

FLEXIBLE SPENDING ACCOUNT (FSA) PROGRAM

Want to stretch your income, reduce costs and pay less in taxes? How? By enrolling in the Flexible Spending Account (FSA) Program administered by Discovery Benefits. You may choose to participate in the Health Care Flexible Spending Account or the Dependent Care Flexible Spending Account, or both depending upon your individual needs.

HEALTH CARE FSA

This account allows you to set aside **pretax** money from each paycheck to pay for eligible out-of-pocket health care expenses (not covered by your medical, dental or vision insurance) that you and your dependents incur throughout the plan year. You may participate in the Health Care FSA even if you do not participate in our medical, dental and/or vision programs.

Eligible health care expenses may include:

- Office visit and prescription drug co-payments
- Deductibles
- Co-insurance
- Expenses not covered through your medical plan
- Out-of-pocket dental, vision or hearing related expenses

Ineligible health care expenses may include:

- Insurance premiums for employer-sponsored benefits deducted from your paycheck on a pre-tax basis
- If you itemize certain medical expenses on your income tax returns, those expenses cannot be submitted for reimbursement under this plan

Not a bad deal at all. By taking advantage of this benefit, you can stretch the money available for health care expenses and reduce your federal income and social security taxes — and depending on where you live, your state and local income taxes as well. The maximum annual election for the Health Care FSA is \$2,650.

If you enroll in the Blue Cross Blue Shield (BCBSM) Simply Blue PPO (HDHP), you may enroll in the Limited Purpose Health Care FSA. You can reimburse yourself for out-of-pocket dental and vision expenses with the Limited Purpose Health Care FSA. Medical and prescription drug expenses aren't eligible under the Limited Purpose plan.

DEPENDENT CARE FSA

To decide whether a Dependent Care FSA is right for you, determine if you will incur eligible expenses. Generally, day care, nursery school, after-school care, elder care and companion service costs that allow you (and your spouse, if applicable) to work or attend school full-time are eligible expenses.

Your dependent care expenses must be for qualified individuals, including:

- Your dependent child under the age of 13 who lives with you for more than half the year
- Your spouse or other tax dependent who is physically or mentally incapable of self-care and lives with you for more than half the year

By contributing to a Dependent Care FSA through payroll deduction, you are able to pay for these eligible dependent care expenses with **pretax** dollars. The maximum annual election for the Dependent Care FSA is \$5,000.

HEALTH SAVINGS ACCOUNT (HSA)

The Health Savings Account is available to employees enrolled in the Blue Cross Blue Shield (BCBSM) Simply Blue PPO (HDHP).

To be eligible to contribute to a Health Savings Account, you cannot be covered by another health plan. This includes a Health Care Flexible Spending Account (unless it is a Limited Health Care Flexible Spending Account) and any health plan that does not qualify as a “high deductible health plan.”

What is a Health Savings Account?

A Health Savings Account is an interest bearing account that gives you a way to pay for current health care expenses (such as deductible and coinsurance) or to save for future health care expenses. A Health Savings Account is owned by you and is portable from employer to employer. The balance rolls over from year to year and may be used for future health care expenses during active employment or retirement.


You can use the money in your Health Savings Account to pay for medical expenses for yourself, your spouse and tax dependents. With a Health Savings Account, you do not have to submit a claim with receipts. You simply pay for eligible expenses with your HSA debit card or set up an online payment that is sent directly to the provider or as a reimbursement to you.

More About Health Savings Accounts

- The maximum annual contribution for 2018 is \$3,450 Single/\$6,900 Family
- Individuals age 55 or older (and not enrolled in Medicare) may contribute an additional amount referred to as a catch-up contribution. The maximum annual catch-up contribution is \$1,000.
- The money in your Health Savings Account can be withdrawn on a taxable basis for reasons other than a medical expense. The distribution is considered taxable income and is subject to a 20% penalty. Once you turn 65, or become disabled and/or enroll in Medicare, any distribution from your Health Savings Account for non-qualified medical expenses is considered taxable income but will not be subject to the 20% penalty.
- Once you turn 65, or become disabled and/or enroll in Medicare, you can continue to use funds from your Health Savings Account. However, after age 65, you will no longer be able to contribute money to it.
- It is your responsibility to report Health Savings Account activity on your tax return, including contributions to and distributions from your Health Savings Account during the year. You will need to maintain records of medical expenses paid for with your HSA funds, so keep your receipts in a safe place.
- For more info on Health Savings Accounts, go to healthequity.com.

Top Reasons to Enroll in an HSA

- ✓ **HSAs triple your savings.** 1) Contributions aren't taxed; 2) Your earnings and growth aren't taxed and 3) Withdrawals to pay for medical care are tax free too.
- ✓ **The money in your account is accessible.** You get a debit card backed by Visa, and by swiping the card at your doctor's office or pharmacy, you withdraw money from your account. Or you can request a disbursement from your HSA. Either way, it's a breeze.
- ✓ **There's no “use it or lose it” rule.** HSAs are designed to follow you into retirement. So the money rolls over year after year.

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- ✓ **Like your 401(k), HSAs grow with time.** You earn interest on the money in your HSA, and better yet, can invest amounts over \$2,000 in mutual funds.
 - ✓ **You own it. You control it.** No matter where you go or what you do, you can take your HSA with you.



BENEFIT SUMMARIES

Reminder: This guide is intended to provide you with a brief summary of your benefits. We have tried to ensure the accuracy of these materials, but if there is any discrepancy between the benefits discussed in this guide and the official plan documents, the official plan documents will rule. Actual benefits will be paid in accordance with the carrier contracts and any amendments to those contracts in place at the time of the claim. Please refer to the carrier booklets for details regarding your coverage, including benefit limitations and exclusions. Henry Ford College reserves the right to amend, modify or terminate any plan at any time and in any manner.

MEDICAL PLAN COMPARISON

	BCBSM Simply Blue PPO (HDHP)		
	IN-NETWORK (Please see the BCBSM Benefits-At-A-Glance for OUT-NETWORK Benefits)	BCN HMO	HAP HMO
CALENDAR-YEAR DEDUCTIBLE	\$2,000 Single / \$4,000 Family Notes: (1) Deductible combines amounts paid under the medical and prescription drug coverage. (2) The full family deductible must be met under a 2-person or family contract before benefits are paid for any person on the contract.	None	None
COINSURANCE PERCENTAGE	80% Coverage	100% Coverage	100% Coverage
CALENDAR-YEAR OUT-OF-POCKET MAXIMUM (Includes deductible, coinsurance & copays)	\$3,000 Single / \$6,000 Family	\$6,350 Single / \$12,700 Family	\$6,600 Single / \$13,200 Family
LIFETIME MAXIMUM BENEFIT	None		
PREVENTATIVE SERVICES			
ROUTINE PHYSICALS WELL-CHILD CARE PAP SMEAR SCREENING MAMMOGRAPHY SCREENING PROSTATE SPECIFIC ANTIGEN (PSA) SCREENING IMMUNIZATIONS	100% Coverage (Not subject to copay, deductible or coinsurance)	100% Coverage	100% Coverage
PHYSICIAN OFFICE SERVICES (NON-PREVENTATIVE)			
PRIMARY CARE OFFICE VISIT	80% after in-network deductible	\$30 Copay	\$30 Copay
SPECIALIST OFFICE VISIT	80% after in-network deductible	\$40 Copay	\$45 Copay
CHIROPRACTIC OFFICE VISIT	80% after in-network deductible	\$40 Copay	Not Covered
URGENT CARE FACILITY	80% after in-network deductible	\$50 Copay	\$50 Copay
LAB AND X-RAY	80% after in-network deductible	100% Coverage	100% Coverage

	BCBSM Simply Blue PPO (HDHP)		
	IN-NETWORK (Please see the BCBSM Benefits-At-A-Glance for OUT-NETWORK Benefits)	BCN HMO	HAP HMO
MATERNITY SERVICES			
PRENATAL AND POSTNATAL CARE	Pre: 100% after in-network deductible Post: 80% after in-network deductible	100% Coverage	\$45 Copay
LABOR, DELIVERY AND NEWBORN CARE	80% after in-network deductible	\$300 Copay Per Admission	\$300 Copay Per Admission
EMERGENCY CARE			
AMBULANCE	80% after in-network deductible	100% Coverage	100% Coverage
HOSPITAL EMERGENCY ROOM	80% after in-network deductible	\$250 Copay	\$250 Copay
INPATIENT HOSPITAL SERVICES			
SEMI-PRIVATE ROOM, SPECIALITY UNITS, PHYSICIAN SERVICES, SURGERY, THERAPY, LABORATORY, RADIOLOGY, HOSPITAL SERVICES AND SUPPLIES	80% after in-network deductible	\$300 Copay Per Admission	\$300 Copay Per Admission
ALTERNATIVES TO HOSPITAL CARE			
HOSPICE CARE	80% after in-network deductible	100% Coverage	100% Coverage
SKILLED NURSING CARE	80% after in-network deductible	100% Coverage	100% Coverage
HOME HEALTH CARE	80% after in-network deductible	100% Coverage	100% Coverage
MENTAL HEALTH AND SUBSTANCE ABUSE CARE			
INPATIENT TREATMENT	80% after in-network deductible	100% Coverage	\$300 Copay Per Admission
OUTPATIENT TREATMENT	80% after in-network deductible	\$15 Copay	\$30 Copay
OTHER SERVICES			
ALLERGY TREATMENT AND INJECTIONS	80% after in-network deductible	100% Coverage	100% Coverage
PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY	80% after in-network deductible	100% Coverage	100% Coverage
VOLUNTARY STERILIZATION	80% after in-network deductible	50% Coverage	100% Coverage
PRESCRIPTION DRUGS			
RETAIL	\$10 Copay Generic \$40 Copay Preferred Brand \$80 Non-Preferred Brand	\$20 Copay Generic \$60 Copay Brand	\$15 Copay Generic \$50 Copay Brand
MAIL ORDER	2 X Retail Copay	2 X Retail Copay	2 X Retail Copay

DELTA DENTAL PLAN

MAXIMUM BENEFIT AMOUNT FOR CLASS I, II AND III SERVICES PER PERSON PER CALENDAR YEAR	\$1,250	
MAXIMUM BENEFIT AMOUNT FOR CLASS IV - ORTHODONIA LIFETIME MAXIMUM PER PERSON	\$1,250	
SERVICE	PPO DENTIST	DELTAPREMIER OR NON-PARTICIPATING DENTIST
CLASS I BENEFITS		
DIAGNOSTIC AND PREVENTIVE SERVICES INCLUDES EXAMS, CLEANINGS, FLUORIDE, AND SPACE MAINTAINERS	Covered-100%	Covered-100%
EMERGENCY PALLIATIVE TREATMENT TO TEMPORARILY RELIEVE PAIN	Covered-100%	Covered-100%
SEALANTS TO PREVENT DECAY OF PERMANENT TEETH	Covered-100%	Covered-100%
BRUSH BIOPSY TO DETECT ORAL CANCER	Covered-100%	Covered-100%
RADIOGRAPHS X-RAYS	Covered-100%	Covered-100%
CLASS II BENEFITS		
ORAL SURGERY SERVICES EXTRACTIONS AND DENTAL SURGERY	Covered-80%	Covered-80%
ENDODONTIC SERVICES ROOT CANALS	Covered-80%	Covered-80%
PERIODONTIC SERVICES USED TO TREAT DISEASES OF THE GUMS	Covered-80%	Covered-80%
RELINES AND REPAIRS TO BRIDGES AND DENTURES	Covered-80%	Covered-80%
MINOR RESTORATIVE SERVICES FILLINGS AND CROWN REPAIR	Covered-80%	Covered-80%
CLASS III BENEFITS		
MAJOR RESTORATIVE SERVICES CROWNS	Covered-50%	Covered-50%
PROSTHODONTIC SERVICES INCLUDES BRIDGES, IMPLANTS, AND DENTURES	Covered-50%	Covered-50%
CLASS IV BENEFITS		
ORTHODONTIC SERVICES ORTHODONTIC AGE LIMIT	Covered-50% Up to age 19	Covered-50% Up to age 19

NOTE:

- Oral exams and cleanings are payable twice per calendar year
- Bitewing x-rays are payable once per calendar year and full mouth x-rays are payable once in any five-year period
- Other exclusions and limitations apply. You are encouraged, but not required, to seek predetermination of benefits so that you will know before the dental service is provided how much, if any, of the cost of that service is not covered under the plan

SUPERIOR VISION PLAN

COVERED SERVICES BENEFIT YEAR: ROLLING 12 MONTHS FROM DATE OF SERVICE		IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
EXAMINATIONS	Limited to one examination per benefit period	Covered in full	Plan pays up to \$37.00 for Ophthalmologist; \$28.00 for Optometrist
FRAMES	Limited to one frame per benefit period	Plan pays up to \$75.00	Plan pays up to \$40.00
LENSES	Limited to one set of lenses per benefit period		
	Single Vision	Covered in full	Plan pays up to \$35.00
	Bifocal		Plan pays up to \$50.00
	Trifocal		Plan pays up to \$60.00
	Progressive	Covered at lined trifocal level	Plan pays up to \$60.00
	Polycarbonate (for children up to age 18)	Covered in full	No coverage
	Photochromic	Plan pays up to \$80	No coverage
Tints, solid or gradient	Covered in full	No coverage	
CONTACT LENSES	Limited to once per benefit period in lieu of eyeglass lenses and frames benefit		
	Elective	Plan pays up to \$100.00	Plan pays up to \$100.00
	Medically Necessary	Covered in full	Plan pays up to \$210.00
LASER VISION CORRECTION		Superior Vision has a nationwide network of refractive surgeons who offer members a discount on services.	No coverage