2013-2014 BENEFIT GUIDE

Henry Ford
Community College

Exempt

Please consider the environment before printing this guide.

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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 Community 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	(800) 637-2227	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
Delta Dental	Dental	(800) 524-0149	www.deltadentalmi.com
Superior Vision	Vision	(800) 507-3800	www.superiorvision.com
Discovery Benefits	Flexible Spending Accounts • Health Care • Dependent Care	(866) 451-3399	www.discoverybenefits.com
Unum	• Life Insurance • Short & Long Term Disability	(800) 421-0344	www.unum.com
	Long Term Care	(800) 227-4165	unuminfo.com/hfcc
Unum Work-Life Balance	Employee Assistance Program (EAP)	(800) 854-1446	www.lifeworks.com User ID & Password: lifebalance
Unum Assist America	Worldwide Travel Assistance Program	Within US (800) 872-1414 Outside US (US Access Code) + (609) 986-1234	www.unum.com/travelassistance
Public School Employees Retirement System Office of Retirement Services	Retirement	(800) 381-5111	www.michigan.gov/ors
Henry Ford Community College	General Benefits Questions Office of Human Resources	(313) 845-9855	hr.hfcc.edu/

YOUR 2013-2014 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 Community 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 spring for the July 1 – June 30 plan year for the benefit programs that Henry Ford Community College offers. During this time, you can review and revise your elections as necessary to best meet the needs of your family. Also at this time, you may add eligible family members to your plan or delete family members if they are no longer eligible. The benefit elections that you make during the annual open enrollment period will become effective July 1, 2013, and will remain in effect through June 30, 2014, unless you have an eligible change in status that permits you to make a change in your election mid-year. Please refer to the section *Making Mid-Year Changes* for details on when and how you may change your benefit elections outside of the annual open enrollment period.

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

When you are ready to enroll, please go to www.benxpress.com/hfcc. The first time that you login your User ID will be the initial letter 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. **Annual enrollment begins on Monday, June 10, 2013 and closes at 11:59 P.M. on Tuesday, June 18, 2013.** 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 your date of hire.

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

Login to:
www.benxpress.com/hfcc

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. 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 are a regular Exempt full-time Henry Ford Community College employee.

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

EXCLUSION UNDER THE MEDICAL PROGRAM

If you or your dependents are enrolled in other "group health coverage" coverage, you and your dependents **may not** enroll under our medical plan. Henry Ford Community College will not provide dual and/or coordinated coverage.

Only persons receiving dual and/or coordinated coverage as of September 1, 1982 shall be allowed to continue unless the administration and the individual mutually agree to terminate this arrangement of coverage. No other persons shall be so entitled.

This exclusion does not apply to the dental and vision plans.

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 Community 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
2. Blue Care Network (BCN) HMO
3. Health Alliance Plan (HAP) HMO
4. No Coverage (waiver)

WHAT'S THE DIFFERENCE BETWEEN AN HMO AND PPO?

When you are selecting medical insurance, choosing the network of health care providers is often the most important decision you will make. Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are types of managed health-care systems. And, both offer excellent access to top quality professionals—but it's important to understand the differences before you choose.

HMOs and PPOs differ in two main ways: **cost** and **access**.

HMO

With an HMO plan, your costs tend to be much lower. HMO plans often have no deductible and HMO members generally pay a nominal co-payment when you visit a doctor, including a hospital stay. This means your out-of-pocket expenses are kept at a minimum.

The tradeoff for these low costs is that your HMO plan comes with restrictions on when you can receive care — and who you can receive it from. To receive coverage, you must select a primary care physician (PCP). Your primary care physician is the provider that you select to coordinate your medical care. Your PCP oversees all of your routine care and must be consulted with before you can see a specialist, who must also be part of the HMO.

To receive coverage, you must get care from a doctor on the plan's pre-approved list of healthcare providers. And if you need specialist care, you'll need a referral from your doctor. For some kinds of specialist care, you'll need approval from the plan's management.

PPO

PPO plans can be more expensive, but have fewer restrictions. Most PPO plans have an individual and family deductible that you must meet and your PPO plan will have higher monthly premium.

But with a PPO, you'll be able to see almost any doctor you choose. PPO plans also have pre-approved lists of healthcare providers (network providers) — but they also provide coverage when you see providers who are not on that list. When you see a network provider, you will save more money — but you won't be stuck without coverage if you choose to see an "out-of-network" provider.

WHICH PLAN IS BEST FOR ME?

Choosing the right plan depends on your unique needs. Of course, there isn't one right answer; the best choice depends on your particular needs. For example, if you are considering an HMO, it's important to make sure that your physician is part of the HMO network, unless you are willing to see another physician. If not, a PPO might be a better choice, because you can still receive at least partial coverage regardless of network affiliation. However, if ongoing out-of-pocket costs are a major concern, an HMO is often a better choice, because there are no deductibles and co-payments are typically lower.

Henry Ford Community College is fortunate to offer employees the choice between the Health Alliance Plan and Blue Care Network HMO options or PPO coverage through Blue Cross Blue Shield of Michigan. Here are some general guidelines that you may want to consider when selecting a Plan:

A PPO may be best for you if:

- You want flexibility to choose any doctor
- You have a chronic condition, such as back pain or arthritis
- You'd prefer to use alternative medicine services such as acupuncture

An HMO may be best for you if:

- You'd prefer fewer billing hassles
- You will need to keep your out-of-pocket costs as low as possible

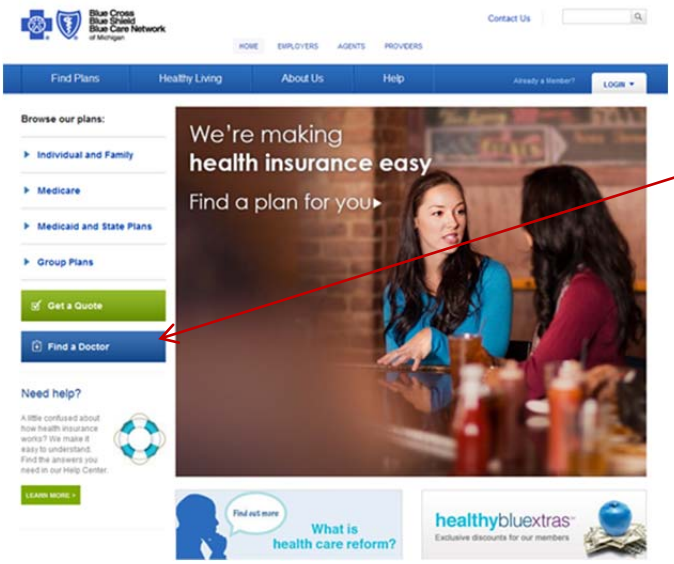
Henry Ford Community College provides excellent medical care coverage, and provider options that meet the needs of our employees. Please take the time to visit the provider websites, evaluate the options, and choose a provider that meets the needs of you and your family. **See the back of the guide for a detailed coverage comparison of the medical plan options available to you.**

#1 BCBSM SIMPLY BLUE PPO

The “PPO” stands for Preferred Provider Organization. The Blue Cross Blue Shield (BCBSM) Simply Blue PPO 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/Traditional.”

You can also call **BlueCard Access®** at **1-800-810-BLUE (2583)** for the names and addresses of doctors and hospitals near you.

#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.

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 "HMO/BCN."

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), DMC, 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. You may not enroll for medical coverage under Henry Ford Community College if you are enrolled in other medical coverage. 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. **Note: you may elect to have dual dental and vision coverage.**

If you choose to participate in the Medical Waiver Program (the No Coverage option), and receive the annual opt out payment a medical waiver card and a verification letter must be on file **with the Office of Human Resources by September 15 of each year in order to receive payment by June 30 of the following year**.

The annual opt out amounts for 2013-2014 are:

- **2 Person:** $1,125
- **Family:** $1,500

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

MEDICAL PREMIUM CONTRIBUTIONS

The following chart shows the monthly pre-tax contribution (based on 12 pays) if you choose to enroll in the BCBSM PPO, BCN HMO or HAP HMO medical plan options.

Monthly Pre-Tax Premium Contributions **Effective July 1, 2013 – June 30, 2014**			
Tier	**BCBSM PPO**	**BCN HMO**	**HAP HMO**
1 Person	$24.22	$70.81	$116.41
2 Person	$58.12	$162.87	$267.74
Family	$72.58	$184.12	$302.65

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.

A summary of the dental coverage can be found in the back of this guide.

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.

A summary of the vision coverage can be found in the back of this guide.

BASIC LIFE & AD&D

Henry Ford Community Colleges provides you with basic life and accidental death and dismemberment insurance at no cost to you. A benefit equal to two (2) times earnings* 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). *Benefit maximums, age reductions, benefit limitations and exclusions apply. Please see the Unum coverage booklet for more details.

LONG TERM CARE

Henry Ford Community Colleges provides you with long term care insurance at no cost to you. This benefit protects against the costs of care you may need if you couldn't independently perform the activities of daily living. The employer-funded base plan benefits include the following:

LEVEL OF CARE	Long Term Care Facility and 50% Professional Home Care
MONTHLY BENEFIT	$3,500 Long Term Care Facility/50% Professional Home Care
BENEFIT DURATION	2 Years Long Term Care Facility/50% Professional Home Care

You may purchase additional long term care benefits, subject to medical underwriting approval, for yourself and family members. Go to **http://unuminfo.com/HFCC** for more plan details and how to apply for additional coverage.

This coverage is subject to policy limitations, benefit maximums and elimination periods. Please see the Unum coverage booklet for more details.

SHORT & LONG TERM DISABILITY

Henry Ford Community College provides you with short & long term disability (STD & LTD) coverage at no cost to you. This benefit replaces a portion of your income if you become disabled and cannot work because of a non-work-related injury or sickness. Some benefit limitations and exclusions apply. Please see the Unum coverage booklet for more details.

	STD BENEFIT	LTD BENEFIT
BENEFITS BEGIN	The latter of: • the 1rst day of approved disability due to injury • the 8th day of approved disability due to sickness OR • The date accumulated paid leave payments end, not to exceed 520 hours of sick bank	The latter of: • the 90th day of approved Total Disability OR • The end of accumulated sick leave
MAXIMUM BENEFIT	70% of earnings, up to $2,000 per week	70% of earnings, up to $8,500 per month
MAXIMUM BENEFIT PERIOD	13 weeks	ADEA - B schedule and NSSRA (see the Unum coverage booklet for the detailed schedule)

EMPLOYEE ASSISTANCE PROGRAM (EAP)

You have access to the comprehensive Work-Life Balance EAP through Unum. The EAP is free, 100% confidential and available to help you and your family members manage work/life issues and so much more. You have unlimited access to consultants by telephone, resources and tools online and up to three face-to-face visits with counselors for help with a short-term problem. Here are just some of the services you may receive:

- **Dependent Care:** Help locating childcare and eldercare
- **Financial Issues:** Access to financial calculators
- **Education & Schooling**: Learn about college testing, admissions, financial aid and advice to help your child get admitted to the school they want to attend
- **Legal Issues:** Legal advice by telephone and access to laws and do-it-yourself legal forms
- **Addiction & Recovery:** Information about drug and alcohol abuse, eating disorders and gambling
- **Retirement Planning:** Access online tools and financial education regarding retirement

You may access a variety of services at the Work-Life Balance EAP website. Or if you would like to talk to a Work-Life Balance consultant for assistance with a particular issue, you can call them anytime 24/7. Again, this service is free and completely confidential.

WORLDWIDE EMERGENCY TRAVEL ASSISTANCE

You also have travel assistance through Assist America and Unum. Assist America offers services to you when you are 100 or more miles away from home or in another country.

Services provided include medical consultation, evaluation and referral in emergency situations, foreign hospital admission assistance, emergency medical evaluations and medically supervised repatriation. Assist America can also work with your physician if you lose or leave your prescription behind.

If you are traveling alone and are expected to be hospitalized for more than seven days, Assist America will arrange and pay the transportation costs for a loved one to join you.

Other services are available. For more information about Assist America, please visit them online or call a representative for help.

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 $2,500.

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, elder care and companion service costs are eligible expenses. 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.

Note: The plan year for the FSA Program is January 1 – December 31. A separate open enrollment for the FSA Program is held in the fall each year

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 Community 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		BCN HMO	HAP HMO
	IN-NETWORK	OUT-NETWORK		
CALENDAR-YEAR DEDUCTIBLE	$250 - 1 member $500 - family	$500 - 1 member $1,000 - family	$100 -1 member $200 - family	None
COINSURANCE PERCENTAGE	80% Coverage	60% Coverage	100% Coverage	100% Coverage
CALENDAR-YEAR COINSURANCE MAXIMUM	$2,500 - 1 member $5,000 - family	$5,000 - 1 member $10,000 - family	N/A	N/A
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 Covered	100% Coverage	100% Coverage
PHYSICIAN OFFICE SERVICES (NON-PREVENTATIVE)				
	Note: Simply Blue applies deductible and coinsurance to office visit services			
PRIMARY CARE OFFICE VISIT	$20 Copay	60% Coverage After Out-Network Deductible	$20 Copay	$20 Copay
SPECIALIST OFFICE VISIT	$20 Copay	60% Coverage After Out-Network Deductible	$40 Copay	$40 Copay
CHIROPRACTIC OFFICE VISIT	$20 Copay	60% Coverage After Out-Network Deductible	$40 Copay	Not Covered
URGENT CARE FACILITY	$20 Copay	60% Coverage After Out-Network Deductible	$50 Copay	$50 Copay
LAB AND X-RAY	80% Coverage After In-Network Deductible	60% Coverage After Out-Network Deductible	100% Coverage	100% Coverage

MEDICAL PLAN COMPARISON Continued

	BCBSM Simply Blue PPO		BCN HMO	HAP HMO
	IN-NETWORK	OUT-NETWORK		
MATERNITY SERVICES				
PRENATAL AND POSTNATAL CARE	80% Coverage After In-Network Deductible	60% Coverage After Out-Network Deductible	$20 Copay	$15 Copay
LABOR, DELIVERY AND NEWBORN CARE	80% Coverage After In-Network Deductible	60% Coverage After Out-Network Deductible	100% Coverage	100% Coverage
EMERGENCY CARE				
AMBULANCE	80% Coverage After In-Network Deductible	80% Coverage After In-Network Deductible	100% Coverage	100% Coverage
HOSPITAL EMERGENCY ROOM	$150 Copay	$150 Copay	$150 Copay	$150 Copay
INPATIENT HOSPITAL SERVICES				
SEMI-PRIVATE ROOM, SPECIALITY UNITS, PHYSICIAN SERVICES, SURGERY, THERAPY, LABORATORY, RADIOLOGY, HOSPITAL SERVICES AND SUPPLIES	80% Coverage After In-Network Deductible	60% Coverage After Out-Network Deductible	100% Coverage	100% Coverage
ALTERNATIVES TO HOSPITAL CARE				
HOSPICE CARE	100% Coverage	100% Coverage	100% Coverage	100% Coverage
SKILLED NURSING CARE	80% Coverage After In-Network Deductible	80% Coverage After In-Network Deductible	100% Coverage	100% Coverage
HOME HEALTH CARE	80% Coverage After In-Network Deductible	80% Coverage After In-Network Deductible	$40 Copay	100% Coverage
MENTAL HEALTH AND SUBSTANCE ABUSE CARE				
INPATIENT TREATMENT	80% Coverage After In-Network Deductible	60% Coverage After Out-Network Deductible	100% Coverage	100% Coverage
OUTPATIENT TREATMENT	80% Coverage After In-Network Deductible	60% Coverage After Out-Network Deductible	100% Coverage	$20 Copay

MEDICAL PLAN COMPARISON Continued

	BCBSM Simply Blue PPO		BCN HMO	HAP HMO
	IN-NETWORK	OUT-NETWORK		
OTHER SERVICES				
ALLERGY TREATMENT AND INJECTIONS	80% Coverage After In-Network Deductible	60% Coverage After Out-Network Deductible	100% Coverage	100% Coverage
PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY	80% Coverage After In-Network Deductible	60% Coverage After Out-Network Deductible	$40 Copay	100% Coverage
VOLUNTARY STERLIZATION	80% Coverage After In-Network Deductible	60% Coverage After Out-Network Deductible	100% Coverage	100% Coverage
PRESCRIPTION DRUGS				
RETAIL	$10 Copay Generic $20 Copay Preferred Brand $30 Non-Preferred Brand		$15 Copay Generic $50 Copay Brand	$10 Copay Generic $40 Copay Brand
MAIL ORDER	1 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	$1,700	
MAXIMUM BENEFIT AMOUNT FOR CLASS IV - ORTHODONIA LIFETIME MAXIMUM PER PERSON	$3,000	
SERVICE	**DELTA PPO OR PREMIER DENTIST**	**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%
RADIOGRAPHS X-RAYS	Covered-100%	Covered-100%
SEALANTS TO PREVENT DECAY OF PERMANENT MOLARS	Covered-100%	Covered-100%
BRUSH BIOPSY TO DETECT ORAL CANCER	Covered-100%	Covered-100%
CLASS II BENEFITS		
ORAL SURGERY SERVICES EXTRACTIONS AND DENTAL SURGERY	Covered-90%	Covered-90%
ENDODONTIC SERVICES ROOT CANALS	Covered-90%	Covered-90%
PERIODONTIC SERVICES USED TO TREAT DISEASES OF THE GUMS	Covered-90%	Covered-90%
RELINES AND REPAIRS TO BRIDGES AND DENTURES	Covered-90%	Covered-90%
MINOR RESTORATIVE SERVICES FILLINGS AND CROWN REPAIR	Covered-90%	Covered-90%
MAJOR RESTORATIVE SERVICES CROWNS	Covered-90%	Covered-90%
CLASS III BENEFITS		
PROSTHODONTIC SERVICES INCLUDES BRIDGES, IMPLANTS, AND DENTURES	Covered-90%	Covered-90%
CLASS IV BENEFITS		
ORTHODONTIC SERVICES **ORTHODONTIC AGE LIMIT**	Covered-90% None	Covered-90% None

- ***When services are received from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This Nonparticipating Dentist Fee may be less than what the dentist charges, which means that the patient will be responsible for the difference.**
- **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**
- **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**
- **Other benefit limitations and exclusions apply. Please see the Delta Dental coverage booklet for more details.**

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 for Ophthalmologist; $28 for Optometrist
FRAMES	Limited to one frame per benefit period	Plan pays up to $175	Plan pays up to $86
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 $200	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