



BENEFITS GUIDE

January 1, 2020 - December 31, 2020

2020

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Please Note: 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.

HAVE QUESTIONS?

BENEFITS CONTACT INFORMATION			
PROVIDER	BENEFIT	PHONE #	WEBSITE
Blue Cross Blue Shield of Michigan	PPO Medical	(877) 790-2583	www.bcbsm.com
Blue Care Network	HMO Medical	(800) 662-6667	www.bcbsm.com
Health Alliance Plan	HMO Medical	(313) 872-8100	www.hap.org
Health Advocate	Health Advocacy	(866) 695-8622	www.HealthAdvocate.com/members
Cigna	<ul style="list-style-type: none"> • Accident • Critical Illness • Hospital Indemnity 	(800) 754-3207	www.cigna.com
Consumerism Card	<ul style="list-style-type: none"> • Teladoc • Discounts 	(800) 800-7616	www.MyMemberPortal.com
Delta Dental	Dental	(800) 524-0149	www.deltadentalmi.com
Superior Vision	Vision	(800) 507-3800	www.superiorvision.com
Discovery Benefits	Flexible Spending Accounts	(866) 451-3399	www.discoverybenefits.com
Health Equity	Health Savings Account	(866) 346-5800	www.healthequity.com
Reliance Standard	<ul style="list-style-type: none"> • Life Insurance • Short & Long Term Disability 	(800) 351-7500	www.reliancestandard.com
ACI Specialty Benefits (Reliance Standard)	Employee Assistance Program (EAP)	(855) 775-4357	http://rsli.acieap.com
OnCall International Travel Assistance	Worldwide Travel Assistance Program	Within US (800) 456-3893 Outside the US (603) 328-1966	N/A
Public School Employees Retirement System Office of Retirement Services	Retirement	(800) 381-5111	www.michigan.gov/ors
Henry Ford College	General Benefits Questions Office of Human Resources	(313) 845-9692	benefits@hfcc.edu

YOUR BENEFIT GUIDE

Welcome! This guide is designed to provide you with an overview of your benefit options. You have the ability under the Henry Ford College benefit plan to customize your benefits to meet the needs of you and your family.

Which benefits are right for you and your family? The choice you make can impact your future. To help you with this important decision, we are providing this guide – you'll find information about our medical and dental plans, vision plan and more inside. This is important benefit information for you and your family. Please take the time to read this information carefully to ensure you are well acquainted with your benefit options.

ANNUAL ENROLLMENT

There is an annual enrollment period held each fall for the benefit programs that Henry Ford College offers. During this time, you can review and revise your elections as necessary to best meet the needs of your family.

Enrollment is conducted using BenXpress, Henry Ford College's online enrollment system.

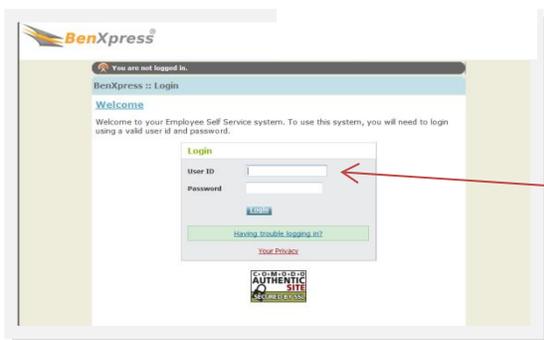
When you are ready to enroll, please go to www.benxpress.com/hfc. The first time that you log in your User ID will be the first initial of your first name and your entire last name. (For example, if your name is John Smith, your User ID is jsmith). Your Password will be the last 6 digits of your social security number. You will have the opportunity to change your Password after your initial login.

BenXpress is available 24 hours a day, 7 days a week during the annual enrollment period. This year's annual enrollment period will be from **Monday, November 18, 2019 to Monday, December 2, 2019**. You may log into the system and make changes as often as you choose during this time. The last changes you make before the end of the enrollment period will be your final elections.

INITIAL ELIGIBILITY PERIOD

Newly eligible employees will become a participant in the Plan on the first day of the month following 60 days of employment.

Enrollment is conducted using BenXpress. Henry Ford College will advise you of the specific period of time in which you must make your initial benefit elections.



Login to:
www.benxpress.com/hfc

User ID: First initial of your first name and last name
Password: Last 6 digits of your social security number

You may login to BenXpress anytime during the year to view your enrollment information and benefit plan documents, change your beneficiaries and more!

MAKING MID-YEAR CHANGES

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. With this program, contributions are deducted from your paycheck before federal, state, and Social Security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation.

These programs are regulated by the Internal Revenue Service (IRS). The IRS requires you to make your pre-tax elections before the start of the plan year (January 1 – December 31). The IRS permits you to change your pre-tax contribution amount mid-year only if you have a change in status, which includes the following:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child
- Marriage, legal separation, annulment, or divorce
- Death of a dependent
- A change in your home address if it causes you to lose eligibility for coverage (this can happen when someone enrolls with an HMO, and then moves out of the HMO's service area)
- A change in employment status if it affects eligibility under the plan (i.e. full-time to part-time)
- A change in election that is on account of, and corresponds with, a change made under another employer plan
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan
- The employee or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility or the employee or dependent becomes eligible for premium assistance subsidy under Medicaid or CHIP

The change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. Or if your spouse's employment terminates and she/he loses medical coverage through their employer, you may elect coverage for yourself and your spouse under our program. Remember that you need to request the change through the Office of Human Resources within 30 days of the event or within 60 days for a loss of Medicaid or Children's Health Insurance Program (CHIP) coverage or when eligibility for premium assistance under Medicaid or CHIP is determined. If you do not notify the Office of Human Resources within the specified timeframe you must wait until the next annual benefit period to make a change.

These rules relate to the program allowing you to pay for certain benefits using pre-tax dollars. Please review the medical booklet and other vendor documents for information about when those programs allow you to add or drop coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ from the pre-tax program.

ELIGIBILITY

You are eligible to participate in the benefit programs if you meet the criteria defined in the Support Staff Association union contract.

Your eligible **dependents** include:

- Your spouse through legal marriage
- Dependent children until the end of the month in which they reach age 26. They may remain covered to any age if they are totally and permanently disabled by either a physical or mental condition subject to certain criteria.
- Eligible children include:
 - Natural Children
 - Step-Children
 - Foster Children
 - Children for whom you are the Legal Guardian
 - Adopted Children
 - Children for whom you are required to provide coverage pursuant to a Court Order, including those subject to a Qualified Medical Child Support Order

DEPENDENT DOCUMENTATION

When you first enroll in or if you change coverage mid-year due to a qualified change in family status event, you are required to provide documentation substantiating the eligibility of any dependents within 30 days from the enrollment or change. Please refer to the list below for a list of acceptable forms of documentation. Copies should be submitted, not originals.

Approved dependent documentation includes:

- **Children under age 26:** Birth Certificate, Adoption Papers, Guardianship Document or Court Order.
- **Children over age 26 (disabled):** Contact the Office of Human Resources for required documentation.
- **Spouse:** Marriage Certificate and first page of IRS Income Tax Filing.

Also, if you or your dependents are enrolled in Medicare, please provide a copy of your Medicare card.

MEDICAL PLAN OPTIONS

Henry Ford College offers several medical plan options to eligible employees. Each of the options offers a comprehensive level of coverage that will protect you and your family from financial hardship should you incur substantial bills as a result of an illness or accident. If you and your family have medical plan coverage elsewhere, for example, through your spouse's employer, you can choose to waive out of the medical coverage.

You may choose among the following medical plan options:

MEDICAL PLAN OPTIONS

1. Blue Cross Blue Shield (BCBSM) Simply Blue PPO High Deductible Health Plan (HDHP)
2. Blue Care Network (BCN) HMO
3. Health Alliance Plan (HAP) HMO
4. No Coverage (waive)

#1 BCBSM SIMPLY BLUE PPO (HDHP)

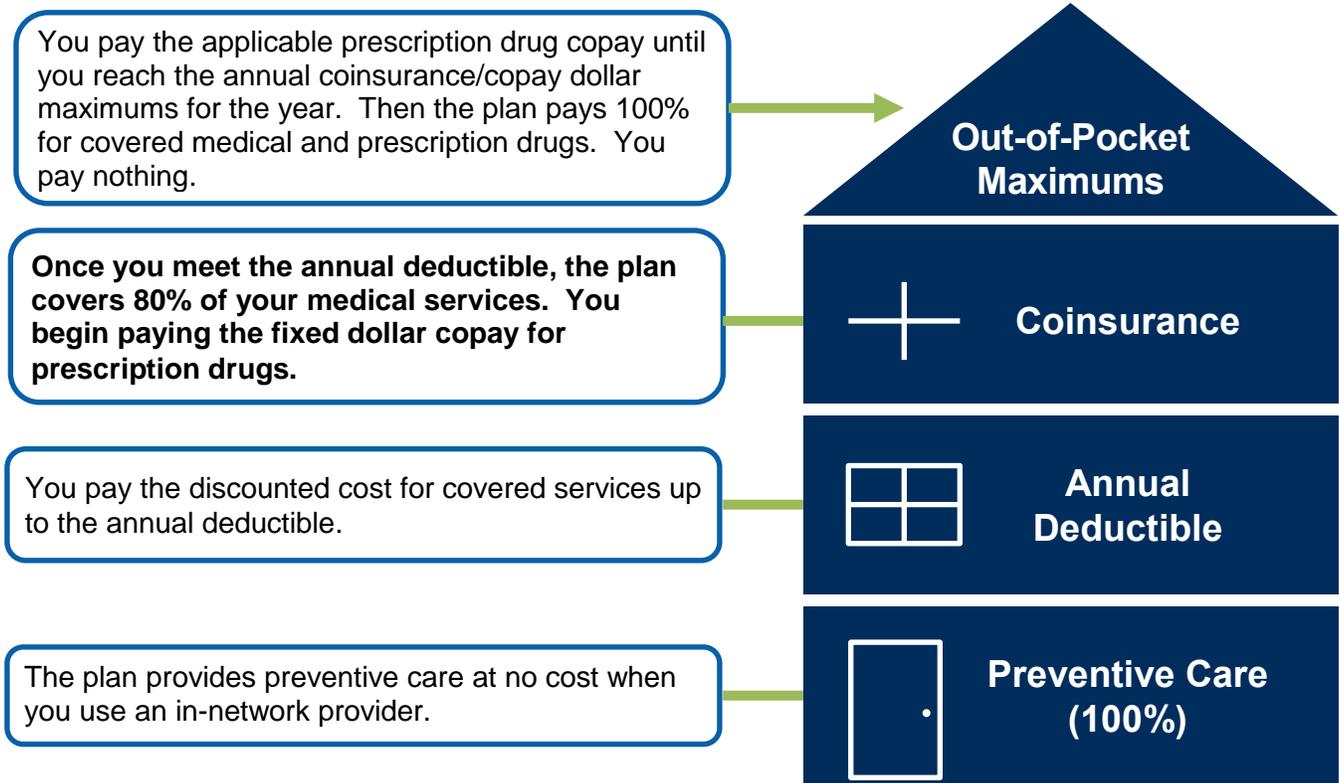
The "PPO" stands for Preferred Provider Organization. The Blue Cross Blue Shield (BCBSM) Simply Blue PPO (HDHP) option offers you comprehensive medical care coverage. You have the highest level of benefits and lowest out-of-pocket expenses when you receive care from BCBSM PPO physicians and facilities anywhere across the country. You don't need to select a Primary Care Physician (PCP) and you can see any BCBSM PPO provider you choose, even a specialist. There are no referrals for hospital, outpatient or ancillary services, and no claim forms when you receive care from BCBSM PPO providers. You can choose to see non-network providers for care, but your benefits will be reduced and your out-of-pocket costs will be higher. You may also be required to pay for services up front and file a claim for reimbursement.

If you choose a non-network provider, there are two types of providers you may encounter: "participating" and "non-participating" providers. Participating providers have signed agreements with BCBSM to accept the BCBSM approved amount as payment in full for covered services. When you use participating providers, you limit your out-of-pocket costs to deductibles, copayments, coinsurances or non-covered services. Non-participating providers have not signed agreements with BCBSM. This means they may or may not choose to accept the BCBSM approved payment as payment in full. If you receive services from a non-participating provider, you may be responsible for the difference between the BCBSM payment and the provider's charges. For example, if your non-participating provider charges \$100 for services and the BCBSM approved amount is \$80, you will be responsible for the \$20 difference, in addition to any deductible, copayment or coinsurance that applies.

To find a BCBSM PPO provider, go to www.bcbsm.com and select "Find a Doctor". When you are asked to choose a plan, select "PPO Plans". You can also call **BlueCard Access®** at **1-800-810-BLUE (2583)** for the names and addresses of doctors and hospitals near you.

How the High Deductible Health Plan Works

As the name implies, this plan carries a high deductible and you need to meet the deductible before the plan begins paying benefits. This applies to all services, including prescription drugs and office visits. However, the deductible does not apply to in-network preventative care.



#2 BCN HMO

Blue Care Network (BCN) is an HMO plan that provides a high level of benefits through one of the largest networks in Southeast Michigan.

When you enroll in BCN, you need to select a Primary Care Physician (PCP) from BCN's list of providers; otherwise BCN will select one for you. You and each of your family members may choose a separate Primary Care Physician (PCP). Your Primary Care Physician (PCP) will be responsible for coordinating all of your medical care. The Primary Care Physician (PCP) will either perform the necessary service or refer you to a specialist. If you do not use your Primary Care Physician (PCP) or have his/her referral for the service, you will not have coverage under this plan (except for life threatening illnesses or injuries). For obstetric or gynecological care, you do not need prior authorization from BCN or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health professional in the network who specializes in obstetrics or gynecology.

If you are enrolled in the BCN medical plan, your specialty medications must be filled through AllianceRx Walgreens Prime at 866-515-1355 or by visiting the website at alliancerxwp.com.

TO FIND A BCN HMO PROVIDER:



To find a BCN HMO provider, go to www.bcbsm.com and select "Find a Doctor".

When you are asked to choose a plan, select "Blue Care Network (HMO)".

You can also call **BCN Member Services** at **1-800-662-6667** for the names and addresses of doctors and hospitals near you.

#3 HAP HMO

HMO stands for “Health Maintenance Organization”. This plan generally offers comprehensive medical care services. Most services are covered in full, although some care may require a copayment. There are no claim forms to complete.

When you enroll in HAP, you must select and use a Primary Care Physician (PCP), who is your first line of defense and the person to refer to in time of medical needs (except for an emergency). A PCP may be an internist, family practitioner, general practitioner, or pediatrician.

In some cases, your PCP may refer you to another provider in the network for treatment, which will be covered by your HMO. In order to see a specialist, you must receive a referral from your PCP. Please note, in most cases, your PCP will refer you to a specialist within the same hospital system as your PCP.

Females may obtain annual well-woman examinations and routine obstetrical and gynecological services from a network OB/GYN without a referral from their PCP.

You may change your PCP at any time simply by calling the Member Services Department. HAP has a program called “Self Direct”. It allows HAP members assigned to a Henry Ford Medical Group (HFMG) PCP to self-refer to these HFMG specialists: Audiology, Dermatology, Cardiology (Adults), Gastroenterology (Adults), Ophthalmology, Obstetrics/ Gynecology, and Otorhinolaryngology (ENT). You may refer to the HAP website for more information.

SELECTING YOUR HAP PRIMARY CARE PHYSICIAN (PCP)

Your PCP is the HAP-affiliated physician you select to coordinate your medical care. A PCP may be a family practitioner, internist or pediatrician. As an HMO member, you must select a PCP. Once you select a PCP, you must see him or her for all routine care and any other specialty services for which you received direction from him/her.

The HAP delivery system has two models – this is important to understand if you want to utilize doctors at multiple affiliated hospital locations:

Integrated delivery system model: This model consists of employed or closely affiliated providers utilizing the Henry Ford Health System (HFHS), Genesis, and ACCESS integrated system of care. This refers to electronics records, e-prescribing and e-visits. An integrated delivery system may also have centralized scheduling. You cannot seek services outside of these four networks.

Open delivery system model: This model consists of physicians and providers that have admitting privileges at more than one facility. Within this model, providers may have multiple relationships for directing medically necessary care.

Both systems have benefits in terms of coordination of care and ease of seeing providers when you need medically necessary services. Your choice of primary care physician (PCP) determines which system model you will receive services through.

To Find a HAP HMO Provider, go to **www.hap.org** and select the “Find a Doctor/Facility” tab. You can also call **HAP Member Services** at **1-800-422-4641** for the names and addresses of doctors and hospitals near you.

#4 NO COVERAGE (MEDICAL WAIVER PROGRAM)

If you have medical coverage from another source, you may decide that the No Coverage option is right for you. If you are declining enrollment for yourself and your dependents because of other medical coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.

To be eligible for the opt-out payment:

- You are required to provide proof of alternative coverage,
- All members of your Tax Family¹ will have to have Minimum Essential Coverage for the entire Plan year (does not include coverage purchased in the individual market, whether or not obtained through the Marketplace); and
- Attestation and proof of alternative coverage is required annually to continue receiving the opt-out payment.

The opt-out payment is not payable if we know or have reason to know that you or any member of your Tax Family does not or will not have the required alternative coverage.

¹Tax Family – includes the employee and all other individuals for whom the employee reasonably expects to claim a personal exemption deduction for the taxable year or years covered by the opt-out time period.

If you choose to participate in the Medical Waiver Program (the No Coverage option), you must have proof of other insurance on file with the Human Resources Office within 30 days of enrollment. Failure to provide proof of other insurance will result in your ineligibility to receive the opt-out payment in June of each year.

The annual opt out amounts are:

- **2 Person:** \$1,600
- **Family:** \$2,000

Opt-out payments are subject to Federal and State income taxation.

MEDICAL PREMIUM CONTRIBUTIONS

The following chart shows the bi-weekly pre-tax contribution if you choose to enroll in the BCBSM PPO (HDHP), BCN HMO or HAP HMO medical plan options.

Bi-Weekly Pre-Tax Premium Contributions Effective January 1, 2020 – December 31, 2020			
Tier	BCBSM PPO (HDHP)	BCN HMO	HAP HMO
1 Person	\$18.26	\$39.54	\$120.06
2 Person	\$43.83	\$90.95	\$276.14
Family	\$54.79	\$102.81	\$312.16

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			
POSTNATAL CARE (PRENATAL COVERED UNDER PREVENTIVE CARE)	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

HEALTH ADVOCATE

Health Advocate is a free service offering a team of highly trained Personal Health Advocates who can work one-on-one with you to help resolve a wide range of healthcare and insurance-related issues that can be challenging for you as well as our Human Resources staff. Personal Health Advocates typically are registered nurses who are supported by a team of medical directors and benefits and claims specialists. Their primary function is to serve as your contact with healthcare providers, insurance companies and health-related community services. By doing all of the work to resolve issues expertly and efficiently, the Personal Health Advocates ensure that you receive the information and support you need to remain fully productive at work, save money and optimize your healthcare experience.

How does the Health Advocate program work?

The Health Advocate program is available to you, your spouse, dependent children, parents and parents-in-law. When you call Health Advocate toll-free, you are assigned a Personal Health Advocate, who works with you to resolve your specific healthcare or benefits issues. Personal Health Advocates can help with a wide variety of concerns, ranging from deciphering claims and uncovering billing errors, to finding specialists and locating elder care. You can work with the same Personal Health Advocate until the issue is completely resolved. Personal Health Advocates are also available to address any follow-up needs. The staff follows careful protocols and complies with government privacy standards. Your medical and personal information is strictly confidential.

How do you contact Health Advocate?

- By phone at 866-695-8622
- By email at answers@HealthAdvocate.com
- Via the phone app available for iPhone and Android users. The free app is called “Health Advocate Smart Help”
- Via our member website at www.HealthAdvocate.com/members

Find the right doctors

We can also find the right hospitals, specialists and other leading providers, anywhere in the country.

Schedule appointments

Our experts can expedite appointments, arrange second opinions and transfer medical records.

Expert, short-term assistance

Our Licensed Professional Counselors can make referrals for more in-depth care, if needed.

Support with work/life issues

Our Work/Life Specialists can help locate childcare, eldercare, legal and financial assistance. Plus, our skilled negotiators can help lower uncovered medical bills!

Resolve benefits issues

We'll do the legwork to resolve insurance claims and billing issues, untangle medical bills and coordinate benefits.

Benefits Gateway™

We'll connect you to all of your benefits, quickly and efficiently.

Professional, caring support

Get personalized help with stress, depression, family problems, substance abuse and much more.

Convenient online resources

Get 24/7, online access to educational materials, webinars and other helpful resources.

WORKSITE VOLUNTARY BENEFITS

Henry Ford College is pleased to offer you and your family the opportunity to elect additional voluntary benefits through Cigna. We will payroll-deduct the after-tax premiums for these products and submit the payment to Cigna on your behalf. Benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and child care!

A high-level summary of the products is below. More information, including premiums, is posted on BenXpress. Each benefit is portable - you can take the coverage with you if you ever change employers.

	Accident	Critical Illness	Hospital Indemnity																				
Purpose	To help cover out-of-pocket expenses when you or a covered family member suffer an accident-related injury on or off the job. Voluntary Accident insurance provides a range of fixed, lump-sum benefits for injuries resulting from a covered accident.	To help cover out-of-pocket expenses when you or a covered family member suffer a covered critical illness or cancer. Voluntary Critical Illness insurance provides a fixed, lump-sum benefit upon diagnosis of a critical illness, which can include heart attack, stroke, paralysis and more.	To help cover out-of-pocket expenses when you or a covered family member are admitted to the hospital for a covered accident or illness. Voluntary Hospital Indemnity insurance provides a range of fixed, lump-sum benefits for hospital inpatient stays.																				
Benefit	Below are examples of some of the fixed, lump-sum benefits on the plan. For complete details, see the Cigna enrollment materials. <table border="1"> <thead> <tr> <th>Benefit Type</th> <th>Benefit Amount</th> </tr> </thead> <tbody> <tr> <td>Emergency Treatment</td> <td>\$200</td> </tr> <tr> <td>Physical Therapy</td> <td>\$50 per session, up to 10 sessions</td> </tr> <tr> <td>Initial Physician Office Visit</td> <td>\$100</td> </tr> <tr> <td>Upper Arm Fracture</td> <td>\$1,000 (\$2,000 for Surgical)</td> </tr> <tr> <td>Leg Fracture</td> <td>\$1,000 (\$2,000 for Surgical)</td> </tr> </tbody> </table>	Benefit Type	Benefit Amount	Emergency Treatment	\$200	Physical Therapy	\$50 per session, up to 10 sessions	Initial Physician Office Visit	\$100	Upper Arm Fracture	\$1,000 (\$2,000 for Surgical)	Leg Fracture	\$1,000 (\$2,000 for Surgical)	Employee: Option of \$5,000, \$10,000, or \$20,000. Spouse: Option of \$5,000 or \$10,000. Dependent child(ren): Option of \$2,500 or \$5,000.	Below are examples of some of the fixed, lump-sum benefits on the plan. For complete details, see the Cigna enrollment materials. <table border="1"> <thead> <tr> <th>Benefit Type</th> <th>Benefit Amount</th> </tr> </thead> <tbody> <tr> <td>Hospital Admission</td> <td>\$1,000</td> </tr> <tr> <td>Hospital Stay</td> <td>\$100 per day, up to 30 days</td> </tr> <tr> <td>Hospital ICU Stay</td> <td>\$200 per day, up to 30 days</td> </tr> </tbody> </table>	Benefit Type	Benefit Amount	Hospital Admission	\$1,000	Hospital Stay	\$100 per day, up to 30 days	Hospital ICU Stay	\$200 per day, up to 30 days
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Hospital Admission	\$1,000																						
Hospital Stay	\$100 per day, up to 30 days																						
Hospital ICU Stay	\$200 per day, up to 30 days																						
Wellness Benefit	A wellness benefit that pays \$50 per year for covered health screenings is included.	A wellness benefit that pays \$50 per year for covered health screenings is included.	A wellness benefit that pays \$50 per year for covered health screenings is included.																				
Pre-Existing Condition Limitation	None	None	Benefits will not be paid for Pre-Existing Conditions until 12 months after the effective date.																				
Limitations and Exclusions	Some limitations and exclusions apply and will be displayed on the Cigna enrollment materials.																						

VOLUNTARY CONSUMERISM CARD/TELADOC

Henry Ford College is pleased to offer you the opportunity to elect the Consumerism Card by New Benefits. Henry Ford College will deduct the after-tax premiums for the Consumerism Card and submit the payment to New Benefits on your behalf. If you elect to enroll in the Consumerism Card, reference the exciting benefits in the membership booklet that will be mailed to your home, call the number on the back of your ID card (1-800-800-7616) or log on to www.MyMemberPortal.com.

This card provides you access to these benefits:

1) Doctors by phone/video



How does it work?

You wake up one morning with sudden cold-like symptoms: stuffy nose, cough, congestion. You have trouble getting an appointment with your existing doctor and you don't want to miss time at work by sitting in an urgent care or ER waiting room.

Simply log in to your account or call Teladoc to request a phone or online video consult with a U.S. board-certified doctor or pediatrician. If a prescription is necessary, it's sent to the pharmacy of your choice.

Highlights:

- 24/7/365 access to a doctor online or by phone
- Fast treatment – Teladoc doctors respond within 24 minutes, on average
- Save money by avoiding expensive urgent care or ER visits - **\$0 consultation fee!**
- Teladoc treats conditions like:
 - ✓ Sinus problems
 - ✓ Allergies
 - ✓ Urinary tract infections
 - ✓ Poison Ivy
 - ✓ Pink eye
 - ✓ Cold and flu

2) Access to discounted prescription, dental, vision and hearing aid services

How does it work?

Do you have a prescription not covered by insurance? Have you reached your dental or vision plan maximum? Do you need cosmetic dentistry not covered by your dental plan? Present your Consumerism Card to the provider to see if you might be eligible for valuable discount savings!

Highlights:

- Keep in mind that your membership is NOT insurance – it is a simple and easy to use discount membership
- 10% to 85% off most medications at a participating pharmacy
- 15% to 50% savings per visit, in most instances, on services such as cleanings, x-rays, fillings, root canals, and crowns
- 10% to 60% off glasses, contacts, laser surgery, exams and even designer eyewear

DENTAL PLAN

You have the option to enroll in Delta Dental PPO coverage and gain access to the nation's largest network of participating dentists. You will have the freedom to visit any dentist for services; however, you will save money on services if you use a participating provider. Nonparticipating Dentists are reimbursed at usual and customary rates, but due to their network nonparticipation, they have the right to require you to pay the difference between Delta's payment and the total charges billed. PPO and Premier Dentists may not bill above the approved amount. Contact Delta Dental to find a participating dentist.

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

VISION PLAN

Regular eye exams are essential. They can assist in the early detection of glaucoma, diabetes, and cataracts. You have the option to enroll in the vision plan through Superior Vision. You will receive maximum benefits when you receive care from an In-Network provider. To find an In-Network provider near you, contact Superior Vision.

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 for Ophthalmologist; \$28 for Optometrist
FRAMES	Limited to one frame per benefit period	Plan pays up to \$75	Plan pays up to \$40
LENSES	Limited to one set of lenses per benefit period		
	Single Vision	Covered in full	Plan pays up to \$35
	Bifocal		Plan pays up to \$50
	Trifocal		Plan pays up to \$60
	Progressive	Covered at lined trifocal level	Plan pays up to \$60
	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	Plan pays up to \$100
	Medically Necessary	Covered in full	Plan pays up to \$210
LASER VISION CORRECTION		Superior Vision has a nationwide network of refractive surgeons who offer members a discount on services.	No coverage

BASIC LIFE AND AD&D

Henry Ford Colleges provides you with basic life and accidental death and dismemberment insurance at no cost to you. A benefit of \$25,000 (regular full-time employees) or \$15,000 (all other employees) will be paid to your beneficiary in the event of your death. If your death is deemed accidental, an accidental death and dismemberment (AD&D) benefit, equal to the amount of your life insurance, is paid to your beneficiary. In addition, a portion of the AD&D benefit will be paid to you if you suffer a loss under the dismemberment portion of the policy (such as the loss of a limb or loss of eyesight). Age reductions, benefit limitations and exclusions apply. Please see the Reliance Standard coverage booklet for more details.

Note that employees who work four (4) hours or less per day are not eligible for this basic life and accidental death and dismemberment insurance.

OPTIONAL LIFE

You may purchase additional Life coverage for yourself, your eligible spouse, and dependent children. The cost of this coverage is payroll deducted in after-tax dollars. Election amounts above the Guaranteed Issue amounts will require evidence of insurability (proof of good health). This means you'll have to answer a few questions about your health and lifestyle and, in some cases, you may be asked to have a physical exam. Amounts of coverage that are subject to the evidence of insurability rules are not effective until approved by Reliance Standard.

Optional Life Coverage Options	
Employee Life	<p>Elect in increments of \$10,000 to a maximum of the lesser of 5x earnings or \$500,000</p> <ul style="list-style-type: none"> ▪ If you are enrolling within 31 days of your first day of eligibility (e.g. as a new hire), you are guaranteed coverage up to \$150,000 (the guaranteed issue amount) ▪ Coverage amounts applied for over the guaranteed issue amount will require evidence of insurability (proof of good health) ▪ If you are currently enrolled, you may increase coverage during our annual enrollment period. Any increase of more than one level above the current coverage amount will require evidence of insurability ▪ If you waived coverage during your initial eligibility period, you can request coverage during our annual enrollment period up to 1 increment without answering any medical questions
Spouse Life	<p>Elect in increments of \$5,000 to a maximum of \$500,000, not to exceed 100% of the Employee's Coverage, Employee Life must be elected</p> <ul style="list-style-type: none"> ▪ If you are enrolling within 31 days of your first day of eligibility, you are guaranteed coverage up to \$25,000 (the guaranteed issue amount) ▪ Coverage amounts applied for over the guaranteed issue amount will require evidence of insurability (proof of good health) ▪ If you are currently enrolled, you may increase coverage during our annual enrollment period. Any increase of more than one level above the current coverage amount will require evidence of insurability ▪ If you waived coverage during your initial eligibility period, you can request coverage during our annual enrollment period up to 1 increment without answering any medical questions
Dependent Child(ren) Life	<p>Elect in increments of \$2,000 to a maximum of \$10,000, Employee Life must be elected</p> <ul style="list-style-type: none"> ▪ Evidence of insurability is not required for Dependent Child(ren) Life

**Life benefits reduce at age 70. Coverage effective dates and increases in coverage may be delayed if you are disabled on the date coverage is scheduled to take effect. Other limitations and exclusions apply. Please review your Reliance Standard booklet for more details.*

LONG TERM DISABILITY

Henry Ford College provides you with long term disability (LTD) coverage at no cost to you. A monthly benefit of 60% of earnings up to a monthly maximum of \$2,500 is paid if you become disabled and cannot work for an extended period of time because of a non-work-related injury or sickness. Benefits begin after 180 days of injury or sickness. Some benefit limitations and exclusions apply. Please see the Reliance Standard coverage booklet for more details.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Reliance Standard Basic Life coverage includes an Employee Assistance Program (EAP) through ACI Specialty Benefits. The EAP provides professional and confidential services to help employees and family members address a variety of personal, family, life, and work-related issues. This benefit is FREE to you and is totally confidential, beginning with your first phone call.

The EAP can assist with many types of issues such as, but not limited to:

- Family and children problems
- Marital/relationship conflicts
- Stress and other emotional difficulties
- Alcohol or other drug use

By referring you to resources in your area, ACI can also provide assistance with other matters, such as:

- Legal issues
- Financial concerns
- Elder care referrals
- Child care resources

Help is easy to access! The EAP provides support through:

- Unlimited telephone consultations
- Up to 3 sessions of professional assessment for employees and family members
- Unlimited legal and financial consultations
- And much, much more!

For more information or help, call 1-855-RSL-HELP (855-775-4357) or go to rsli.acieap.com.

WORLDWIDE TRAVEL ASSISTANCE PROGRAM

You also have 24/7/365 access to travel assistance through OnCall International and Reliance Standard. Assistance is available to you when you are 100 or more miles away from home. Below are the types of services available:

- **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 Assistance 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 Assistance Services Include:** medical referrals for local physicians/dentists, medical case monitoring, prescription assistance and eyeglasses replacement, convalescence arrangements.

Travel assistance services are available via toll-free or collect call telephone numbers that connect directly to OnCall's Global Response Center. You can reach them at (800) 456-3893.

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 \$2,750.

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 2020 is \$3,550 Single / \$7,100 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.
- ✓ **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.