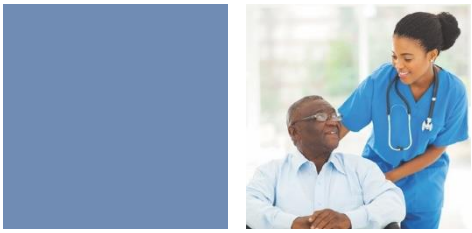
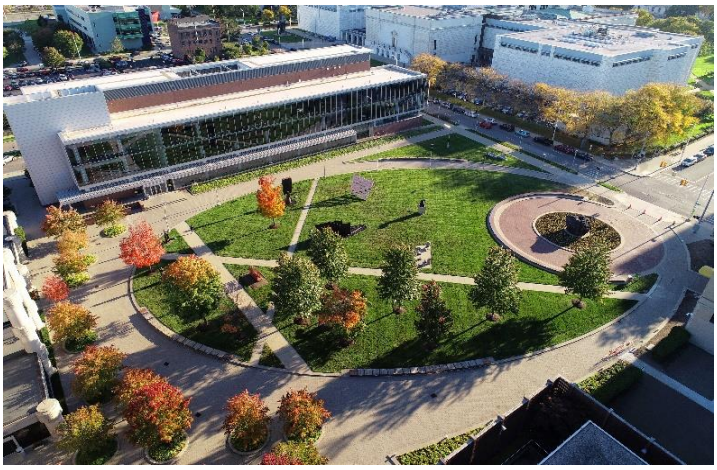


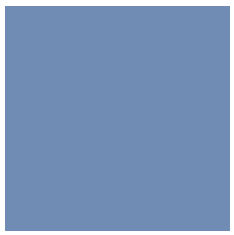
COLLEGE *for* Creative STUDIES







# 2021 Benefit Guide

Updated 2/2/2021

# Table of Contents



This brochure summarizes the benefit plans that are available to College for Creative Studies eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

# A Message to Our Employees

## Dear College for Creative Studies Employees,

Each year The College begins reviewing the benefit programs offered to its employees in early June. The review process takes into consideration, among other things, medical trends, benefits costs, insurance carrier access and service, as well as employee feedback.

Health Care reform continues to pose a financial challenge for employer sponsored health care. As a result, each year The College must carefully weigh all plan options and costs accordingly.

The College recognizes and appreciates you and the contributions you make to help us succeed and be a leader in our field. It's one of the reasons proving a high-quality benefit program to you and your family is one of our highest priorities.

If after reviewing this document you find you have questions, please be sure to address them with your Human Resources representative. We want to be sure you get the answer you need to make an informed decision. If you provide coverage to a spouse, take this guide home so that he/she can become familiar with the plan offerings.

We begin the process of evaluating our employee benefits package so early in the year because it is a process that takes much time and consideration. It includes reviewing proposals from other insurance carriers, reviewing the impact of Federal and State legislation, making decisions based on the benefits available, as well as the affordability for both the employees and The College.

The College will spend well over 1 million dollars providing Medical, Dental, Vision, Basic Life, Accidental Death and Dismemberment, Long Term Disability, an Employee Assistance Program and Flexible Spending Accounts benefits to our employees and their dependents.

The College recognizes that each employee through her/his hard work and dedication have been instrumental in making us the success we are today. We thank each and every one of you and hope that you will be part of The College for Creative Studies family for many years to come.

# Benefits for You & Your Family

College for Creative Studies benefits program is designed to help you stay healthy, feel secure, and maintain a work/life balance. Offering a competitive benefits package is just one way we strive to provide our employees with a rewarding workplace. Please read the information provided in this guide carefully. For full details about our plans, please refer to the summary plan descriptions. Listed below are The College for Creative Studies benefits available during open enrollment:

- Medical
- Dental
- Vision
- Life and AD&D
- Long Term Disability
- Voluntary Life
- Flexible Spending Accounts
- Employee Assistance Program

## Who is Eligible?

Employees working at least 30 hours and their eligible dependents may participate in The College for Creative Studies benefits program.

Generally, for The College for Creative Studies benefits program, dependents are defined as:

- Legal Spouse – Same or opposite gender
- Domestic Partner – Same or opposite gender
  - Criteria is as follows:
  - Must be 18 years of age or older
  - Neither person is legally married
  - Cannot be related by blood or marriage
  - Lived together at the same regular and permanent residence for the last 12 consecutive months (must provide documentation)
  - Are financially interdependent
- Children – coverage is available until the end of the calendar year in which the child turns age 26, with the exception of Voluntary Life coverage which is age 20 or 24 if a full-time student
- Dependent under a qualified medical Child Support Order
- Disabled Dependent – Children of the subscriber who are totally and permanently disabled with either a physical disability or mental retardation prior to the age or 19. Michigan law requires that disabled dependents continue coverage as regular family members if certain criteria are met (See HR for more details)
- Principally supported Children – Who are not the offspring of the employee or spouse, but are related by blood or marriage may be enrolled if:
  - The child is under age 19 and unmarried
  - The child is legally resided with the subscriber
  - The child is not Medicare eligible
  - The child is claimed as a tax dependent on the subscriber's most recent federal income tax filing
  - The child has been principally supported by the subscriber for a minimum of nine consecutive months before coverage is effective.
- You must report to Human Resources within 30 days of the date a dependent cease to meet the definition of eligible dependent

## New Hire Enrollment

Newly hired employees are eligible for coverage on the first of the month following 30 days of employment with the exception of Long-Term Disability which has a waiting period of 1st of the month following one year of employment.

## When and How Do I Enroll?

You can enroll as a new hire or during open enrollment at the end of the year effective the 1st of the year.

Each employee is required to complete his/her enrollment online via BenXpress at https//www.benxpress.com/ccs.

## Changing Coverage During the Year

You can change your coverage during the year when you experience a qualified change in status, such as marriage, divorce, birth, adoption, placement for adoption, or loss of coverage. The change must be reported to the Human Resources Department within 30 days of the event. The change must be consistent with the event.

# Spousal Surcharge

Working spouses/domestic partners are required to enroll in their employer's medical plan. Your spouse/domestic partner enrolling in his/her employer's coverage helps to keep The College's health care costs from large increases. All cost saving strategies employed by The College are for the sole purpose of making benefit plans offered affordable to employees while at the same time providing comprehensive coverage.

If your spouse/domestic partner is eligible to participate in his/her own employer's medical plan and you elect to enroll him/her in The College's medical benefit plan, you will pay a surcharge of $100 per month.

If your spouse/domestic partner ceases to be eligible for his/her employer's health plan during the plan year, the surcharge can be waived. You must provide documentation to Human Resources within 30 days of the loss of their eligibility for medical benefits.

The surcharge does not apply to a non-working spouse/domestic partner, or who is ineligible for medical benefits through his/her employer. The surcharge is only applied to medical benefits.

If you are married or in a domestic partner relationship, you will be asked to attest during the enrollment process in BenXpress. You will confirm that your spouse/domestic partner:

- Is or is not employed
- Is or is not eligible for medical benefits through his/her employer

The College reserves the right to contact Blue Cross Blue Shield of Michigan (BCBSM), Blue Care Network (BCN) or your spouse's/domestic partner's employer to verify any and all statements. If any statements are proven to be false, disciplinary action may be taken.

# Medical Insurance

The College provides two comprehensive medical benefits plan options from which to choose:

- Blue Cross Blue Shield of Michigan (BCBSM) Simply Blue PPO $1500
- Blue Care Network (BCN) HMO

Please remember to review all information provided regarding the medical plan options in order to make the best decision for you and your eligible dependents

# BCBSM Simply Blue PPO $1500 Option

"PPO" stands for Preferred Provider Organization.

You receive a higher benefits level and lower out-of-pocket expenses when you receive care from PPO providers. You can receive services from any provider you choose, even a specialist.

### Go to www.bcbsm.com to locate PPO Providers

Select "find a Doctor" located on the left side of the page, on the following screen click on "search without logging in". It will ask you for your area. Next, on the top right-hand slide of the screen where it says "plan", select "PPO Plans" then follow the prompts and complete the parameters of your search.

Additional Directories by provider categories are listed at the bottom of this page and includes Approved Autism Evaluation Centers and Board-Certified Behavior Analysts, Hemophilia Network, Ambulatory Surgical Facilities and Provider Delivered Care Management Physicians. *Access to quality and cost information related to a provider requires you to register for Member Secured Services.*

Non-PPO providers are divided into two categories: physicians who participate with BCBSM but do not participate in the PPO program and physicians who do not participate with BCBSM. You pay more out-of-pocket and no benefit is paid by BCBSM for routine preventive services when provided by a non-PPO provider.

A non-PPO provider who participate with BCBSM must accept BCBSM's approved amount – they cannot balance bill you the difference between their charged amount and BCBSM's approved amount. A non-participating BCBSM provider can balance bill you for the difference in the amount they charge, and the amount approved by BCBSM in addition to your out-of-network deductible and co-insurance.

Be sure to choose your provider wisely and try to use in-network PPO providers whenever possible in order to obtain the greatest benefit possible from your coverage.

**A detailed benefit summary of the BCBSM Simply Blue PPO Plan is included in this guide on pages 13 and 14**

**Note**: BCBSM coverage at non-participating hospitals is limited to services needed to treat an accidental injury or medical emergency. There is no coverage for non-emergency hospital services performed by a non-participating hospital or services received at non-participating physical therapy facilities, mental health or substance abuse treatment facilities, ambulatory surgery facilities, end stage renal dialysis facilities, home infusion therapy provider hospices outpatient physical therapy facilities, skilled nursing facilities or home health care agencies. (Note, coverage for emergency services at non-participating hospitals is limited. Refer to the BCBSM Certificate of Coverage for more details).

# Blue Care Network HMO Option

- HMO Stands for Health Maintenance Organization. Blue Care Network (BCN) HMO has more than 5,000 primary care physicians. 17,000 specialists and most of the leading hospitals in Michigan. To locate a BCN provider, visit www.bcbsm.com.
- You, and each person in your family are required to choose a Primary Care Physician (PCP) when you enroll for coverage. The PCP you choose will perform and coordinate all your care under this program.
- Each Family member is able to choose his/her own PCP from Blue Care Network's list of providers. Family members are not required to have the same PCP. Until you choose a PCP, BCN will designate one for you.
- No benefit is payable for services received from a provider without a referral from your PCP. The only exception to this is in the case of a true emergency situation.
- You may change your PCP by calling BCN customer service at (800) 662-6667 or visiting the BCN website at www.bcbsm.com.
- Female members may receive routine services, well woman visits and obstetrical services from a BCN participating gynecologist or obstetrician without a referral from the PCP. You don't need to choose a Woman's Choice doctor (gynecologist or obstetrician) when you enroll for BCN coverage.

## BCN Deductible, Co-insurance & Out-of-Pocket Maximum Provisions

The BCN plan has a $5,000 single or $10,000 two person/family deductible requirement.

You are responsible for the first $250 of the single or $500 of the two person/family deductible, as well as 10% of the balance that exceeds that total up to a maximum out-of-pocket of $1,600 single or $3,200 for two-person or family

After you meet your $250/$500 deductible requirement, The College for Creative Studies funds 90% of the remaining deductible up to a maximum of $4,750 single/$9,500 family

Please keep in mind, your out-of-pocket maximum is inclusive of your deductible requirement, coinsurance, and all copays (i.e. office visits, urgent care, emergency room and prescriptions). This means your maximum responsibility for covered services will equal $1,600 single/$3,200 two person or family for the entire plan year.

| Single Enrollment Example | | | |
|---|---|---|---|
| **BCN Insured Benefits Plan (per calendar year)** | | **Employee Responsibility** | **The College Pays** |
| **Deductible** | $5,000 | $250 of deductible, plus 10% of claim balance up to $1,350 maximum | 90% of claim balance up to $4,750 maximum |
| **Coinsurance** | Plan pays 90% of claims after $5,000 deductible is met | | |
| **Out-of-Pocket Maximum** | $6,350 | $1,600 | |

**A detailed summary of the BCN HMO Plan is included in this guide on pages 13 and 14**

# Prescription Drugs – BCBSM Simply Blue PPO $1500

Copays for a 30-day supply are:

- $20 generic or select prescribed over the counter drugs
- $60 formulary brand drugs
- $80 or 50% whichever is greater but no more than $100 for non-formulary brand drugs
- 20% of approved amount but no more than $200 for generic or formulary specialty drugs
- 25% of approved amount but no more than $300 for non-formulary specialty drugs

A **Generic** drug is the same as the equivalent brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken and the way it should be used. The FDA must approve all generic drugs. Generic drugs are the most cost-effective option for treatment.

A **Formulary Brand** drug has proven effectiveness and safety records and requires pre-authorization by your physician when a generic drug is available.

A **Non-Formulary Brand** drug may include new drugs, FDA approved drugs that are being used for non-approved uses, and drugs which have been approved for a condition they were not originally approved. These drugs require prior authorization by your physician if a generic or formulary brand drug is available and have not been prescribed for treatment prior to prescribing this classification of drug. These drugs have the highest copayment.

**Generic and Formulary Brand Specialty Drugs** are drugs with a proven record of safety and effectiveness for serious medical conditions such as Multiple Sclerosis.

**Non-Formulary Brand Specialty Drugs** are those drugs listed as non-preferred formulary drugs and may not have proven record for safety or the clinical value may not be as high as the Generic or Formulary Brand Specialty Drugs.

*Most generic contraceptive are covered 100% when prescribed for the purpose of contraception. In order for Brand Name Drugs to be covered 100%, your physician will be required to provide prior authorization.*

You can purchase a 90-day supply of most maintenance drugs for two copays from a local retail pharmacy that participates with this discount program. Nearly all chain and independent pharmacies participate.

**Step Therapy** – Requires you to have tried alternative therapy first or your doctor have clinically documented why you cannot take the alternate therapy. Step Therapy may include select covered over-the-counter products. This also applies to mail order drugs. Details about which drugs require step therapy are available at www.bcbsm.com. Log in under "I am a Member" and click on "Prescription Drugs."

**Prior Authorization** – Mandatory Maximum Allowable Cost is imposed when a Formulary Brand name drug is filled by the pharmacist and a generic equivalent drug is available. You will be required to pay the difference in cost between the formulary brand name drug and the maximum allowable cost for the generic drug plus your copay regardless of whether you or your doctor requests the formulary brand name drug. If you obtain a non-formulary brand name drug when a generic equivalent is available, the non-formulary brand name drug is not covered benefit. The only exception to this is if your physician requests and receives authorization for the non-formulary brand name drug from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order. You will pay the applicable copay when prior authorization is received.

## BCBSM Express Scripts Mail Order Drug Program

*You may have our prescriptions filled through the Express Scripts Mail Order Drug Program which helps save money.*

The mail order program administered by Express Scripts has two copays for an 84 – 90-day supply of your prescription. For a new prescription, ask your physician to write a prescription for a 14-day supply from your local pharmacy and another prescription for a 90-day supply, along with the refill requirement for Medco pharmacy. If it is a refill for a drug you currently take, make sure you have a prescription through at least a 14-day supply of the drug and request a new prescription for a 90-day supply including the refill requirements for submission to Medco. To learn more visit www.bcbsm.com or www.express-scripts.com.

- Generic Drug – You pay $40 for an 84 – 90-day supply
- Formulary Brand Drug – you pay $120 for an 84 – 90-day supply
- Non-Formulary Brand Drug – you pay the greater of $160 or 50%, but no more than $200 for a 90-day supply
- Generic/Formulary and Non-Formulary Specialty Drugs – Only covered through Option Care.

# Prescription Drugs – BCN HMO

**Copays for a 30-day supply are:**

- $15 generic drugs
- $50 formulary drugs

Formulary brand name prescriptions require your Primary Care Physician to receive prior authorization before writing a prescription.

*Most generic contraceptive are covered 100% when prescribed for the purpose of contraception. In order for Brand Name Drugs to be covered 100%, your physician will be required to provide prior authorization.*

## BCN Mail Order program

Like BCBSM, BCN allows you to save money by having prescriptions filled through the Express Scripts Mail Order Drug Program.

**Copay for a 90-day supply are:**

- $30 generic drugs
- $100 formulary brand drugs

For a new prescription, ask your physician to write a prescription for a 14-day supply from your local pharmacist and another prescription for a 90-day supply, along with the refill requirement for Express Scripts pharmacy. If it is a refill for a current drug, make sure you have at least a 14-day supply of your drug and request a new prescription for a 90-day supply including the refill requirement for submission to Express Scripts. To learn more visit www.bcbsm.com or www.express-scripts.com.

# Blue 365 Discount program

This program allows members enrolled in either a BCBSM or BCN benefit plan to access special member discounts and trusted health and wellness resources. It provides you not only savings and special offers on a variety of healthy products and services from various companies across the state of Michigan but also businesses from around the U.S. through Blue365, the national savings program.

Offers vary: Please visit https://www.blue365deals.com/BCBSMI/offers

# Blue Cross Online Visits

**BCN HMO and BCBSM PPO members have access to quality health care, anytime any place with 24/7 online health care through Blue Cross Online Visits for the same cost as your primary care office visit copay (BCN - $30, BCBSM - $40)**

## Life is Online 24/7/365

You're used to the convenience of banking, shopping and taking care of personal business online when you're pressed for time, or when it's convenient for you. Medical care doesn't have to be any different. Why not see a board-certified doctor online too?

## No Appointment needed

You can get fast, convenient, affordable online health care 24 hours a day, seven days a week, wherever you are in the U.S. Just choose an available doctor, click and go. It's as simple as using your mobile device or computer to meet with a doctor face-to-face, online when:

- Your primary care doctor isn't available.
- You can't leave your home or workplace.
- You're on vacation or traveling for work.
- You're looking for affordable after-hours care.

## It's for the whole family

Family members on your plan can also use 24/7 online health care. Just add your spouse and children to your account so it's ready when they need to use it.

## When should I use an online doctor?

You can use Blue Cross Online Visits award-winning and easy-to-use online health care technology, for common, nonemergency illnesses, such as:

- Sinus and respiratory infections
- Vomiting
- Diarrhea
- Rashes
- Cold, flu and seasonal allergies
- Headache
- Urinary tract infections
- Pinkeye

**Once you are logged-in online or through your mobile device you are able to choose a physician that is right for you, talk to them and then even get a prescription if needed.**

**At the end of the visit you will receive a full report to share with your doctor and will even be able to view an explanation of benefits statement online at www.bcbsm.com.**

**You may also have a consultation with a doctor over the phone by calling (844) SEE-DOCS, but Blue Cross Online Visits preferred method of consultation is over the internet or through their mobile app.**

## Access Mental Health Services through Online Visits:

- Schedule an appointment
- Access 45-minute therapy sessions
- Video-only sessions
- Costs vary depending on provider and type of service

**Get Started with 24/7 Online Health Care. Download the BCBSM Online Visits app from the app Store or Google Play**

# Medical Benefits Overview

| Benefit Coverage | BCBSM Simply Blue PPO $1500 | | BCN HMO |
|---|---|---|---|
| | In-Network Benefits | Out-of-Network Benefits | Schedule of Benefits |
| **Annual Deductible** | | | |
| Individual | $1,500 | $3,000 | $5,000 |
| Family | $3,000 | $6,000 | $10,000 |
| Coinsurance | 80% | 60% | 90% |
| **Maximum Out-of-Pocket*** | | | |
| Individual | $6,350 | $12,700 | $6,350 |
| Family | $12,700 | $25,400 | $12,700 |
| **Physician Office Visit** | | | |
| Primary Care | $40 copay | 60% after deductible | $30 copay |
| Specialty Care | $60 copay | 60% after deductible | $30 copay after deductible |
| **Preventive Care** | | | |
| Adult Periodic Exams | 100% | 100% | 100% |
| Well-Child Care | 100% | 100% | 100% |
| **Diagnostic Services** | | | |
| X-ray and Lab Tests | 80% after deductible | 60% after deductible | 90% after deductible for Diagnostic Test and X-rays<br>100% for Laboratory and Pathology Services |
| Complex Radiology | 80% after deductible | 60% after deductible | 90% after deductible |
| Urgent Care Facility | $60 copay | 60% after deductible | $55 copay |
| Emergency Room Facility Charges* | $250 copay | $250 copay | $250 copay after deductible |
| Inpatient Facility Charges | 80% after deductible | 60% after deductible | 90% after deductible |
| Outpatient Facility and Surgical Charges | 80% after deductible | 60% after deductible | 90% after deductible |
| **Mental Health** | | | |
| Inpatient | 80% after deductible | 60% after deductible | 90% after deductible |
| Outpatient | 80% after deductible | 80% after deductible | $30 copay |
| **Substance Abuse** | | | |
| Inpatient | 80% after deductible | 80% after deductible | 90% after deductible |
| Outpatient | 80% after deductible | 80% after deductible | $30 copay |
| **Other Services** | | | |
| Chiropractic | $40 copay | 60% after deductible | $30 copay after deductible; 30 Visits |

| Benefit Coverage | BCBSM Simply Blue PPO $1500 | | BCN HMO |
|---|---|---|---|
| | In-Network Benefits | Out-of-Network Benefits | Schedule of Benefits |
| **Retail Pharmacy (30 Day Supply)** | | | |
| Generic (Tier 1) | $20 copay | $20 copay Plus an Additional 25% of the approved amount | $15 copay |
| Preferred (Tier 2) | $60 copay | $60 copay Plus an Additional 25% of the approved amount | $50 copay |
| Non-Preferred (Tier 3) | $80 copay or 50% of approved amount (whichever is greater), but no more than $100 | $80 copay or 50% of the approved amount (whichever is greater) but no more than $100 plus an additional 25% of approved amount | Not covered |
| Preferred Specialty (Tier 4) | 20% of the approved amount, but no more than $200 | 20% of the approved amount, but no more than $200 plus an additional 25% | Tiered copay applies |
| Nonpreferred Specialty (Tier 5) | 25% of the approved amount, but no more than $300 | 25% of the approved amount, but no more than $300 plus an additional 25% | Not Covered |
| **Mail Order Pharmacy (90 Day Supply** | | | |
| Generic (Tier 1) | $40 copay | Not covered | $30 copay |
| Preferred (Tier 2) | $120 copay | Not covered | $100 copay |
| Non-Preferred (Tier 3) | $80 copay | Not covered | Not covered |
| Preferred Specialty (Tier 4) | Not covered | Not covered | Not covered |
| Nonpreferred Specialty (Tier 5) | Not covered | Not covered | Not Covered |

| Employee Contributions – BCBSM Simple Blue PPO $1500 - (Semi - Monthly) | |
|---|---|
| **Medical PPO - (BCBS)** | |
| Employee | $168.82 |
| Employee & 1 Dep | $416.72 |
| Employee & 2+ Deps | $524.83 |

| Employee Contributions – BCN HMO - (Semi - Monthly) | |
|---|---|
| **Medical HMO - (BCN)** | |
| Employee | $65.63 |
| Employee & 1 Dep | $153.75 |
| Employee & 2+ Deps | $173.58 |

# Preventive Care Services

BCBSM and BCN health plan cover certain evidence-based preventive services and immunizations with no cost sharing when in-network providers are used. This means that, under the provisions of the Affordable Care act, some members do not need to pay a copay or meet a deductible first when receiving these services from a provider in the BCBSM or BCN network.

## Some of the preventive care services that are covered at no cost share include:

**Routine preventive for Children***

Appropriate screenings based on gender and age

- Newborn visits
- Tuberculosis testing
- Anemia testing
- Lead exposure
- Pelvic exam and pap test
- Development and behavior
- Lipid profile
- Depression
- Obesity and counseling
- Nutrition counseling

**Routine preventive for Adults**

Appropriate screenings based on gender and age

- Lipid profile
- Diabetes
- Pelvic exam and pap testing
- Breast exam and mammogram
- PSA testing
- Bone density testing
- Colonoscopy
- Flu Shots
- HPV Immunizations

*Birth to age 18

# Dental Insurance

The College provides you with two Dental plan options from which to select:

1. Delta Dental PPO
2. Delta Care EPO

## Delta Dental PPO

A Delta PPO network dentist has agreed to accept Delta's approved amount as payment in full, less your deductible and coinsurance.

To locate a Delta Dental PPO provider, access the website at www.deltadentalmi.com.

Delta Dental offers enhanced Dental coverage for enrollees with certain high-risk medical conditions such as:

- Patients with a history of cardiac conditions
- Diabetics and periodontal (gum) disease
- Pregnant women who had periodontal (gum) disease
- Kidney failure patients who are undergoing dialysis
- People with suppressed immune systems due to chemotherapy and/or radiation treatment, HIV positive status, organ transplant and/or stem cell (bone marrow) transplant.

The improved benefits include coverage of up to two teeth cleanings (either routine cleanings or periodontal maintenance cleanings) per benefit year.

- Routine cleaning will be covered at the same copayment level as other preventive services
- Periodontal maintenance cleaning will be covered at the same percentage as other periodontal service.

## Delta Care EPO

You do not need to choose a primary care dentist. You have access to all providers in the Exclusive Provider Organization (EPO) Network for all services. Your EPO primary care dentist will refer you to a specialist when necessary.

The schedule of benefits on the next page reflect average percentages levels for EPO services for illustrative purposes. There are set member copayments established based on the services being received. It's important you discuss with your dentist the costs you will be responsible for before receiving services.

EPO coverage is based on a member copayment schedule, but the approximate coverage levels are 100% for Preventive Services, 85% for Basic Services and 70% for Major Services

| Benefit Coverage | Delta Dental of Michigan Dental PPO | | Delta Dental of Michigan Dental EPO |
|---|---|---|---|
| | In-Network Benefits | Out-of-Network Benefits | In-Network Benefits |
| **Annual Deductible** | | | |
| Individual | $50 | $50 | None |
| Family | $150 | $150 | None |
| Waived for Preventive Care | yes | yes | N/A |
| Per Person / Family | $1,500 | $1,000 | N/A |
| Preventive | 100% | 100% | 100% |
| Basic | 75% | 50% | 85% |
| Major | 50% | 50% | 70% |
| Orthodontia | 50% | 50% | $1,050 savings per member |
| Adult (and Covered Full-Time Students, if Eligible) | Not covered | Not covered | Not covered |
| Dependent Child(ren) | Covered up to age 19 | Covered up to age 19 | Covered up to age 19 |
| Lifetime Maximum | $800 | $800 | $1,050 |

| Employee Contributions - PPO - (Semi - Monthly) | |
|---|---|
| **Dental PPO - Employee Contributions** | |
| Employee | $5.16 |
| Employee & 1 Dep | $9.34 |
| Employee & 2+ Deps | $17.68 |

| Employee Contributions - EPO - (Semi - Monthly) | |
|---|---|
| **Dental EPO - Employee Contributions** | |
| Employee | $4.24 |
| Employee & 1 Dep | $7.99 |
| Employee & 2+ Deps | $14.48 |

# Vision Insurance

The College provides you with the opportunity to purchase vision coverage insured through NVA. You do not need to be enrolled in the medical plan to enroll for vision benefits. Visit the NVA website at www.e-nva.com for more information, including a list of NVA doctors in your area, or call NVA's Customer Service at (800) 672-7723.

**When you receive services from an NVA participating provider, you realize lower out-of-pocket expenses. If you elect to use a non-participating NVA provider, you will pay more out-of-pocket.**

| Benefit Coverage | National Vision Administrators (NVA) | |
|---|---|---|
| | In Network | Out-of-Network |
| **Copay** | | |
| Routine Exams (Annual) | $10 copay | Optometrist and Ophthalmologist up to $35 |
| **Vision Materials** | | |
| Lenses | $25 copay, every 12 months | Up to $35 or more, every 12 months |
| Contacts<br>Covered in lieu of frames. | Elective contacts covered up to $130 allowance, every 12 months<br>Medically necessary contacts are paid in full, every 12 months | Elective contacts covered up to $105 allowance, every 12 months<br>Medically necessary contacts covered up to $210 in full, every 12 months |
| Frames | Covered at up to $130 allowance, every 24 months | Up to $45, every 24 months |

| Employee Contributions (Semi - Monthly) | |
|---|---|
| **Vision - Employee Contributions** | |
| Employee | $2.71 |
| Employee & 1 Dep | $6.50 |
| Employee & 2+ Deps | $8.13 |

# Life and Accidental Death & Dismemberment Insurance

College for Creative Studies provides at no cost to eligible employees Basic Life and Accidental Death & Dismemberment (AD&D) insured by The Standard. New employees are eligible to enroll first of the month following 30 days of employment.

The life portion of the policy pays a benefit to your beneficiary in the event of your death. The life benefit amount is the lesser of two times your annual salary or $500,000. Life benefits reduce for employee age 65 and older.

If your death is the direct result of an accident, the AD&D portion of the policy will pay your beneficiary a benefit equals to your life benefit. Benefits may also be payable for other losses, such as the loss of a limb.

# Voluntary Life Offerings

Personal protection for you and your family members is important as the economic hardship caused by death can devastate a family. You may purchase in $25,000 increments up to $100,000 affordable group term life insurance coverage, insured by The Standard via payroll deduction. You may also purchase Spouse and Dependent Child Life and AD&D insurance. Dependent children are eligible until age 20 (or age 24 if a full-time student at an accredited educational institution).

Evidence of insurability is required if you elect to enroll after 31 days of your original eligibility date or you wish to increase your benefit amount.

Coverage effective dates and increases in coverage may be delayed if you and/or your dependents are disabled on the date coverage is scheduled to take effect.

## Employee optional life monthly rates by benefit level

| Age Bracket | $25,000 | $50,000 | $75,000 | $100,000 |
|---|---|---|---|---|
| **<29** | $1.50 | $3.00 | $4.50 | $6.00 |
| **30-34** | $1.63 | $3.25 | $4.88 | $6.50 |
| **35-39** | $1.70 | $3.40 | $5.10 | $6.80 |
| **40-44** | $2.25 | $4.50 | $6.75 | $9.00 |
| **45-49** | $4.18 | $8.35 | $12.53 | $16.70 |
| **50-54** | $3.00 | $6.00 | $9.00 | $12.00 |
| **55-59** | $7.75 | $15.50 | $23.25 | $31.00 |
| **60-64** | $10.25 | $20.50 | $30.75 | $41.00 |
| **65-69** | $17.75 | $35.50 | $53.25 | $71.00 |
| **70-74** | $38.50 | $77.00 | $115.50 | $154.00 |
| **75+** | $144.00 | $288.00 | $432.00 | $576.00 |

## Employee optional life monthly rates by benefit level

| | Option 1 $2.00 | Option 2 $1.50 |
|---|---|---|
| **Spouse** | $15,000 | $10,000 |
| **Child(ren)** | $10,000 | $5,000 |

# Long-Term Disability Insurance

The College understands how difficult it is to save for an illness or accident that may prevent you from working for an extended period of time. The College provides at no cost long-term disability coverage effective the first of the month following 12 months of employment. The benefit is insured by The Standard.

Your benefit eligibility is equal to 60% of your base monthly earnings and its payable following 180 days of total disability.

You will be considered totally disabled if your illness or injury prevents you from performing all the material and substantial duties of your own occupation during the first 24 months of your disability. After 24 months, if your disability prevents you from performing the duties for any occupation for which you are suited by education, training and experience, your benefit may be continued.

Benefits are payable to age 65 or until you are no longer considered disabled under the plan.

No benefit is payable for any disability occurring as the result of a pre-existing condition unless you have been insured and actively at work for 12 months following the effective date of your coverage. A pre-existing condition is a medical condition for which you were under the care of a physician, received treatment or were taking prescription drugs during the 3-month period prior to your effective date of coverage under the Long-Term Disability Plan.

**It is important for you to review The Standard's benefits book for all benefit provision of the plan including exclusion and limitations.**

# Flexible Spending Accounts

The Flexible Spending Account (FSA) plan with BASIC allows you to set aside pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars. The plan is comprised of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

## How an FSA works:

- Choose a specific amount of money to contribute each pay period, pre-tax, to one or both accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service **OR** submit the appropriate paperwork to be reimbursed by the plan.

## Important rules to keep in mind:

- The IRS has a "use it or lose it" rule. If you do not use the full amount in your FSA, you may lose any remaining funds.
- Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.
- You cannot transfer funds from one FSA to another.

# Health Care Flexible Spending Account (HCFSA)

Eligible expenses under the HCFSA include deductibles, coinsurance and copays paid for medical dental and/or vision services. Generally, health care expenses that would qualify as a deduction on your personal federal income tax form will qualify for reimbursements as long as the expense is paid out-of-pocket by you.

- **The maximum annual election for the HCFSA is $2,750**
- **You are able to carryover $550 to the next plan year**
- For a complete list of expenses eligible for reimbursement, visit the IRS website at https://www.irs.gov/pub/irs-pdf/p502.pdf
- Thanks to the Coronavirus Aid, Relief and Economic Security (CARES) Act, you can use your HCFSA funds to buy over-the-counter medications without a prescription, like Tylenol and other pain relievers, heartburn medications, allergy relief and more.

## HCFSA Debit Card

Each enrolled member typically receives two debit cards. Cards and replacement cards can be requested in lots of two at a cost of $5. The cards will have the same number and member name and you must have each member using the card sign the back.

The debit card allows you to pay for services immediately with your card. The debit card works at vendors with special medical Merchant Category Code (MCC). Some vendors have a special inventory control system that lets the IRS know that you've used your card for an approved purchase. Your card will work as long as the provider you use the medical MCC or the special inventory control system.

When service costs are outside the fixed office visit or prescription drug copays, BASIC will request documentation of the service send a copy of the receipt for service. You will have 14 days to substantiate the claim. **If you don't send requested documentations for BASIC, your debit card will be deactivated, and you will be required to repay the plan the sum in question.**

# Dependent Care Flexible Spending Account

This account allows you to pay for eligible dependent care expenses with pre-tax dollars.

Child, elder care and companion services are eligible expenses, as are Social Security and other taxes you pay a caregiver.

Your dependents must be:

- Under age 13 or mentally or physically unable to care for themselves
- Spending at least 8 hours a day in your home
- Eligible to be claimed as a dependent on your federal income tax
- Receiving care when you are at work and your spouse (if you are married) is at work or is searching for work, is in school full time, or is mentally or physically disabled and unable to care for the dependents

**The maximum annual election for the Dependent Care Flexible Spending Account is $5,000.** However, if you and your spouse both work, the IRS currently limits your maximum contribution to a Dependent Care FSA as follows:

- If you file separate personal income tax returns, the annual contribution amount is limited to $2,500 each for you and your spouse
- If you file a joint income tax return and your spouse also contributes to a Dependent Care Reimbursement Account, your family combined limit is $5,000
- If your spouse is disabled or a full-time student, special limits apply
- If you or your spouse earns less than $5,000, the maximum is limited to the earnings under $5,000

If you contribute to a DCFSA account, you must file an IRS form 2441 with your federal income tax return. Form 2441 is simply an informational form on which you report the amount you paid for day care. Additionally, you must also complete a dependent care certification form provided on the enrollment portal.

# Enrollment Preparation and Contributions

## Medical, Dental and Voluntary Vision

Make your elections by completing the enrollment process online via https://benxpress.com/ccs. It is important that you verify all the information pertaining to yourself and your dependents. If there are any errors in the spelling of the names, dates of birth, social security numbers or address you may experience a problem when you go to receive services.

## Optional Benefit Plans

Optional benefit plans include the Health Flexible Spending Account, the Dependent Care Flexible Spending Account and the Optional Employee and Optional Dependent Life/AD&D benefits. Be sure that you review all provisions of these benefits and provide accurate information in order to be sure your elections are correct.

## Premium Conversion Plans

In order to participate in the medical, dental or vision plan options, The College asks you to contribute a portion of the premium.

The Section 125 Premium Conversion Plan allows your health plan contributions to be deducted from your compensation on a pre-tax basis. Contributions taken on a pre-tax basis are not subject to federal state, or FICA taxes. Your savings are dependent on your individual contribution and income tax bracket.

The Premium Conversion plan is governed by the Internal Revenue Code, which prohibits you form changing your election during the plan year (January 1 – December 31) unless you experience a qualified change in status. These events are listed on page 27 of this guide. This rule also requires the qualified change in status be consistent with the change you wish to make to your benefit election.

## Semi-Monthly Payroll Contributions

| | Single | Two Person | Family |
|---|---|---|---|
| **BCBSM Simply Blue PPO** | $168.72 | $416.72 | $524.83 |
| **Blue Care Network HMO** | $65.63 | $153.75 | $173.58 |
| **Delta Dental PPO** | $5.16 | $9.34 | $17.68 |
| **Delta Dental EPO** | $4.24 | $7.99 | $14.48 |
| **NVA Vision** | $2.71 | $6.50 | $8.13 |
| **Spousal Surcharge** | N/A | $50.00 | $50.00 |

# Employee Assistance Plan (EAP)

The Employee Assistance Program will be provided to eligible full-time employees by The College for Creative Studies. Ulliance, Inc. formally known as T.E.A.M., is the provider for EAP services.

An EAP is a program is designed to assist employees and their family members.

Ulliance is one of the best resources for providing help resolving any concerns affecting you and your family member's personal or work lives no matter the issue!

- Family/children problems
- Marital/relationship conflicts
- Stress or other emotional difficulties
- Grief/loss issues
- Chemical dependency problems

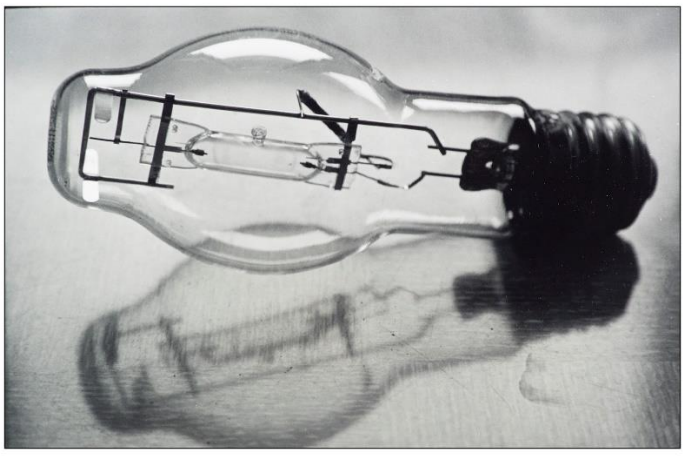
Consider using Ulliance's services to assist you in making changes that could enhance your quality of life.

- Child/elder care
- Legal concerns
- Financial resources
- Fitness and nutrition
- Smoking cessation
- Alternative medicine
- Carrier changes

Contact Ulliance Inc. at (800) 448-TEAM or visit www.team-eap.com ,24 hours a day, 7 days a week.

# Employee Savings Plan

Full-time employee and eligible part-time employees are able to participate in The College for Creative Studies' Employee Savings Plan on the first of the month following 30 days of employment. Eligible employees can participate with their own funds immediately. The College will contribute 3% of your gross per pay earnings the first of the month following 30 days. Employees may choose to contribute a percentage of their pay, on a pre-tax basis, within IRS guidelines. The plan provider is TIAA-CREF. Please see Human Resources for more information.



# Contacts

## Have Questions? Need Help?

College for Creative Studies is excited to offer access to the **USI Benefit Resource Center (BRC)**, which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals and their primary responsibility is to assist you.

**The Specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time at 855-874-0829 or via e-mail at BRCMidwest@usi.com**. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

## Carrier Customer Service

| BENEFITS PLAN | CARRIER | PHONE NUMBER | WEBSITE |
|---|---|---|---|
| Medical HMO | Blue Care Network of Michigan | (800) 637-2227 | www.bcbsm.com |
| Medical PPO | BC/BS of Michigan | 800 662-6667 | www.mibcn.com |
| Dental | Delta Dental | (800) 524-0149 | www.deltadentalmi.com |
| Vision | National Vision Administrators (NVA) | (800) 672-7723 | www.e-nva.com |
| Life and AD&D | Standard Insurance Company | (888) 937-4783 | www.standard.com |
| Long Term Disability (LTD) | Standard Insurance Company | (888) 937-4783 | www.standard.com |
| Voluntary Life | Standard Insurance Company | (888) 937-4783 | www.standard.com |
| Flexible Spending Accounts | BASIC | (800) 444-1922 | www.basiconline.com |
| Employee Assistance Program | Ulliance Inc. | (800) 448-TEAM | www.team-eap.com |


# Call the Benefit Resource Center ("BRC"), We're Here To Help!

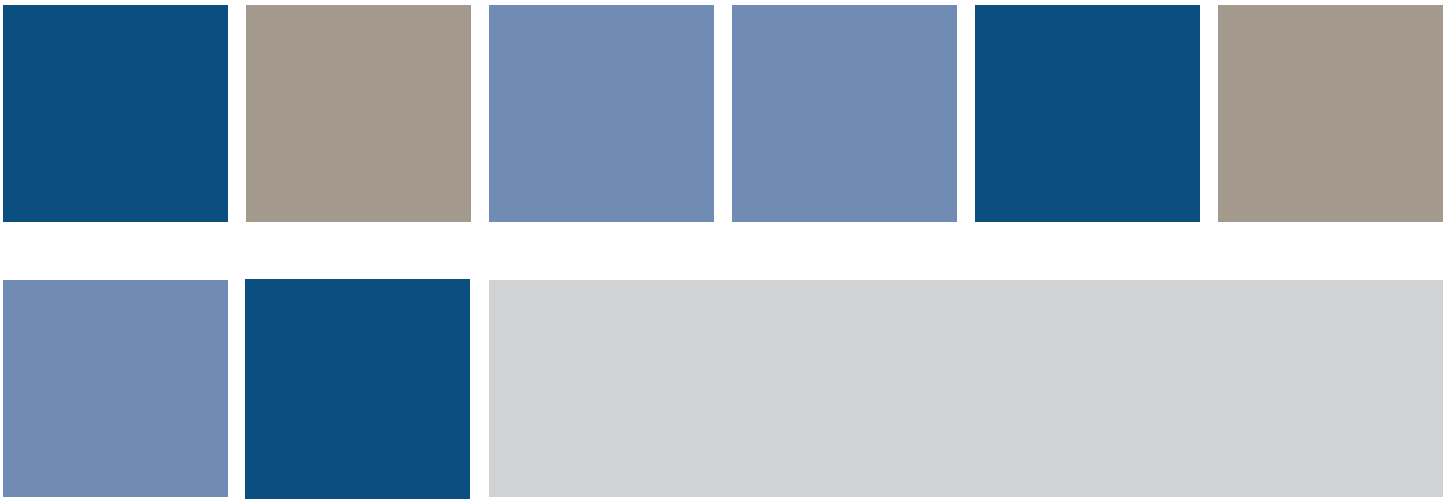
## We speak insurance. Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution
- Medicare basics with your employer plan
- Coordination of benefits
- Finding in-network providers
- Access to care issues
- Obtaining case management services
- Group disability claims
- Filing claims for out-of-network services

USI®

**Benefit Resource Center**

BRCMidwest@usi.com | Toll Free: 855-874-0829



Raquel Diroff
201 E Kirby
Detroit, Michigan 48202

# REQUIRED NOTIFICATIONS

## Important Legal Notices Affecting Your Health Plan Coverage

### THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance apply.

### NEWBORNS ACT DISCLOSURE - FEDERAL

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

### NOTICE OF 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 this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

## PATIENT PROTECTION MODEL DISCLOSURE

BCN HMO Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. 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.

## CONTACT INFORMATION

### CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Human Resources

201 E Kirby

Detroit, Michigan United States 48202

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

# Your Information. Your Rights. Our Responsibilities.

*Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.*

## Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

## Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

## Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

## Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.**Get a copy of health and claims records**

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

### Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

### Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

- In these cases we never share your information unless you give us written permission:

Marketing purposes

Sale of your information

## Our Uses and Disclosures

**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

**Help manage the health care treatment you receive**

We can use your health information and share it with professionals who are treating you.

*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

**Pay for your health services**

We can use and disclose your health information as we pay for your health services.

*Example: We share information about you with your dental plan to coordinate payment for your dental work.*

**Administer your plan**

We may disclose your health information to your health plan sponsor for plan administration.

*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

**Run our organization**

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

*Example: We use health information about you to develop better services for you.*

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

## Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

## Other Instructions for Notice

- Effective 2/1/2021
- Questions regarding this information can be directed to Human Resources

## Important Notice from College for Creative Studies 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 College for Creative Studies 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:**

1. **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.**

2. **College for Creative Studies has determined that the prescription drug coverage offered by The College for Creative Studies Benefits Plan 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 College for Creative Studies coverage will be affected. If you joined a Medicare drug plan after a COBRA qualified event, your COBRA coverage may end.

If you do decide to join a Medicare drug plan and drop your current College for Creative Studies coverage, be aware that you and your dependents will not 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 College for Creative Studies and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through College for Creative Studies changes. You also may request a copy of this notice at any time.

## For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

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|---|---|
| Date: | 2/1/2021 |
| Name of Entity/Sender: | College for Creative Studies |
| Contact--Position/Office: | Human Resources |
| Address: | 201 E Kirby, Detroit, MI 48202 |

**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)**.

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**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, 2020. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid | COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) |
|---|---|
| Website: http://myalhipp.com/<br><br>Phone: 1-855-692-5447 | Health First Colorado Website: https://www.healthfirstcolorado.com/<br><br>Health First Colorado Member Contact Center:<br><br>1-800-221-3943/ State Relay 711<br><br>CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus |

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| | CHP+ Customer Service: 1-800-359-1991/ State Relay 711<br><br>Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program<br>HIBI Customer Service: 1-855-692-6442 |
| **ALASKA – Medicaid** | **FLORIDA – Medicaid** |
| The AK Health Insurance Premium Payment Program<br><br>Website: http://myakhipp.com/<br><br>Phone: 1-866-251-4861<br><br>Email: CustomerService@MyAKHIPP.com<br><br>Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx | Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br><br>Phone: 1-877-357-3268 |
| **ARKANSAS – Medicaid** | **GEORGIA – Medicaid** |
| Website: http://myarhipp.com/<br><br>Phone: 1-855-MyARHIPP (855-692-7447) | Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br><br>Phone: 678-564-1162 ext 2131 |
| **CALIFORNIA – Medicaid** | **INDIANA – Medicaid** |
| Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx<br><br>Phone: 916-440-5676 | Healthy Indiana Plan for low-income adults 19-64<br><br>Website: http://www.in.gov/fssa/hip/<br><br>Phone: 1-877-438-4479<br><br>All other Medicaid<br><br>Website: https://www.in.gov/medicaid/<br><br>Phone 1-800-457-4584 |
| **OKLAHOMA – Medicaid and CHIP** | **UTAH – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br><br>Phone: 1-888-365-3742 | Medicaid Website: https://medicaid.utah.gov/<br><br>CHIP Website: http://health.utah.gov/chip<br><br>Phone: 1-877-543-7669 |
| **IOWA – Medicaid and CHIP (Hawki)** | **MONTANA – Medicaid** |
| Medicaid Website:<br><br>https://dhs.iowa.gov/ime/members<br>Medicaid Phone: 1-800-338-8366 | Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br><br>Phone: 1-800-694-3084 |

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|---|---|
| Hawki Website:<br><br>http://dhs.iowa.gov/Hawki<br><br>Hawki Phone: 1-800-257-8563 | |
| **KANSAS – Medicaid** | **NEBRASKA – Medicaid** |
| Website: http://www.kdheks.gov/hcf/default.htm<br><br>Phone: 1-800-792-4884 | Website: http://www.ACCESSNebraska.ne.gov<br><br>Phone: 1-855-632-7633<br><br>Lincoln: 402-473-7000<br><br>Omaha: 402-595-1178 |
| **KENTUCKY – Medicaid** | **NEVADA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br><br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br><br>Phone: 1-855-459-6328<br><br>Email: KIHIPP.PROGRAM@ky.gov<br><br>KCHIP Website:<br>https://kidshealth.ky.gov/Pages/index.aspx<br><br>Phone: 1-877-524-4718<br><br>Kentucky Medicaid Website: https://chfs.ky.gov | Medicaid Website: http://dhcfp.nv.gov<br><br>Medicaid Phone: 1-800-992-0900 |
| **LOUISIANA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br><br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) | Website: https://www.dhhs.nh.gov/oii/hipp.htm<br><br>Phone: 603-271-5218<br><br>Toll free number for the HIPP program: 1-800-852-3345, ext 5218 |
| **MAINE – Medicaid** | **NEW JERSEY – Medicaid and CHIP** |
| Enrollment Website:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br><br>Phone: 1-800-442-6003<br><br>TTY: Maine relay 711 | Medicaid Website:<br><br>http://www.state.nj.us/humanservices/<br><br>dmahs/clients/medicaid/<br><br>Medicaid Phone: 609-631-2392<br><br>CHIP Website: http://www.njfamilycare.org/index.html |

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|---|---|
| Private Health Insurance Premium Webpage:<br><br>https://www.maine.gov/dhhs/ofi/applications-forms<br><br>Phone: -800-977-6740.<br><br>TTY: Maine relay 711 | CHIP Phone: 1-800-701-0710 |
| **MASSACHUSETTS – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Website:<br>http://www.mass.gov/eohhs/gov/departments/masshealth/<br><br>Phone: 1-800-862-4840 | Website:<br>https://www.health.ny.gov/health_care/medicaid/<br><br>Phone: 1-800-541-2831 |
| **MINNESOTA – Medicaid** | **NORTH CAROLINA – Medicaid** |
| Website:<br><br>https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp<br><br>Phone: 1-800-657-3739 | Website: https://medicaid.ncdhhs.gov/<br><br>Phone: 919-855-4100 |
| **MISSOURI – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br><br>Phone: 573-751-2005 | Website:<br>http://www.nd.gov/dhs/services/medicalserv/medicaid/<br><br>Phone: 1-844-854-4825 |
| **OREGON – Medicaid** | **VERMONT– Medicaid** |
| Website:<br>http://healthcare.oregon.gov/Pages/index.aspx<br><br>http://www.oregonhealthcare.gov/index-es.html<br><br>Phone: 1-800-699-9075 | Website: http://www.greenmountaincare.org/<br><br>Phone: 1-800-250-8427 |
| **PENNSYLVANIA – Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website:<br>https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx<br><br>Phone: 1-800-692-7462 | Website: https://www.coverva.org/hipp/<br><br>Medicaid Phone: 1-800-432-5924<br><br>CHIP Phone: 1-855-242-8282 |
| **RHODE ISLAND – Medicaid and CHIP** | **WASHINGTON – Medicaid** |
| Website: http://www.eohhs.ri.gov/<br><br>Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) | Website: https://www.hca.wa.gov/<br><br>Phone: 1-800-562-3022 |

| SOUTH CAROLINA – Medicaid | WEST VIRGINIA – Medicaid |
|---|---|
| Website: https://www.scdhhs.gov<br><br>Phone: 1-888-549-0820 | Website: http://mywvhipp.com/<br><br>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **SOUTH DAKOTA - Medicaid** | **WISCONSIN – Medicaid and CHIP** |
| Website: http://dss.sd.gov<br><br>Phone: 1-888-828-0059 | Website:<br><br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br><br>Phone: 1-800-362-3002 |
| **TEXAS – Medicaid** | **WYOMING – Medicaid** |
| Website: http://gethipptexas.com/<br><br>Phone: 1-800-440-0493 | Website:<br>https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br><br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2020, 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.

# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 6-30-2023)

## PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one–stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

### Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost–sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer–offered coverage. Also, this employer contribution –as well as your employee contribution to employer–offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after–tax basis.

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

# PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

| | | |
|---|---|---|
| 3. Employer name<br>College for Creative Studies | 4. Employer Identification Number (EIN)<br>38-1550064 | |
| 5. Employer address<br>201 E Kirby | 6. Employer phone number<br>313 - 664-7651 | |
| 7. City<br>Detroit | 8. State<br>MI | 9. ZIP code<br>48202 |
| 10. Who can we contact about employee health coverage at this job?<br>Raquel Diroff | | |
| 11. Phone number (if different from above) | 12. Email address<br>rdiroff@collegeforcreativestudies.edu | |

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:
    those working 30 hours a week eligible on the first of the month following 30 days of employment.
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    legal spouse, domestic partner (stipulations apply), children and principally supported children under the age of 26, those under a qualified medical child support order, disabled dependents.
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the

employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

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• An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)