2020 Benefit Guide
Full Time Academy

the Henry Ford®

Plan Year January 1, 2020—December 31, 2020

The Henry Ford's Benefit Objectives

The Henry Ford is committed to offering a comprehensive employee benefits package that allows us to continue to attract and retain the best employees. Because each employee has unique needs, we have designed a package so you can customize coverage to meet your needs and the needs of your family.

Our plans include medical, dental and vision coverage, along with a variety of tax-favored accounts (403b and FSA) and financial protection programs. These plans provide preventative measures to avoid and the security to address any unforeseen situations that you or your family may encounter. So with these objectives in mind, we are pleased to present our benefits package for 2020.

This Benefits Guide provides summary information on certain The Edison Institute dba: The Henry Ford (THF) benefits. The benefits are governed by the official plan documents (which may include underlying contracts). This guide is not intended to amend or revise any official plan document or change the terms of any plan in any way. This guide is believed to be accurate as of the print date; however, it is subject to change without notice. In the event of any inconsistency between the plan documents and the information in this guide, the terms of the plan documents, as interpreted by the plan administrator in its sole discretion, control in all cases. THF reserves the right to amend, suspend, or terminate these benefits plans or programs at any time for any reason.

This guide is intended for distribution only to employees eligible for THF benefits plans and programs described herein. If you inadvertently receive this Benefits Guide or information about benefit programs that are inapplicable to you, receipt of this guide or other benefit information shall not be deemed to constitute a waiver of any applicable eligibility requirements. This guide is for information purposes only and is neither an offer of any payment of benefits nor a guarantee of continued employment or payment of any future benefits. Nothing contained in this guide alters the at-will nature of employment of THF at-will employees. To the extent eligible employees are employed by THF pursuant to a written employment agreement, nothing in this guide alters any provisions therein, including, but not limited to, the duration, term or termination provisions of the agreement.

Benefit Summary

Benefit	Carrier
Medical Coverage	Blue Care Network (BCN)
Dental Coverage	Delta Dental
Vision Coverage	VSP; Heritage Vision
Flexible Spending Account (FSA) & Dependent Care	TASC
Group Life, STD, LTD, Voluntary Life, Accident & Critical Illness	UNUM
Employee Assistance Program (EAP)	LifeBalance by LifeWorks

Your Admin Team

The Henry Ford has partnered with the J.S. Clark Agency in order to provide you with superior employee benefit service and administration. With over 30 years of employee benefit management experience, J.S. Clark is ready to support The Henry Ford employees with all their benefit needs. This includes administration of our health and welfare benefits program.

Trained Benefits Specialists are available to answer questions regarding your benefits and enrollment. You may contact them Monday - Friday from 8:00 - 4:00. While your first line of action should be to contact Member Services with the carriers, J.S. Clark is available should you need additional assistance.

Claims Issues:

Monica Swigart —Account Manager

248-663-1191 or monica@jsclarkagency.com

ID Card Request:

Ryan Miller—Group Administration

Benefit Basics

As a Henry Ford employee, you are eligible for most benefits if you work at least 30 hours per week. Benefits are effective on the 91st of the month following your date of hire. We have non -J.S. Clark benefits at day 1, day 60, etc. You may enroll your eligible dependents for coverage once you are eligible. Your eligible dependents include you married spouse and your eligible children (including natural, step children, legally adopted/guardianship). Once your benefit elections become effective, they remain in effect until the end of the year unless you have a qualified event.

Qualified Life Events

You may change your benefit elections during the year if you experience a qualified life event, including:

- Marriage
- Divorce or legal separation
- Birth or adoption of a child
- Death of an eligible dependent
- Change in employment status for you or your spouse

You must notify Talent & Culture within 30 days of the qualified life event. Depending on the type of event, you may be asked to provide proof of the event. If you do not contact Talent & Culture within 30 days of the qualified event, you will have to wait until the next annual enrollment period to make changes.

Key Terms

What is a copayment?

A flat dollar amount you pay for services rendered. Under Health Care Reform, copays are added to the TROOP. Copays may apply to services such as office visits, ER visits, or prescriptions.

What is Annual Out of Pocket Maximums - (True Out-Of-Pocket maximum)?

The most you pay during a policy period before insurance begins paying 100% of the allowed amount. This limit includes deductibles, coinsurance, flat dollar copays and prescription drug copays. Check your plan for your specifics.

What is a deductible?

The amount you owe for health care services before your insurance begins to pay. For example, if your deductible is $500, your plan won't pay anything until you've met your $500 deductible. The deductible may not apply to all services.

Medical Plan Overview

The Henry Ford offers you medical coverage through Blue Care Network (BCN). Below is a brief overview of the coverage offered.

Please refer to your Summary of Benefits for a more comprehensive list of additional coverages and limitations.

Plan Design	Blue Care Network Classic Plan HMO
Calendar Year Plan Deductible (Individual/Family)	$250/$500
Calendar Year Coinsurance	N/A
Total Out of Pocket Maximum (Individual/Family)	$6,350/$12,700 Includes Deductible, Coinsurance and Copayments
Preventive Care	Covered at 100%
Primary Care Office Visit	$30 copay
Specialist Office Visit	$30 copay
Urgent Care	$50 copay
Emergency Room	$150 copay - waived if admitted
Prescriptions Drugs 30 day **Generic** **Brand Name** **Contraceptives** **Mail Order 90 day**	 $10 copay $40 copay Included 2x copay
2020 Medical Rates (Bi-Weekly)	
Tier	**Employee Rate (26 pays)**
Single	$33.77
Two Person	$78.7
Family	90.98

Medical Opt Out Credit $36.92
(Must supply other proof of coverage)
***If you and a family member are both employed under The Henry Ford's health plans you will not be eligible for the opt out credit if you are covered under that family members plan.**

Prescription Drug Program

Under the plan you may visit any pharmacy for your prescription needs, but have lower expenses when you use network pharmacies. Find a provider near you online at **www.bcbsm.com** or **www.mibcn.com.** Generally, with a prescription from a physician, the affiliated pharmacy will dispense an equivalent generic drug. To maximize your prescription drug benefit and avoid paying any additional cost difference, ask your prescribing physician to help you determine whether a generic alternative is available and appropriate for you.

Mail Order Prescription Drug Program

The plan also offers a convenient and cost-saving prescription drug program for long-term maintenance medication through Express Scripts. **By using the Express Scripts Mail Order Prescription Drug (MOPD) program, you pay two copayments for a 90-day supply of maintenance medication under the plan.**

Maintenance medication is taken on a regular or long-term basis.

For example, the following conditions may be treated with maintenance medication: asthma, high blood pressure, ulcers, arthritis, heart or thyroid conditions, emphysema, and diabetes. To participate, have your doctor write you a 90-day prescription, then mail an enrollment form or complete the online enrollment form at **www.bcbsm.com/pharmacy**. Your order will be sent to your home via UPS or First Class Mail. Reorder information will be included in your prescription shipment.

Prior Authorization: Certain clinical criteria must be met before some drugs are covered. Your doctor should call our pharmacy help desk to request prior authorization for these drugs.

Step Therapy: Requires that you have tried an alternative therapy first or that your doctor has clinically documented why you cannot take the alternate therapy. Step therapy may include select covered over-the-counter products.

Plan Design Item Prescription Drugs 30 day	Blue Care Network Classic Plan HMO
Generic	$10 copayment
Brand name	$40 copayment
Contraceptives	Included
Mail Order 90 day	2X copayment

Flexible Spending Account

Flexible Spending Accounts (FSAs) are designed to save you money on your taxes. Each pay period, funds are deducted from your pay on a pretax basis and are deposited to your Health Care and/or Dependent Care FSA. You then use your funds to pay for eligible health care or dependent care expenses.

Flexible Spending Account (FSA) Administrator - TASC

Account Type	Eligible Expenses	Annual Contribution Limits	Benefit
Health Care FSA	Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses and doctor-prescribed over the counter medications)	Maximum contribution is $2,700 per year	Saves on eligible expenses not covered by insurance; reduces your taxable income
Dependent Care FSA	Dependent care expenses (such as day care, after school programs or elder care programs) so you and your spouse can work or attend school full-time	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns)	Reduces your taxable income

Easily Manage Your Card Online - www.tasconline.com

Our dynamic MyTASC website makes card management easy. Simply log in to your MyTASC account online and select **Manage My Card** to perform the following functions:

- View card information.
- View allowed benefits.
- Reissue a card (due to never received, damaged, lost/stolen, or name change).
- Request a PIN for ATM access.
- Schedule a funds transfer.
- Request an additional card for spouse and/or dependent.

A debit card is available to pay for your eligible expenses. Simply swipe your card for copays, deductible, etc. and the provider will be paid directly from your account. Keep all documentation of expenses as it may be required to be submitted to verify the eligible charge.

Dental Coverage

Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler and costs are lower. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease, and is an important part of maintaining your medical health.

Your dental plan will be administered by Delta Dental of Michigan. The Dental plan does not require in-network providers be used, however, Delta Dental network providers will charge lower fees there-by making your dental dollars go farther and lowering your out of pocket costs.

Plan Provision	Delta Dental of Michigan		
Network	**PPO Dentist**	**Premier Dentist**	**Nonparticipating Dentist**
Annual deductible (Individual/Family)	$0	$0	$0
Annual maximum (per person)	$1,500	$1,500	$1,500
Diagnostic and Preventive Services: Includes exams, cleanings, fluoride and space maintainers	100%	100%	100%
Basic Services: Includes fillings and crown repair, root canals, periodontics, x-rays and oral surgery	80%	60%	60%
Major Services: Includes crowns, bridges, implants and dentures	50%	50%	50%
Orthodontia (up to age 19)	50% $1,500 lifetime maximum	50% $1,500 lifetime maximum	50% $1,500 lifetime maximum
Coverage Level	**2020 Dental Rates (Bi-Weekly)**		
Single	$1.83		
Two Person	$3.60		
Family	$6.60		

Dental Opt Out Credit $2.00
(Must supply other proof of coverage)
***If you and a family member are both employed under The Henry Ford's health plans you will not be eligible for the opt out credit if you are covered under that family members plan.**

DELTA DENTAL

To find a provider participating in your dental plan network, visit www.deltadentalmi.com

Vision Coverage

The VSP vision plan covers routine eye exams and also pays for all or a portion of the cost of glasses or contact lenses.

No ID Cards are necessary, simply notify your vision provider that you have a VSP plan. If you use a VSP provider, they will verify your benefits and you will only pay the amount not covered by the plan at the time of purchase.

Benefit	In-Network
Exam	$20 copay for exam and glasses
Frequency **Exam** **Lenses** **Frames** **Contacts (instead of glasses)**	12 months 12 months 24 months 12 months
Frames	$130 allowance; $150 allowance for featured frame brands
Lenses **Single vision lenses** **Lined Bifocal / Trifocal lenses**	Combined with exam
Elective Contact Lenses	$130 allowance; Up to $60 copay for exam (fitting and evaluation)
Extra Savings	30% savings on additional glasses or sunglasses from a VSP provider Lasik Vision Correction: up to15% on regular or 5% on promotional pricing
Coverage Level	**2020 Vision Rates (Bi-Weekly)**
Single	$0.63
Two Person	$0.96
Family	$1.72

To find a participating vision provider, visit www.vsp.com or call 800-877-1795.

Vision Coverage

The Heritage vision plan covers routine eye exams and also pays for all or a portion of the cost of glasses or contact lenses. Benefits are payable each calendar year.

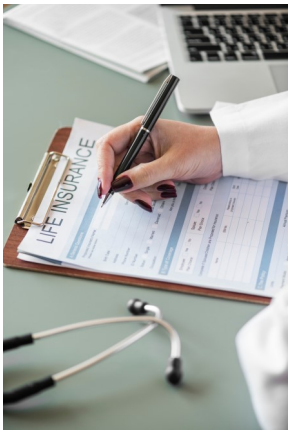
No ID Cards are necessary, simply notify your vision provider that you have a Heritage Vision plan. If you use a Heritage provider, they will verify your benefits and you will only pay the amount not covered by the plan at the time of purchase.

Benefit	In-Network
Exam	100%
Frequency **Exam** **Lenses** **Frames** **Contacts (instead of glasses)**	12 months 12 months 12 months 12 months
Frames	$100 retail allowance Member pays retail frame cost over allowance, less 20% discount on balance over allowance
Lenses **Single vision lenses** **Lined Bifocal / Trifocal lenses**	100%
Standard Contact Fitting	100%; $40 copay
Elective Contact Lenses	$75 retail allowance Member pays retail contact cost over allowance, less 10% discount on balance over allowance
Medically Necessary	100%; No copay **Prior Approval Required; Covered up to Usual & Customary Amount**
Coverage Level	**2020 Vision Rates (Bi-Weekly)**
Single	$0.57
Two Person	$0.57
Family	$0.57

To find a participating vision provider, visit www.heritagevisionplans.com or call 800-252-2053.

Heritage vision plans

Life & AD&D Insurance Coverage



Life insurance is an important part of your financial security, especially if others depend on you for support. Accidental Death & Dismemberment (AD&D) insurance is designed to provide a benefit in the event of an accidental death or dismemberment.

The Henry Ford provides Basic Life and AD&D Insurance to all eligible employees working at least 40 hours a week at *no cost to you*. This benefit includes two times your annual earnings to the nearest thousand up to a maximum of $500,000 of term life insurance.

Disability Insurance Coverage

The goal of our Disability Insurance Plan is to provide you with income replacement should you become disabled and unable to work due to a non-work-related illness or injury. Benefits are available to full-time employees working 40 hours per week. The Plan is administered by UNUM.

The Henry Ford is paying for the cost of this coverage. Coverage is guaranteed so you don't have to answer any medical questions.

Why is this coverage so valuable?

Your employer is paying for the cost of this coverage so you can use the money however you choose. It can help pay for your rent or mortgage, groceries, out of pocket medical expenses and more.

Short Term & Long Term Disability Insurance

Short Term Disability Insurance

Pay you a weekly benefit if you have a covered disability that keeps you from working.

Coverage amounts

Covers 60% of your weekly income, up to a maximum benefit of $1,500 per week.

The weekly benefit may be reduced or offset by other sources of income. The IRS may require you to pay taxed on certain benefit payments. See your tax advisor for details.

Elimination period (EP)

This is the number of days that must pass between your first day of a coverage disability and the day you can begin to receive your disability benefits.

Your benefits would begin after you become disabled for 7 days and your claim is subject to approval by Unum.

Benefit duration (BD)

The maximum number of weeks you can receive benefits while you're disabled. You have a 25 week duration.

Long Term Disability Insurance

Replaces part of your income if a disability keeps you out of work for a long period of time.

Coverage amounts

Covers 60% of your monthly income, up to a maximum benefit of $13,000.

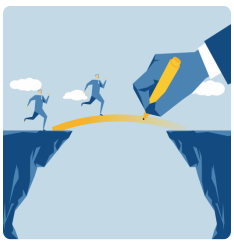
The monthly benefit may be reduced or offset by other sources of income. The IRS may require you to pay taxed on certain benefit payments. See you tax advisor for details.

Elimination period (EP)

Your elimination period is 180 days. This is the number of days that must pass after a covered accident or illness before you can begin to receive benefits. All claims are subject to approval by Unum. Additional paperwork may be required in order for Unum to process LTD claims and payments

Benefit duration (BD)

This is the maximum length of time you can receive benefits while you're disabled. You can receive benefits up to the Social Security normal retirement age.



Term Life Insurance

Term Life Insurance can provide money for your family if you die or are diagnosed with a terminal illness.

Who can get Term Life coverage?

If you are actively at work at least the required hours per week, you may apply for coverage for:

You	Choose from $10,000 to $500,000 in $10,000 increments, up to 5 times your earnings. You can get up to $150,000 with no health questions. This is your guaranteed issue amount.
Your Spouse	Get up to $500,000 of coverage in $5,000 increments. Spouse coverage cannot exceed 100% of the coverage amount you purchase for yourself. You spouse can get up to $25,000 with no health questions, if eligible (see delayed effective date. This is their guaranteed issue amount.
Your Children	Your children get up to $10,000 of coverage in $2,000 increments if eligible (see delayed effective date). One policy covers all of your children until their 19th birthday - or until their 26th birthday if they are full time students. The maximum benefit for children from birth to 6 months is $1,000.

What else is included?

A "Living Benefit"

If you are diagnosed with a terminal illness with less than 12 months to live, you can request 100% if your life insurance benefit (up to $250,000) while you are still living. This amount will be taken out of the death benefit, and may be taxable.

Waiver of Premium

Your cost may be waived if you are totally disable for a period of time.

Portability

You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Accident Insurance

Accident Insurance can pay a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur off the job and it includes a range of incidents, from common injuries to more serious events.

Why is this coverage so valuable?

- It can help you with out of pocket expenses that you medical plan doesn't cover, like copays and deductibles.
- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.
- You can keep you coverage if you change jobs or retire, you'll be billed directly.

Accident Insurance

Can pay you money for covered accidental injuries and their treatment.

What's included?

A Wellness Benefit

Every year, each family member who has Accident coverage can also receive $50 for getting a health screening test, such as:

- Blood tests
- Chest X-rays
- Stress tests
- Colonoscopies
- Mammograms

How to file a claim:

Simply call Unum at 800-635-5597 or go online www.unum.com to file your wellness claim! You will need the following information:

- First and last name
- Employee's social security number
- Name and date of the test
- Physician's name and facility where the test was performed.

Critical Illness Insurance

If you are diagnosed with an illness that is covered by this insurance, you can receive a benefit payment in one lump sum. You can use the money however you want.

Why is this coverage so valuable?

- The money can help you pay for out of pocket medical expenses, like copays and deductibles.
- You can use this coverage more than once.

Critical Illness Insurance

Can pay money directly to you when you're diagnosed with certain serious illnesses.

What's covered?

- Heart attack
- Blindness
- Major organ failure
- End stage kidney failure
- Benign brain tumor
- Coronary artery bypass surgery (pays at 25% of lump sum benefit)
- Coma that last at least 14 consecutive days
- Stroke whose effects are confirmed at least 30 days after the event
- Occupational HIV
- Permanent paralysis of at least two limbs due to a covered accident
- Cancer
- Carcinoma in situ - pays 25% of your coverage amount. (Carcinoma in situ is defined as cancer that involves only cells in the tissue in which it began and that has not spread to near by tissues).

What else is included?

A Wellness Benefit

Every year, each family member who has Critical Illness coverage can also receive $50 for getting a health screening test, such as:

- Blood tests
- Chest X-rays
- Stress tests
- Colonoscopies
- Mammograms
- And other tests listed in your policy

How to file a claim:

Simply call Unum at 800-635-5597 or go online www.unum.com to file your wellness claim! You will need the following information:

- First and last name
- Employee's social security number
- Name and date of the test
- Physician's name and facility where the test was performed.

Employee Assistance Program

When you find yourself in need of some professional support to deal with personal, work, financial or family issues your Employee Assistance Program (EAP) can assist. This is a free confidential service paid by The Henry Ford.

- **5 face to face counseling sessions, per issue**
- **Unlimited telephonic support for a broad range of topics**

Consultants are available to help 24 hours a day, 7 days a week, 365 days a year.

This benefit is available to you and your immediate family.

For more information please call 877-259-3785 or visit them online at lifebalance.lifeworks.com

User ID: edison Password: lifebalance

Fiducius
A Better Kind of Benefit

Help Our Employees with the Student Loan Relief Benefit

the Henry Ford

We now offer the voluntary Loan Relief™ benefit from Fiducius. You can help our employees **increase their take home pay** by reducing their monthly student loan payments an average of 81% with the loan forgiveness solution.

How the Process Works for Our Employees

1. Complete initial registration
2. Learn about loan options
3. Talk with financial planner
4. Get personal plan
5. Enroll & start saving

For any questions or login issues, contact Fiducius at 1.513.645.5400 or info@getfiducius.com

Start Now

Employees visit **https://thehenryford.myfiducius.com/register**
Register with code **THF** & employees learn how much they save.

A Win-Win Benefit!

"Seeing a notice with the promise of help on my student loans from Fiducius made me curious, yet skeptical. Since the email came from management, I thought it had to be true. My financial planner spoke with my husband and I to discuss my savings plan. Considering Fiducius does all the work and saves my family over $500 per month and over $60,000 in the end, my husband and I thought it was a win-win!"

Haley Coddens Healthcare Practice Manager

Support for the Student Loan Benefit

Fiducius enables employers to achieve recruiting, retention, and productivity goals, while empowering employees to achieve financial wellness. Their student loan financial planning approach addresses the unique situation of each employee. Visit www.getfiducius.com for more information and success stories.

@getfiducius

Member Services Contact Information

Carrier	Coverage	Contact Information	Website
Blue Care Network (BCN)	HMO Medical	800.662.6667	www.bcbsm.com
TASC	FSA & Dependent Care	800.422.4661	www.tasconline.com
Delta Dental	Dental	800.524.0149	www.deltadentalmi.com
VSP	Vison	800.877.7195	www.vsp.com
Heritage Vision	Vison	800.252.2053	www.heritagevisonplans.com
Unum	Life, STD, LTD & Voluntary Life Life	877.225.2712	www.unum.com
LifeBalance by LifeWorks	Employee Assistance Program	877.259.3785	www.lifebalance.net
Prescription Information	**Coverage**	**Contact Information**	**Website**
Express Scripts	Mail Order Medication	800.992.1551	www.express-scripts.com
Walgreens Specialty Drugs	Specialty Drugs Order	866.515.1355	
Accredo Limited Distribution	Specialty Drugs Order	800.803.2523	
J&B Medical Supplies	Diabetic Supplies	888.896.6233	www.portal.jandbmedical.com
Benefit Contacts	**Company**	**Contact Information**	**Email**
Jennifer Schwartzenberger	The Henry Ford	313.982.6152	jennifers@thehenryford.org
Monica Swigart	JS Clark Agency	248-355-9600	monica@jsclarkagency.com
Online Benefit Portal			
www.dayforceHCM.com			
The Henry Ford Online Benefit Portal			
www.thehenryford.org/benefits			
password: Liberty_Craftworks			

Important Regulatory Notices

Waiving Coverage

We understand you may be covered under another group health plan and may not need the benefits or a lower level of benefits. If you are covered under another group health plan, you may waive medical and dental coverage and receive an opt-out payment. The opt-out payment amounts for the 2020 plan year are:

Medical - $36.92 per pay. **Dental - $2.00 per pay**

In order to take advantage of the opt-out payments when you waive benefits, you must provide proof of other coverage to Human Resources and verify your waiver of benefits through the online portal. If you and a family member are both employed by The Henry Ford, you will not be eligible for the opt-out payment if you have coverage under that family member's health plan.

Important note regarding the waiving health coverage and opt-out payment eligibility:

This health plan is a qualifying health plan in accordance with the employer mandates of the Affordable Care Act (ACA). If you waive coverage it may affect eligibility for subsidized coverage in the Marketplace (health exchange). To be eligible for the opt-out payment you must certify you are waiving coverage for yourself and/or your dependents and that you will not be eligible to enroll in the health plan until the next open enrollment period (for a January 1, 2021 effective date unless you experience a family status change or qualifying event.

In addition, to be eligible for the opt-out payment for waiving health coverage you must certify that you and all of your tax eligible dependents are enrolled in other group health coverage that is considered to be affordable, minimum essential coverage. Although the opt-out payment can be used for any purpose, it is not intended to be a form of reimbursement for coverage in the Marketplace (health exchange).

Patient Protection Notice

Blue Care Network generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, Blue Care Network designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Blue Care Network at 800.662.6667. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Blue Care Network or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Blue Care Network at 800.662.6667.

HIPPA Privacy Notice

The American Recovery and Reinvestment Act expanded HIPAA by requiring new notices in the event of an unauthorized use, access, or disclosure of protected health information. If a covered entity (such as our medical claims administrator) discovers a breach in privacy and security protocols, they will provide, within 60 days of discovery, notice by first class mail to each individual whose protected health information has been (or is reasonably believed to have been) breached.

Elective Abortion Rider

Your employer has purchased an optional rider for elective abortions from your insurance carrier; this coverage may be used by any covered dependent without notice to the employee.

HIPPA Special Enrollment Rights

Important note regarding Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the plans if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependent's other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage). If mid-year enrollment is requested due to loss of other coverage, you will be required to provide proof of loss of coverage through the other health plan in order to enroll.

In addition, you may be able to enroll yourself and your dependents on your benefit plans mid-year under a family status change that would include:

Your marriage

Birth, adoption or placement for adoption of an eligible child

A change in your child's eligibility for benefits

Change in address that affects eligibility for coverage

A significant change in your or your spouse's health coverage or cost of benefit

Receiving a Qualified Medical Child Support Order (QMCSO)

However, you must request enrollment within 30 days after the event triggering the newly eligible dependent. To request special enrollment, contact the Human Resources Department. Human Resources will request documentation for proof of newly eligible dependents.

Family Status Change (a.k.a. life events):	Required Documentation:
Newly married	Marriage certificate
Birth or adoption of a child	Birth certificate , adoption papers
Divorce	Copy of divorce decree (only certain pages are required)
Death of a eligible dependent	Death certificate
Change in employment status for you or your spouse	A letter from prior/new employer or insurance carrier or certificate of creditable coverage (COCC)

Failure to report and provide documentation of your family status change within 30 days of the event will result in you being unable to add or drop your dependent (s) until the earlier of another family status change event or the next annual open enrollment.

Provided notification is timely, a COBRA Election Notice and Election Form is provided to qualified beneficiaries within 14 days of the date of the qualifying event or loss of coverage; Human Resources is made aware of the loss of coverage; or Human Resources is made aware of a qualifying event. We are not required to offer Human Resources

Special enrollment rights also exist in the following two circumstances, in which you or your dependents will have sixty (60) days from the date of the eligibility event to request special enrollment in the group health plan coverage:

If you or your dependents experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or

If you or your dependents become eligible for premium assistance under an optional state Medicaid or SCHIP. If you decline enrollment for yourself or your dependents (including your spouse) due to other health insurance or group health coverage, and lose your other coverage, or if the employer stops contributing towards you or your dependents' other coverage, you may enroll in this plan within 30 days from the date your other coverage ends (or after the employer stops contributing toward the other coverage).

Your coverage will become effective the date your other coverage is lost. (This may vary with certain situations. You should consult your spouse's employer for continuation rights between the date of loss and coverage effective date.) In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Women's Health & Cancer Rights Act

The Women's Health and Cancer Right Act (WHCRA) for 1998 was a part of the omnibus appropriations bill passed by Congress and signed into law on October 21, 1998. This law applies to group health plans, health insurance companies and HMOs, if the plans or coverage provides medical and surgical benefits for a mastectomy. Under WHCRA, mastectomy benefits must include coverage for:

- Reconstruction of the breast upon which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical or balanced appearance,
- Prostheses (or breast implant), and
- Physical complications at all stages of mastectomy, including lymphedema.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds it is cosmetic in nature or otherwise does not meet the coverage definition of medically necessary. Benefits must be provided on the same basis as for any other illness or injury under the medical plan. Mastectomy benefits may have yearly deductibles and coinsurance like those established for other benefits under the plan or coverage.

The WHCRA will not allow:

Plans and insurance issuers to deny patients eligibility or continued eligibility to enroll or renew coverage under the plan to avoid the requirements of WHCRA.

Plans and insurance issuers to provide incentives to or penalize doctors to cause them to provide care in a manner not supportive with WHCRA.

WHCRA is administered by the U.S. Departments of Labor and Health and Human Services. More information is available from the Department of Labor's website, at **www.dol.gov/ebsa**.

Michelle's Law

Under Michelle's Law (H.R. 2851), existing health benefits must be continued for dependent postsecondary students if a serious illness or injury requires they take a medical leave of absence from school or change their student status. Beginning October 8, 2009, individual and group plans must continue a student's coverage up to a year from the first day of the absence or change in status or date on which such coverage would have otherwise ended under the terms of the plan.

Newborn's Act Disclosure

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Human Resources.

Emergency Services

If an emergency room claim is denied, and you feel it was an emergency situation, you should request a copy of the emergency room report or ask the hospital to resubmit the claim with the emergency room notes. A medical professional will review the claim to see if the signs and symptoms at the time of treatment met the criteria of an emergency.

Medicare Part D Creditable Coverage Notice

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Edison Institute dba: The Henry Ford and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The Edison Institute dba: The Henry Ford has determined that the prescription drug coverage offered is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current The Edison Institute dba: The Henry Ford coverage may be affected. If you do decide to join a Medicare drug plan and drop your current The Edison Institute dba: The Henry Ford coverage, be aware that you and your dependents may be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with The Edison Institute dba: The Henry Ford and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Cafeteria Plan & Employee Contributions

By participating in the cafeteria plan, you can pay for the cost of some of your insurance coverage with **pre-tax** dollars (before taxes are withheld). When you have the cost deducted from your pay on a pre-tax basis, your net take home pay is higher than if the contribution is deducted on a post-tax basis. Employee's save an average of 28-40% on deduction amounts due to the tax savings of the cafeteria plan.

Under the cafeteria plan:

You must make your election prior to the beginning of each plan year.

You cannot change your election during the plan year, except in the event of a family status change as defined by the Internal Revenue Service (IRS).

These family status changes include the following:

marriage or divorce

birth or adoption of a child

death of an eligible dependent

change in employment status of you or your spouse

If you experience an eligible family status change you must report the change to Human Resources within 30 days of the date of the event. If you wait more than 30 days you are required to wait until the next open enrollment period to make changes to your elections.

OCR Notice of Non-Discrimination

The Edison Institute dba The Henry Ford complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Edison Institute dba The Henry Ford does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Edison Institute dba The Henry Ford:

Provides free aids and services to people with disabilities to communicate effectively with us, such as: Qualified sign language interpreters and Written information in other formats (large print, audio, accessible electronic formats)

Provides free language services to people whose primary language is not English, such as: Qualified interpreters and Information written in other languages

If you need these services, contact Jennifer Schwartzenberger

If you believe that The Edison Institute dba The Henry Ford has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Jennifer Schwartzenberger
20900 Oakwood Blvd
Dearborn, MI 48124
313.982.6152
jennifers@thehenryford.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Jennifer Schwartzenberger is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
Toll Free: 1-800-868-1019,
800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Important CHIP Notice

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: **http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm** Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: **http://www.ACCESSNebraska.ne.gov** Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: **http://www.eohhs.ri.gov/** Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: **https://dhcfp.nv.gov** Medicaid Phone: 1-800-992-0900	Website: **https://www.scdhhs.gov** Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: **http://dss.sd.gov** Phone: 1-888-828-0059	Website: **http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program** Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: **http://gethipptexas.com/** Phone: 1-800-440-0493	Website: **http://mywvhipp.com/** Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: **https://medicaid.utah.gov/** CHIP Website: **http://health.utah.gov/chip** Phone: 1-877-543-7669	Website: **https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf** Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: **http://www.greenmountaincare.org/** Phone: 1-800-250-8427	Website: **https://wyequalitycare.acs-inc.com/** Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: **http://www.coverva.org/programs_premium_assistance.cfm** Medicaid Phone: 1-800-432-5924 CHIP Website: **http://www.coverva.org/programs_premium_assistance.cfm** CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)