Reimbursement Account, Health Savings Account and/or Dependent Care Reimbursement Account displayed correctly for the upcoming plan year?

Once you are ready to enroll, please logon to the ***Educated Choices*** Web site to select your benefit options. Your elections will then be recorded and processed.

Confirmation Email

At the end of the enrollment period, a confirmation email will be sent to your email address on file in the enrollment system. It will provide a link for you to click and review your confirmation statement online.

Please review this statement VERY CAREFULLY to ensure that your selections were processed correctly. If you have any questions regarding your benefit coverage or options described herein, please contact:

Sarah Dare
Benefits Coordinator
sdare@bloomfield.org
(248) 341-5431

Karen Healy
Director, Human Resources and Payroll
khealy@bloomfield.org
(248) 341-5432

Bloomfield Hills Schools

The contents of this booklet are 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. For more information, please contact the Human Resources Department.

NOTES

NOTES

2018 Open Enrollment Schedule:

November 1. . . . . Annual Enrollment Period Begins

November 8 . . . . . Annual Enrollment Period Ends

January 1 . . . . . Benefits effective

January 12, 2018. . . . . Full Plan Year Payroll Deductions/ Contributions Begin

Confirmation statements are available on-line.

2018 Open Enrollment Assistance Schedule:

Thursday November 2	Gary Doyle Center (Computer Lab)
9:30 a.m.-12:00 p.m.	7273 Wing Lake Road, Bloomfield Hills, MI 48301
2:30-5:00 p.m.	FLU CLINIC 2:30—4:30 p.m.
Friday, November 3	Gary Doyle Center (Computer Lab)
7:30 a.m.—12:00 p.m.	7273 Wing Lake Road, Bloomfield Hills, MI 48301
	FLU CLINIC 8:00—10:00 a.m.
Tuesday November 7	Gary Doyle Center (Computer Lab)
1:00-5:00 p.m.	7273 Wing Lake Road, Bloomfield Hills, MI 48301
Wednesday, November 8	Gary Doyle Center (Computer Lab)
8:00 a.m.—12:00 p.m.	7273 Wing Lake Road, Bloomfield Hills, MI 48301

Bloomfield Hills Schools

2018 Annual Open Enrollment
Frequently Asked Questions

What is the plan year?
January 1 – December 31, 2018

When is the annual enrollment period?
November 1 through November 8, 2017

When will the benefit elections for this enrollment be effective?
January 1 through December 31, 2018.

What if I do not want to change my benefit selections?
Enrollment is mandatory. You must log on to the web enrollment system to enroll for your benefits for the 2018 plan year.

Log on to https://benefits.plansource.com

We will again be utilizing the benefits administration system to help you manage and understand your employee benefit plans. To log in for the first time, type in your assigned user name by using the **first initial of your first name, up to 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, then your user name would be *jwillia1234*.

Next you will enter your password. The **first time you log into the site, your password will be your date of birth in numeric format without any slashes**. It will be entered in the following format: YYYYMMDD. For example, if your date of birth is January 5, 1970, enter 19700105 as the password. Once you have entered your user name and password, click the 'Log In' button. If your password needs to be re-set please contact the BHSD Benefits Center at 866.369.1387.

Can I enroll online if I am a part-time staff member?
Yes, part-time staff members also enroll online.

How do I determine what benefits I am eligible to receive and what option is the best fit for me?
The benefit plans you are eligible to receive are detailed on the Benefit Summaries included in the workbook. For further clarification, you should review your employment agreement for specific program eligibility provisions.

Additional benefit education materials describing your benefit options are included in the workbook. Please review your workbook and Benefits at a Glance/Summary of Benefits carefully so your choice in benefits will be an ***Educated Choice.***

Where can I find a list of doctors who participate in my medical plan?
Provider directories are available on the carrier web site www.bcbsm.com, type in your zip code, type of provider and select type of coverage (i.e., High Deductible Health Plan), then do a physician search.

How do I enroll?
You must enroll for your benefits via the online site. Log on to https://benefits.plansource.com **Enrollment is mandatory.**

How do I opt out of medical coverage?
You can opt out of medical coverage for yourself and your dependents as indicated in your employment agreement. When you enroll, you should decline the medical option and enroll into the Medical Opt Out plan. Make sure to check the box next to each of your dependents. This information is used to determine who would be eligible for medical coverage and the value of your opt out amount (single, two-person or family).

Do I need to complete a Beneficiary Form?
No. Your beneficiary information will be stored on line in the enrollment system. During the enrollment process, you will be asked to enter beneficiary information for your employee life insurance policies. **Note that you must go on line during the annual enrollment period indicated above and declare a beneficiary.** You will need to enter the name, address, date of birth and Social Security number for your beneficiary. Please have this data readily available prior to logging in.

What are the eligibility requirements for my dependent(s) in order for them to be covered under my medical dental and vision plan?
Coverage in the medical, dental and vision plans is for you, your spouse and your eligible dependents. Children are eligible until the end of the month that they reach age 26.

What are the eligibility requirements for coverage under my life insurance plan for my dependent(s)?
All employees must be actively at work to be eligible for the life insurance plan. If a child dies from birth to age 14 days, the benefit will be $500. Between the ages of 15 days and 26 years, the benefit will be $5,000 or $10,000, depending on the option chosen.

PLEASE NOTE: Dependent children between the ages of 19-26 may be covered under your dependent life insurance plan through the end of the month in which they turn age 26. Please be sure to have available Social Security number(s) for all covered dependents.

How can I access my FSA reimbursement accounts?

As a reimbursement participant, you will have access to a reimbursement administration system via the web or by calling the Benefit Center toll free at 866.369.1387. The PlanSource (formerly NGE) system will provide services to help you manage your reimbursement accounts. To access the reimbursement account system, log onto http://www.nextgenerationenrollment.com/, click on 'Participants' and then click on 'FSA/HRA/HSA Plan Participants'. Finally, click on 'FSA/HRA/HSA System Login", then enter your Employee ID and your Employer ID. Your Employer ID is NGE4965. You will have the ability to submit claims, check your balance, update your personal information and view past claims. If you need your Employee ID please contact PlanSource at 866.369.1387.

What is the maximum amount of money I can contribute to the Health Care Reimbursement Account for the calendar year?

The maximum you may contribute to a Health Care Reimbursement Account is $2,650.

What is the maximum amount of money a family can contribute to the Dependent Care Reimbursement Account for the calendar year?

The maximum you may contribute to a Dependent Care Reimbursement Account is $5,000 per family per calendar year. Please be sure to coordinate your contributions with your spouse, if applicable.

Health Savings Account (HSA)
Frequently Asked Questions

What is a Health Savings Account (HSA)?
An HSA is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high deductible health plan (HDHP). This is not an option for someone who is not enrolled in a high deductible health plan or someone who is age 65 or older and enrolled in Medicare. The funds contributed to an HSA are not subject to federal income tax at the time of deposit.

What is a High Deductible Health Plan (HDHP)?
An HDHP is a health insurance plan with lower premiums and higher deductibles than a traditional health plan.

Why do I need to know this?
Your medical plan option is a High Deductible Health Plan (HDHP) accompanied by a Health Savings Account (HSA).

What is the difference between an HSA and a Flexible Spending Account (FSA)?
Unlike a flexible spending account (FSA), HSA funds roll over and accumulate year to year if not spent. HSAs are owned by the individual. HSA funds may currently be used to pay for qualified medical expenses at any time without federal tax liability or penalty. Withdrawals for non-medical expenses are treated very similarly to those in an individual retirement account (IRA) in that they may provide tax advantages if taken after retirement age, and they incur penalties if taken earlier.

Can I be enrolled into both the HSA and FSA plans?
No, you cannot be enrolled into the HSA and the traditional FSA plan. However, you can use your existing HSA account for medical, dental and vision expenses.

What are my options if I am age 65 (or over)?
If you are age 65 or over and enrolled in Medicare, IRS regulations prevent you from enrolling into the HSA. However, you will be eligible to enroll into the traditional FSA plan.

Are they any eligibility requirements that would make me ineligible to enroll into the HSA plan?
Yes, during the enrollment process you will be asked the following six questions to determine your eligibility to enroll into the
HSA. If you can answer yes to any of these questions you are not eligible to enroll into the HSA.

1. Are you currently enrolled in Medicare?
2. Are you or your spouse enrolled in another medical plan that is not a high-deductible health plan?
3. Per IRS regulations, one cannot be enrolled into a Health Savings Account (HSA) and a Health Care Flexible Spending Account (FSA) at the same time. On January 1, will you or your spouse be enrolled in an FSA or have money left in an FSA?
4. Will you be claimed as a dependent on another person's tax return this year?
5. Are you or your spouse receiving VA benefits that are not connected to a service-related disability?
6. Do you receive health benefits under TRICARE (the health care program for active duty and retired members of the uniformed services, their families and survivors)?

Will Bloomfield Hills Schools be funding any portion of my HSA?

If you enroll into the HSA plan, BHSD **may** fund a portion of your HSA election. The amount BHSD may fund will be detailed on your confirmation statement, which you can access and view online.

How can I access my HSA account?

As an HSA participant, you will have access to your online bank account via the web at https://www.healthequity.com or by calling 866-382-5310, 8 am to 7 pm CST, Monday through Friday. The online system provides immediate service to assist you in managing your funds. Paying insurance bills online is just a few clicks away.

What is the maximum amount of money I can contribute to the Health Savings Account for Calendar Year 2018?

Contribution and Out-of-Pocket Limits for Health Savings Accounts and High-Deductible Health Plans			
	2018	**2017**	**Change**
HSA contribution limit (employer + employee)	Self-only: $3,450 Family: $6,900	Self-only: $3,400 Family: $6,750	Self-only: +$50 Family: +$150
HSA catch-up contributions (age 55 or older)*	$1,000	$1,000	No change**
HDHP minimum deductibles	Self-only: $1,350 Family: $2,700	Self-only: $1,300 Family: $2,600	Self-only: +$50 Family: +$100
HDHP maximum out-of-pocket amounts (deductibles, co-payments and other amounts, but not premiums)	Self-only: $6,650 Family: $13,300	Self-only: $6,550 Family: $13,100	Self-only: +$100 Family: +$200

* Catch-up contributions can be made any time during the year in which the HSA participant turns 55.
** Unlike other limits, the HSA catch-up contribution amount is not indexed; any increase would require statutory change.

IMPORTANT NOTICE

REGARDING HEALTH RISK ASSESSMENT CREDITS FOR THE 2018 PLAN YEAR

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When both spouses are employed by Bloomfield Hills School District and both have dual medical coverage, only one staff member will receive the Health Risk Assessment Credit

2018 Flex Deduction/Contribution Schedule

	01/12/2018	No Deductions/Contributions this pay period (break between Plan Years)
#20	01/26/2018	
#19	02/09/2018	
#18	02/23/2018	
#17	03/09/2018	
#16	03/23/2018	
#15	04/06/2018	
#14	04/20/2018	
#13	05/04/2018	
#12	05/18/2018	
#11	06/01/2018	
#10	06/15/2018	
	06/29/2018	No Deductions/Contributions taken for Summer
	07/13/2018	No Deductions/Contributions taken for Summer
	07/27/2018	No Deductions/Contributions taken for Summer
	08/10/2018	No Deductions/Contributions taken for Summer
	08/24/2018	No Deductions/Contributions taken for Summer
#9	09/07/2018	
#8	09/21/2018	
#7	10/05/2018	
#6	10/19/2018	
#5	11/02/2018	
#4	11/16/2018	
#3	11/30/2018	
#2	12/14/2018	
#1	12/28/2018	

This benefit summary prepared by

Arthur J. Gallagher & Co.