

COLLEGE *for* Creative STUDIES



2024 Benefit Guide
Effective January 1 – December 31

Table of Contents

| | |
|---|----|
| A Message to Our Employees..... | 4 |
| Benefits for You & Your Family | 5 |
| Spousal Surcharge | 6 |
| Medical Insurance | 7 |
| Medical Benefits Overview | 16 |
| Dental Insurance | 26 |
| Vision Insurance..... | 28 |
| Life and Accidental Death & Dismemberment Insurance | 29 |
| Voluntary Life Offerings | 29 |
| Short-Term Disability Insurance..... | 30 |
| Long-Term Disability Insurance | 30 |
| Flexible Spending Accounts | 31 |
| Dependent Care Flexible Spending Account..... | 32 |
| Enrollment Preparation and Contributions | 34 |
| Legal Shield and ID Shield | 35 |
| Employee Assistance Plan (EAP) | 36 |
| Employee Savings Plan 403(b) | 37 |
| Contacts..... | 38 |
| Benefit Resource Center | 39 |
| Carrier Contacts | 40 |
| REQUIRED NOTIFICATIONS..... | 42 |

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,

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.

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.

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 is pleased to announce that there will be no changes to the benefit plans. However, there is a slight change to the medical, dental, and vision plan contributions.

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.

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 per week and their eligible dependents may participate in The College for Creative Studies benefits program.

- 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, except for 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 of 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 except for 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.

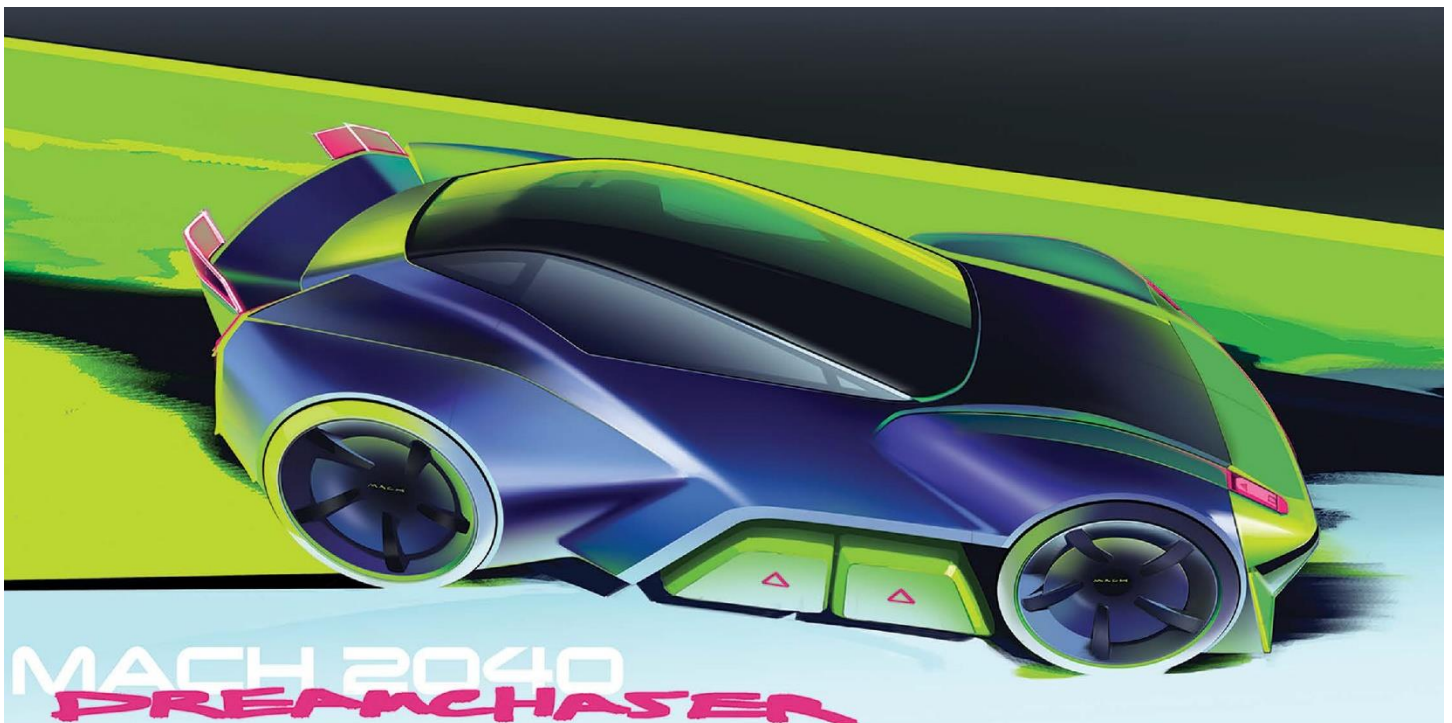
If your spouse/domestic partner ceases to be eligible for his/her employer's health plan during the plan year, the surcharge can be waived. You must provide documentation to Human Resources within 30 days of the loss of their eligibility for medical benefits.

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 side 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 PPO provider who participates 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 can 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.

| Single Enrollment HRA 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 | |

EXAMPLE:

Scenario #1: Joe has had a diagnostic test performed and has already met his \$250 deductible

- BCN approved charge = \$500
- Employee co-insurance (10%) = \$50
- CCS portion of HRA = \$450

Scenario #2: Joe has had a diagnostic test performed and has not met his \$250 deductible

- BCN approved charge = \$500
- Employee deductible = \$250
- Employee co-insurance 10% = \$25
- CCS portion of HRA = \$225

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.

BENEFITS 101: FREQUENTLY ASKED QUESTIONS

Know the basics of how your health insurance works

WHAT IS A DEDUCTIBLE?

A deductible is a fixed amount of money that you must pay for medical expenses before your insurance coverage starts paying. This does not include the premium amount that is taken out of your paycheck each month. For example, if your plan has a \$2,000 deductible, you pay the first \$2,000 of medical expenses. After that, the plan will pay a percentage of the expenses.

WHAT IS COINSURANCE?

Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount. You pay coinsurance after you have met your deductibles. For example, if the coinsurance percentage is 20% and the plan's allowed amount for an office visit is \$100. Once you've met your deductible, your coinsurance payment of 20% would be \$20. The health insurance plan pays the rest of the allowed amount.

WHAT IS A COPAY?

A copay is a fixed or flat dollar amount you must pay each time you visit the doctor or purchase medicine. This amount will vary depending on where you go for care, the type of doctor you see and the kind of medicine you need. Not all plans have copays.

WHAT IS AN OUT-OF-POCKET MAXIMUM?

This is the most you could pay in deductible, copay and coinsurance in a year. Once the maximum-out-of-pocket limit is reached, the plan covers 100% of all eligible expenses.

WHAT IS AN EXPLANATION OF BENEFITS (EOB)?

An EOB is a statement that comes in the mail and explains details about a submitted insurance claim. The EOB shows the portion that was paid by the insurance carrier and what payment, if any, will be the patient's responsibility. Even though it resembles a bill, it is not. The bill for your portion will come from the health care provider and should be paid to the provider.

WHAT COUNTS AS A PREVENTIVE CARE VISIT?

In general, a preventive care visit is one where you are going for a general checkup and don't have a specific concern. If you have a specific ailment for the doctor to check on, this is typically considered a diagnostic visit. Be aware, however, if you go to the doctor for a yearly check-up and bring up ailments to the doctor, part of the visit might be billed as preventive and part as diagnostic.

IF I CHANGE PLANS, CAN I KEEP MY DOCTOR?

It depends. Different plans have different networks of providers and you should check with your doctor to confirm they work with the new carrier and plan. This is an important consideration, because in-network providers are less costly than out-of-network providers. And some plans don't have any out-of-network coverage, which means you'd be responsible for 100% of the cost of services provided at a doctor that's out-of-network.



Prescription Drugs – BCBSM Simply Blue PPO \$1500

Prescription drug coverage will be provided through OptumRx. Please visit www.bcbsm.com for a list of participating pharmacies.

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 contraceptives are covered 100% when prescribed for the purpose of contraception. 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 OptumRx Mail Order Drug Program

You may have your prescriptions filled through the OptumRx Mail Order Drug Program which may save you money.

The mail order program administered by OptumRx 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 any refill requirement. 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 any refill requirements. To learn more visit www.bcbsm.com or www.optumrx.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

Prescription drug coverage will be provided through OptumRx. Please visit bcbsm.com for a list of participating pharmacies.

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 contraceptives are covered 100% when prescribed for the purpose of contraception. 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 OptumRx 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 any refill requirement. 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 days supply including any refill requirement. To learn more visit www.bcbsm.com or www.optumrx.com.



Blue Care Network Price Edge

Price Edge will help you manage your health — and your budget by saving you money on non-specialty, generic medications, even if they're not covered by your benefits.

- Featuring digital and mobile tools you can use to check prices and improve your knowledge of costs for certain generic drugs
- Applying the cost of your covered medications to your out-of-pocket maximum and deductible balances
- Retaining your medical history to make sure our clinical programs and drug safety checks continue to protect your health

To check the price of a medication, log in to your secure member account at bcbsm.com or on our mobile app:

- Click on My coverage.
- Click on Prescription.
- Click on Find & price medications.
- Select Find pricing and coverage on the mobile app.
- In the Search section, enter the name of the medication.

The price of your medication may vary as medications are added to or removed from the program.

If your medication is covered, you'll receive the following alert: **“Your price has been discounted with Price Edge for a competitive low market price.”**

If your medication isn't covered, you'll receive the following alert: **“This drug is not covered by your plan, but we've discounted the price with Price Edge. The cost for this noncovered medication will not apply to your deductible or out-of-pocket maximum.”**





Save with instant discounts on some generic medications

Shopping around for the lowest price for your medication can be challenging and time-consuming. Fortunately, you now have a discount program included with your Blue Care Network prescription drug plan. This program will do all the hard work for you.

Paying less for your prescriptions just got easier

Price Edge will save you money on nonspecialty, generic medications, even if they're not covered by your benefits.

Fill your prescriptions as usual and use your current network pharmacy. You'll receive these services at no additional cost.

- **Finding discounts:** Price Edge searches for prices offered by drug discount cards.
- **Reviewing your benefits:** Prices for eligible medications are automatically compared to your prescription drug benefits.
- **Applying the lowest price:** You'll pay the lowest price available for eligible drugs, including nonspecialty, generic medications that your prescription drug benefits don't cover.

Convenient discounts and comprehensive support

Price Edge will help you manage your health — and your budget.

- **Featuring digital and mobile tools** you can use to check prices and improve your knowledge of costs for certain generic drugs
- **Applying the cost of your covered medications** to your out-of-pocket maximum and deductible balances
- **Retaining your medical history** to make sure our clinical programs and drug safety checks continue to protect your health

To check the price of a medication, log in to your secure member account at bcbsm.com or on our mobile app:

- Click on *My coverage*.
- Click on *Prescription*.
- Click on *Find & price medications*. Select *Find pricing and coverage* on the mobile app.
- In the *Search* section, enter the name of the medication.

The price of your medication may vary as medications are added to or removed from the program.

If your medication is covered, you'll receive the following alert: "Your price has been discounted with Price Edge for a competitive low market price."

If your medication isn't covered, you'll receive the following alert: "This drug is not covered by your plan, but we've discounted the price with Price Edge. The cost for this noncovered medication will not apply to your deductible or out-of-pocket maximum."



Medical Benefits Overview

| Benefit Coverage | BCBSM Simply Blue PPO \$1500 | | BCN HMO |
|--|------------------------------|-----------------------|---|
| | In-Network Benefits | OutofNetwork 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 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 | OutofNetwork 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 2) | \$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 |
| Non-preferred 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 | \$176.08 |
| Employee & 1 Dep | \$432.02 |
| Employee & 2+ Deps | \$541.03 |

Employee Contributions – BCN HMO - (Semi - Monthly)

Medical HMO - (BCN)

| | |
|--------------------|----------|
| Employee | \$73.24 |
| Employee & 1 Dep | \$169.25 |
| Employee & 2+ Deps | \$189.59 |

Diabetes Management

Livongo

Blue Cross and Blue Care Network offers you a diabetes management program powered by Livongo.

Diabetes Management is critical. If not correctly managed, type 2 diabetes can lead to several other chronic conditions that affect your employees' health and wellness, as well as benefit costs. Livongo's diabetes management program focuses on glucose monitoring for people with diabetes and lowering their A1C.



Maven Maternity & Menopause Programs

Maternity Program

Blue Cross is working with Maven to ensure anyone on your health plan who's pregnant has the best experience possible as they navigate through the stages of pregnancy and postpartum. This program provides digital support for pregnancy and postpartum at no cost. If someone on your health plan is pregnant, they can download the Maven app and register. Spouses or partners on your plan can also register and participate at no cost. The program includes:

- Comprehensive care through prenatal and postpartum time periods
- High-risk pregnancy management
- Early detection for risk factors, which can lead to reduction in preterm birth, low birth weight and C-section
- Guidance for parents with an infant in the NICU
- Support for a loss
- Coaching to prepare for returning to work
- Content and support tools, which are specific to each week of pregnancy



Menopause Program

Blue Cross recognizes menopause is an important phase in your life, and they have partnered with Maven to bring you a holistic and specialized support program. This no-cost program provides instant access to expert advice and resources to anyone on your health plan who's experiencing physical and mental symptoms related to menopause. Support through this program includes:

- Early identification of menopausal symptoms and treatment guidance
- 24/7 virtual access to a coaching care team specializing in perimenopause, menopause and postmenopause
- Guided education and in-app communities to connect with others in the same stage of life
- 1:1 mental health support throughout the menopausal journey



Maternity program

A digital program through Maven that provides personalized care navigation, clinical support and education



Pregnancy is a journey.

We support you through it all.

We're working with Maven to ensure anyone on your health plan who's pregnant has the best experience possible as they navigate through the stages of pregnancy and postpartum.

Get started today at bcbsm.com/mavenfamily.

This program provides digital support for pregnancy and postpartum at **no cost**. If someone on your health plan is pregnant, they can download the Maven app and register. Spouses or partners on your plan can also register and participate at **no cost**. The program includes:

- Comprehensive care through prenatal and postpartum time periods
- High-risk pregnancy management
- Early detection for risk factors, which can lead to reduction in preterm birth, low birth weight and C-section
- Guidance for parents with an infant in the NICU
- Support for a loss
- Coaching to prepare for returning to work
- Content and support tools, which are specific to each week of pregnancy




Key features of the Maven app

Through the Maven app, all participants get full access to:

| A personal care advocate | Personalized resources | 24/7 video appointments |
|---|--|---|
| <p>A care advocate is matched to each user, based on personal preferences, who can:</p> <ul style="list-style-type: none"> • Provide personalized, one-on-one support to answer questions • Recommend the right types of coaches for specific needs • Help find high quality, in-network providers | <p>Users have access to a library of content personalized to their specific journey:</p> <ul style="list-style-type: none"> • Content includes prenatal health, postpartum depression, returning to work with confidence and more • Trustworthy, clinically approved articles • Community forums to engage with others on similar journeys • Classes led by providers that cover a variety of topics | <p>Users can schedule video appointments with top-rated coaches.*</p> <ul style="list-style-type: none"> • Speak with coaches from more than 30 clinical specialties, including OB-GYNs, mental health specialists, lactation consultants, nutritionists, doulas and sleep coaches • Coaches are available to speak with in more than 35 languages • A chat option is also available |


*Maven coaches don't replace in-person care or relationships with participants' established care teams and providers. They're additional resources to schedule appointments for supplemental care and support.

The program doesn't replace any health care coverage. It's additional support to help along the pregnancy journey.



Menopause program


This digital program through Maven provides personalized care navigation, clinical and emotional support, and education.



An important phase of life

With 6,000 women reaching menopause daily in the United States¹, no one should have to experience symptoms in silence. With Maven, you have 24/7 support from early menopause and perimenopause through menopause and postmenopause.

Get started today at bcbsm.com/mavenmenopause.



Fast Company

Menopause: A holistic, specialized support program

This **no-cost** program provides instant access to expert advice and resources to anyone on your health plan who's experiencing physical and mental symptoms related to menopause. Support through this program includes:

- Early identification of menopausal symptoms and treatment guidance
- 24/7 virtual access to a coaching care team specializing in perimenopause, menopause and postmenopause
- Guided education and in-app communities to connect with others in the same stage of life
- 1:1 mental health support throughout the menopausal journey



A complete digital experience

Through this program, all participants get full access to:

| A care advocate | Personalized resources | 24/7 video appointments |
|---|--|--|
| <p>A care advocate is matched to each user, based on personal preferences, who can:</p> <ul style="list-style-type: none"> • Provide one-on-one support to answer questions • Recommend the right types of care for specific needs • Help find high quality, in-network providers | <p>You have access to personalized, educational support resources:</p> <ul style="list-style-type: none"> • Trustworthy, clinically approved articles • Community forums to engage with others on similar journeys • Classes led by clinical professionals | <p>You can schedule video appointments with top-rated coaches:*</p> <ul style="list-style-type: none"> • Speak with coaches from clinical specialties, including OB-GYNs, mental health specialists, career coaches and more • Coaches are available to speak with in more than 35 languages • A chat option is also available |

*Maven coaches don't replace in-person care or relationships with established care teams and providers. They're additional resources.

Menopause is an important stage in a woman's health care journey. You and others on your health plan aren't alone and have 24/7 support.

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 Virtual Care by Teladoc Health

BCN HMO and BCBSM PPO members have access to quality health care, anytime any place with 24/7 online health care through Blue Cross Virtual Care by Teladoc Health for the same cost as your primary care office visit copay (BCN - \$30, BCBSM - \$40). **Members enrolled in the BCN HMO plan will need to select a virtual primary care provider.**

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. Open the Teladoc Health app. Or open the Blue Cross app, click *Find a Doctor* and then *Virtual Care*. It's as simple as using your mobile device, computer, or tablet 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 award winning Virtual Care by Teladoc Health, a easy to use online health care technology, for common illnesses, such as:

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

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



How to Have a Virtual Visit

1. Open the Teladoc Health app. Or open the Blue Cross app, click *Find a Doctor* and then *Virtual Care*.
2. Choose a service: 24/7 Care or Mental Health.
3. Pick a doctor or begin a scheduled visit.
4. Meet with the doctor or therapist online.
5. Get a prescription, if appropriate, sent to your preferred pharmacy.
6. After your visit, you can share an optional visit summary with your primary care provider.

Start Using Virtual Care Today

Scan the QR code below or visit www.bcbsm.com/virtualcare to download the Teladoc Health app today!



If you have questions or need help with your Virtual Care account or an online visit, please call 1-800-835-2362, 24/7.



Virtual care that's always there

GET CARE WHEN YOU NEED IT, WHEREVER YOU ARE.

With **Virtual Care** by Teladoc Health®, you and everyone on your health plan can get virtual medical and mental health care from a smartphone, tablet or computer.

Virtual Care is included with your Blue Cross Blue Shield of Michigan and Blue Care Network health care plan.



24/7 CARE

Have a virtual visit with a U.S. board-certified doctor for minor illnesses such as colds, sore throats, urinary tract infections and pink eye. Visits are available for adults and children.

Medical visits are available 24/7, anywhere in the U.S., when your primary care provider isn't available. You don't need an appointment and the average wait time is 10 minutes. Prescriptions, if needed, can be sent to your preferred pharmacy.

MENTAL HEALTH

Through the Mental Health option, you can connect with a licensed therapist or U.S. board-certified psychiatrist when you're dealing with stressful situations or issues such as grief, anxiety and depression.

Mental health visits require an appointment, but many therapists and psychiatrists have evening and weekend availability.

SIGN UP TODAY

Visit bcbsm.com/virtualcare for a link to download the Teladoc Health app.



Family members ages 18 and older will need to create their own Virtual Care accounts. When updating or creating an account, choose your plan name and enter your member ID so your coverage is applied correctly. Call **1-800-835-2362** with any questions about your account or to arrange a telephone visit.



Easy access to outpatient behavioral health care

*Dealing with a mental health or a substance use concern isn't easy.
Finding the right care should be.*

Untreated behavioral health conditions can affect your employees' overall health, which can lead to loss of work productivity and increased absenteeism. That's why we've added Quartet to your Blue Cross Blue Shield of Michigan or Blue Care Network plan. This resource helps your employees and their eligible family members 18 and older, living in Michigan, easily connect to outpatient behavioral health care based on their personal needs and preferences.

It's easy as 1, 2, 3.

- 1 Complete an assessment.**
 Your employees will complete a questionnaire online or by phone so Quartet can understand their needs.
 - **Online:** Visit www.quartethealth.com/get-care/mi/BCBSM.*
 - **By phone:** Call 1-877-258-4010 from 9 a.m. to 6 p.m. Eastern time.
 Employees who participate in our care management program could be referred to Quartet by a Blue Cross or BCN care manager.
- 2 Get help finding the perfect provider match.**
 Quartet will match your employees to a behavioral health provider that's right for them based on their specific needs and eligibility.
- 3 Make an appointment****
 Your employees will work with the matched provider to schedule an appointment. Quartet will reach out one week after the initial appointment to make sure the provider is a good fit and re-match if necessary.

Whether your employees need help managing substance use, anxiety or depression, or have other mental health concerns, Quartet does the legwork to match them with the care they need.

Dental Insurance

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

- Delta Dental PPO
- 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 services.

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



Dental Insurance

| 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% after copay based on procedure* |
| Major | 50% | 50% | 70% after copay based on procedure* |
| Orthodontia | 50% | 50% | 50% after copay based on procedure * |
| Orthodontia Adult | Not covered | Not covered | Not covered |
| Orthodontia Dependent Child(ren) | Covered up to age 19 | Covered up to age 19 | Covered up to age 19 |
| Orthodontia Lifetime Maximum | \$800 | \$800 | N/A* |

*EPO Coverage is based on Delta Dentals member copayment schedule, but approximate coverage levels are 100% preventive, 85% basic, 70% major services, and 50% for orthodontia services.

| Employee Contributions - PPO - (Semi - Monthly) | |
|---|---------|
| Dental PPO - Employee Contributions | |
| Employee | \$5.96 |
| Employee & 1 Dep | \$10.83 |
| Employee & 2+ Deps | \$20.57 |

| Employee Contributions - EPO - (Semi - Monthly) | |
|---|---------|
| Dental EPO - Employee Contributions | |
| Employee | \$4.87 |
| Employee & 1 Dep | \$9.19 |
| Employee & 2+ Deps | \$16.77 |



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 Covered in lieu of frames. | Elective contacts covered up to \$150 allowance, every 12 months Medically necessary contacts are paid in full, every 12 months | Elective contacts covered up to \$105 allowance, every 12 months Medically necessary contacts covered up to \$210 in full, every 12 months |
| Frames | Covered at up to \$150 allowance, every 24 months | Up to \$45, every 24 months |

Employee Contributions (Semi - Monthly)

Vision - Employee Contributions

| | |
|--------------------|--------|
| Employee | \$3.09 |
| Employee & 1 Dep | \$7.41 |
| Employee & 2+ Deps | \$9.27 |



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 employees 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 |

Dependent 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 |

Short-Term Disability Insurance

The College provides Short Term Disability benefits which provides short-term income protection for eligible employees. Benefits will begin paying on the 8th day of your injury or illness. Benefit amount and duration are based on your length of employment. The chart below outlines the Short-Term Disability benefits available at no cost to you!

For information about your short-term disability benefit, please refer to your Employee Handbook.

| Length of Employment | PTO Required | Percent of pay | | | |
|----------------------|----------------|----------------|----------|----------|----------|
| | | 100% | 90% | 80% | 70% |
| Less than 180 days | N/A | N/A | N/A | N/A | N/A |
| 180 days to 2 years | Waiting period | N/A | N/A | 12 weeks | 13 weeks |
| 2 years to < 5 years | Waiting period | 6 weeks | N/A | 7 weeks | 12 weeks |
| 5 years of more | Waiting period | 12 weeks | 13 weeks | N/A | N/A |

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 SSNRA (SSNRA means your normal retirement age under Federal Social Security Act, as amended) 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 provisions of the plan including exclusions 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 if the expense is paid out-of-pocket by you.

- **The maximum annual election for the HCFSA is \$3,200**
- **You are able to carryover \$640 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 choose uses 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, please send a copy of the receipt for service. You will have 14 days to substantiate the claim. **If you don't send requested documentation 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 with pre-tax dollars such as child, elder care and companion services are eligible expenses, as are Social Security and other taxes you pay a caregiver. **THIS IS NOT FOR HEALTH CARE RELATED EXPENSES FOR YOUR DEPENDENTS.**

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.



Flexible Spending Accounts

What is a Flexible Spending Account? How do they work?

FLEXIBLE SPENDING ACCOUNTS WHAT IS A FLEXIBLE SPENDING ACCOUNT?

A Flexible Spending Account (FSA) is a special type of account you (and sometimes your employer) put money into to pay for certain out-of-pocket health care expenses. Your contributions to this account are not taxed, so you will save the amount that would have been paid in taxes on this money.



“USE OR LOSE” RULE

FSAs are subject to a “use or lose” rule, as required by the IRS. This means that the money in the account must be spent by the end of the plan year and can’t be carried over to the next year. When choosing your contribution for the year, you should be careful to choose an amount that is enough to cover expected expenses, but not so much that you may forfeit it if you don’t incur enough eligible expenses over the course of the year.

Some plans may have a **grace period** or **carry-over**. A **grace period**, which can be up to two and a half months past the plan year, allows you to submit any qualified medical expenses incurred during the **grace period** using money left in the account. If your plan ended 12/31 and had a two-and-a-half-month **grace period**, you would have until 3/15 to spend the money in your FSA.

If your plan has a **carry-over** provision, you may carry over up to \$550 (in 2021) of unused funds to next year. Plans can’t have both a **grace period** and a **carry-over**. Check with your HR or FSA vendor to see if your plan has either of these provisions.

TYPES OF FSAs

There are two different types of FSAs: health care FSAs and dependent care FSAs. You can have both types of accounts at the same time and contribute to both. The money in the two types of the accounts are separate and money in one account cannot be used for reimbursement of the other type of expense.

1

HEALTH CARE FSAs



2

DEPENDENT CARE FSAs



Enrollment Preparation and Contributions

Medical, Dental and Voluntary Vision

Make your elections by completing the enrollment process online via <https://www.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 from 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 | \$176.08 | \$432.02 | \$541.03 |
| Blue Care Network HMO | \$73.24 | \$169.25 | \$189.59 |
| Delta Dental PPO | \$5.96 | \$10.83 | \$20.57 |
| Delta Dental EPO | \$4.87 | \$9.19 | \$16.77 |
| NVA Vision | \$3.09 | \$7.41 | \$9.27 |
| Spousal Surcharge | N/A | \$50.00 | \$50.00 |

Legal Shield and ID Shield

LegalShield | IDShield | Plan Summary

Life happens... Are you prepared?
Save time, money, and get peace of mind!

Have you ever?

- Wanted to know your legal rights?
- Needed your Will or medical directive prepared or updated?
- Received a moving traffic violation?
- Signed any type of contract?
- Been in a frustrating consumer dispute?
- Been a victim of a data breach?
- Been concerned about security when using public Wi-Fi?
- Been afraid of having your or your family's identity stolen?
- Had unauthorized withdrawals from your bank account or credit cards?
- Had your social media accounts hacked?
- Worried about being a victim of identity theft?

LegalShield | Top LegalShield Benefits

Access to a Provider Law Firm for legal advice and consultation on any personal legal matter, even pre-existing ones.

Estate Planning Preparation — Will, Medical Directives, Healthcare Power of Attorney.

Moving Traffic Ticket Assistance with non-criminal, moving traffic matters when driving with a license and proper registration.

Document Review — Your provider law firm reviews personal documents (up to 15 pages each).

Letters And Phone Calls made on your behalf to help resolve consumer legal disputes.

Uncontested Family Law — Divorce, separation, adoption and/or name change.

Discounted Legal Services — For legal matters that are not covered at 100%, get a 25% discount on the provider law firm's standard rate.

Provides 24/7/365 emergency legal access for covered emergencies.

IDShield | Top IDShield Benefits

360 Degree Protection — Threat monitoring of your identity, credit, financial accounts, device, online reputation and social media.

Monthly Score Tracker — watch your credit score and map your credit trends

Financial Protection — \$1 Million Identity Fraud Protection for unauthorized electronic fund transfers and identity theft-related expenses.

Full-Service Restoration — In case of theft, you get a licensed private investigator to restore your identity to its pre-theft status.

Unlimited Consultation gives you access to an identity theft specialist for consultation on any identity theft or online privacy concern.

Real-time Alerts — Receive an alert on your mobile app, member portal and email when a threat is detected to your identity or credit.

Provides 24/7/365 live support for identity theft emergencies.

Your Payroll Deduction 24 Pays

| Individual Plan | Family Plan |
|-----------------------------------|-----------------------------------|
| \$8.48 LegalShield Plan | \$9.48 LegalShield Plan |
| \$4.48 IDShield Plan | \$9.48 IDShield Plan |
| \$12.95 Dual Plan | \$16.95 Dual Plan |

Pre-Paid Legal Services, Inc. ("PPLSI") provides access to legal services offered by a network of provider law firms to LegalShield members through membership-based participation. Neither LegalShield nor its officers, employees or sales associates directly or indirectly provide legal services, representation, or advice. See a legal plan for complete terms, coverage, amounts and conditions. IDShield is a product of LegalShield. LegalShield provides access to identity theft protection and restoration services. For complete terms, coverage and conditions, please see an identity theft plan. All Licensed Private Investigators are licensed in the state of Oklahoma. An Identity Fraud Protection Plan ("Plan") is issued through a nationally recognized carrier. LegalShield/IDShield is not an insurance carrier. This covers certain identity fraud expenses and legal costs as a result of a covered identity fraud event. See a Plan for complete terms, coverage, conditions, limitations, and family members who are eligible under the Plan.

FOR MORE INFORMATION CONTACT YOUR INDEPENDENT ASSOCIATE OR VISIT:

Lisa Schiller, CITRMS
 lisa@schillerandcompany.com
 248-887-6275-O www.schillerandcompany.com

CLIENT MICROSITE:
shieldbenefits.com/ccsmi



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 your EAP services.

An EAP is a program 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

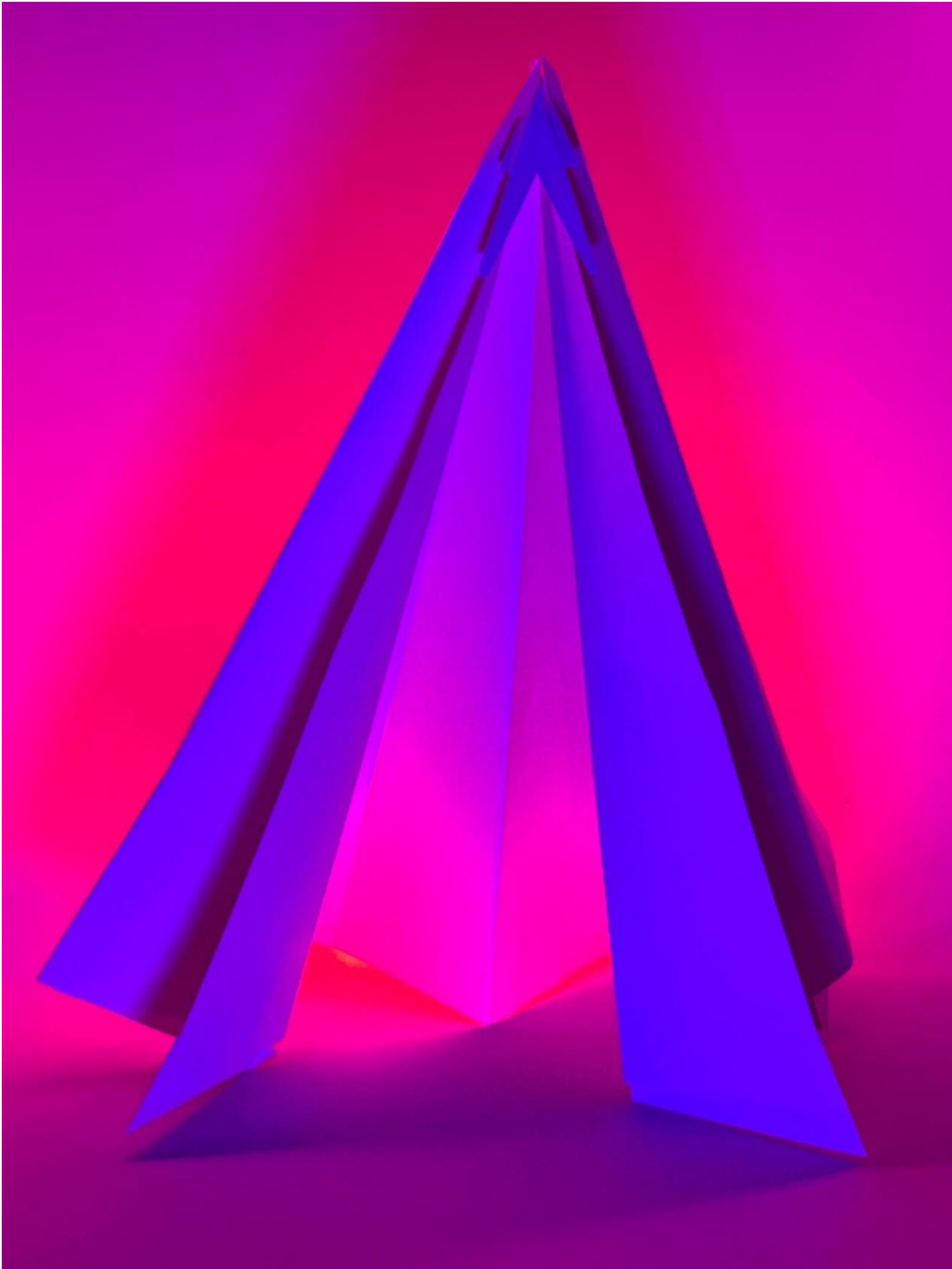
Contact Ulliance Inc. at (800) 448-TEAM or visit www.team-eap.com, 24 hours a day, 7 days a week.



Employee Savings Plan 403(b)

Full-time employees and eligible part-time employees can 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 or post-tax (Roth IRA) basis, within IRS guidelines. The plan provider is TIAA-CREF. Please see Human Resources for more information.

For 2024, employees may contribute up to \$23,000 of their income and employees 50 years of age or older can contribute an additional \$7,500 for catch-up contributions.



Contacts

USI Mobile App – MyBenefits2GO

College for Creative Studies is pleased to offer on-the-go access to key benefit information through the USI Mobile App, MyBenefits2GO. Search for “MyBenefits2GO” and download the free app on your smartphone. Add your name and email then enter the code **H98510** when prompted.

Benefits Information When You Need It Most

College for Creative Studies

FIND IT IN THE APP STORE

Search for 'MyBenefits2GO' and download our free app.

Enter this code when prompted:

H98510

HIGHLIGHTS OF THE MyBenefits2GO APP

- Access benefits information on the go
- Convenient contact information for Carriers and HR
- Organized plan information in one place
- View the most updated plan information
- Store your ID cards in the app



MyBenefits2GO: FREE MOBILE BENEFITS APP FOR ANDROID AND IPHONE

The MyBenefits2GO app gives you on-the-go access to your benefit and insurance policy details, HR contact information and more!

The app is a quick and simple way for you and your enrolled dependents to access benefit summaries and other important information about our group plans. Store photos of ID cards in the app and easily locate carrier and HR contact information—all in one place. The MyBenefits2GO app is free for iPhone and Android.

Getting In Touch

The app provides employees and their enrolled dependents single-point contact information for benefits resources and insurance carriers.

Keeping Up-to-Date

The app automatically connects you with the most updated plan information and allows for message reminders from your employer.

Lightening Wallets

The app allows you to store and share images of your ID cards, freeing up space and giving you access when you need it.

Staying Organized

The app gives you access to benefit plan information and ID cards—all in one place.

Benefit Resource Center

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.

Why won't they pay my claim?
Services denied?!

How can my claim still be "in process"? It's been two months!

I called my insurance carrier, but now I'm just more confused.

Do I have mail-order prescription benefits?

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



Benefit Resource Center

BRCMidwest@usi.com | Toll Free: 855-874-0829
Monday through Friday 8:00am to 5:00pm Eastern & Central
Standard Time

Carrier Contacts

Carrier Customer Service

| BENEFITS PLAN | CARRIER | PHONE NUMBER | WEBSITE |
|-----------------------------|--------------------------------------|----------------|--|
| Medical HMO | Blue Care Network of Michigan | (800) 662-6667 | www.bcbsm.com |
| Medical PPO | BC/BS of Michigan | (877) 790-2583 | www.bcbsm.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 and AD&D | 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 |
| LegalShield / ID Shield | Legal Shield | (800) 654-7757 | www.legalshield.com/info/ccsmi |

College for Creative Studies
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 following deductibles and coinsurance apply:

BCBSM SB PPO \$1500: \$1,500/\$3,000 deductible and 80% coinsurance

BCN HMO \$5,000: \$5,000/\$10,000 deductible and 90% coinsurance

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 30 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

Blue Care Network 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. Until you make this designation, Blue Care Network will designate one for you.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Care Network, www.bcbsm.com.

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 for certain 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 Blue Care Network, www.bcbsm.com.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a

case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Raquel Diroff
201 E Kirby
Detroit, Michigan United States 48202
313-664-7651
rdiroff@collegeforcreativestudies.edu

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 Date of Notice: October 1, 2023
- Contact:
Raquel Diroff
201 E Kirby
Detroit, Michigan United States 48202
313-664-7651
rdiroff@collegeforcreativestudies.edu

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

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 Benefit 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.

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

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 not 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 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 [Insert Name of Entity] 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 Human Resources 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).

Date: 1/1/2024
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)**.

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, 2023. Contact your State for more information on eligibility –

| | |
|--|---|
| ALABAMA – Medicaid | ALASKA – Medicaid |
| Website: http://myalhipp.com/ Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx |
| ARKANSAS – Medicaid | CALIFORNIA – Medicaid |
| Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov |
| COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+) | FLORIDA – Medicaid |
| Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442 | Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268 |

| | |
|--|---|
| <p align="center">GEORGIA – Medicaid</p> <p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p> | <p align="center">INDIANA – Medicaid</p> <p>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: https://www.in.gov/medicaid/ Phone: 1-800-457-4584</p> |
| <p align="center">IOWA – Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p> | <p align="center">KANSAS – Medicaid</p> <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p> |
| <p align="center">KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p> | <p align="center">LOUISIANA – Medicaid</p> <p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p> |
| <p align="center">MAINE – Medicaid</p> <p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p> | <p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspreassistance@accenture.com</p> |
| <p align="center">MINNESOTA – Medicaid</p> <p>Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p> | <p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p> |
| <p align="center">MONTANA – Medicaid</p> | <p align="center">NEBRASKA – Medicaid</p> |

| | |
|--|---|
| Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 |
|--|---|

| | |
|---|--|
| NEVADA – Medicaid | NEW HAMPSHIRE – Medicaid |
| Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218 |
| NEW JERSEY – Medicaid and CHIP | NEW YORK – Medicaid |
| 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 | Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831 |
| NORTH CAROLINA – Medicaid | NORTH DAKOTA – Medicaid |
| Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100 | Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825 |
| OKLAHOMA – Medicaid and CHIP | OREGON – Medicaid |
| Website: http://www.insureoklahoma.org Phone: 1-888-365-3742 | Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075 |
| PENNSYLVANIA – Medicaid and CHIP | RHODE ISLAND – Medicaid and CHIP |
| Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) |
| SOUTH CAROLINA – Medicaid | SOUTH DAKOTA - Medicaid |
| Website: https://www.scdhhs.gov Phone: 1-888-549-0820 | Website: http://dss.sd.gov Phone: 1-888-828-0059 |
| TEXAS – Medicaid | UTAH – Medicaid and CHIP |
| Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493 | Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669 |
| VERMONT– Medicaid | VIRGINIA – Medicaid and CHIP |
| Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924 |
| WASHINGTON – Medicaid | WEST VIRGINIA – Medicaid and CHIP |

| | |
|--|--|
| Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| WISCONSIN – Medicaid and CHIP | WYOMING – Medicaid |
| Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002 | Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2023, 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 1/31/2026)



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

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: College for Creative Studies | | 4. Employer Identification Number (EIN) 38-1550064 | |
| 5. Employer address: 201 E. Kirby | | 6. Employer phone number 313.664.7651 | |
| 7. City: Detroit | 8. State: MI | 9. ZIP code: 48202 | |
| 10. Who can we contact about employee health coverage at this job? Raquel Diroff | | | |
| 11. Phone number (if different from above) | | 12. Email address: Rdiroff@ccsdetroit.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:
Employees working at least 30 hours per 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

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.