

Education Achievement Authority of Michigan

Benefits and Enrollment Guide



September 1, 2012 Enrollment

Health ■ Dental ■ Vision ■ Life ■ Disability

2012 Benefit Summary Guide Overview

Education Achievement Authority of Michigan offers eligible employees a variety of benefits that can provide you and your family with health care coverage, financial protection and more, tailored to best fit your needs. Our benefits program is an important part of your overall compensation and with the assistance of Hylant Group, we are regularly assessing the quality and cost of the benefits to ensure we offer the most competitive package possible. Changes and relevant new information are highlighted below, however, we encourage you to review this guide in its entirety.

Enrollment Period: Enrollment is only available beginning August 14, 2012 through August 17, 2012. This is the only opportunity you will have to enroll in the benefit programs offered through Education Achievement Authority. You will be locked into the plan selections until the next open enrollment period unless there is a qualifying event (marriage, divorce, birth, adoption or change in custody of a child, death of a dependent, change in employment status). All changes must be made within 30 days of the event.

- **Healthcare:** You have the option of choosing between a PPO and an HMO plan through Blue Cross Blue Shield and Blue Care Network. More information can be found on page 5 of this guide.
- **Dental & Vision:** You have the option of enrolling in dental and vision covered offered through Blue Cross Blue Shield. More information can be found on page 6 of this guide.
- **Life & Disability:** You have the option of enrolling in a voluntary life and disability insurance program. Premiums for these plans are paid for by the employee. More information can be found on page 8 of this guide.
- **Employee Contributions:** Employees will be asked to share the cost of their insurance benefits. Your contribution amounts are outlined in these enrollment materials.
- **Online Enrollment Tool:** Employees will need to access *HR Connection* in order to enroll in the benefit programs offered by Education Achievement Authority. Navigate to **www.hrconnection.com** and enter your **user name** and **password**. Click **Time to Enroll** from the upper left corner. Your user name and password will be emailed to the email address on file with your employer so be sure to check your email shortly for this important information!
- **Customer Service Hotline:** In order to help you with your benefit questions, claim issues, enrollment and general inquiries, you and your dependents may contact Hylant Group. **Hylant Group is a one-source helpline for all of your benefit questions. Please call the toll-free number (1.800.609.9614) and speak to a customer service specialist who knows your benefit plan and can help with any questions.**

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This booklet is intended for illustrative and information purposes only. The plan documents, insurance certificates and policies will serve as the governing documents. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern. The Education Achievement Authority of Michigan reserves the right to change or terminate at any time, in whole or in part, the employee benefit package, with respect to all or any class of employees, former employees and retirees.

Contact Information

Broker



General Claims and Benefit Information

Toll Free: 800-609-9614

www.hylant.com

Medical—PPO	Blue Cross Blue Shield of Michigan	877-790-2583	007035233-0002	www.bcbsm.com
Medical—HMO	Blue Care Network	800-662-6667	00416841-0001	www.mibcn.com
Dental	Blue Cross Blue Shield of Michigan	877-790-2583	007035233-0002 00416841-0001	www.bcbsm.com
Vision	Blue Cross Blue Shield of Michigan (VSP)	877-790-2583	007035233-0002 00416841-0001	www.bcbsm.com www.vsp.com
Voluntary Life & Disability Insurance	UNUM	866-679-3054	294381 294380	www.unum.com
Employee Assistance Program <small>available to employees who elect the Voluntary LTD coverage</small>	UNUM	800-854-1446		www.lifebalance.net User ID: lifebalance Password: lifebalance
Travel Assistance Program <small>available to employees who elect the Voluntary LTD coverage</small>	UNUM	Within the US: 800-872-1414 Outside the US: 609-986-1234 Via E-Mail: medservices@assistamerica.com Reference Number: 01-AA-UNM-7216		
Online Enrollment Tool	HR Connection	www.hrconnection.com You will be receiving an email sent to the email address on file with your employer shortly with important information and instructions of how to login to HR Connection to enroll in the benefit programs offered by Education Achievement Authority. <i>If you do not receive this information, please contact the Hylant Group's Customer Service Department (800.609.9614) and they will be able to retrieve the information for you.</i>		

When contacting any of the companies above it is important to have the Insurance card or I.D. number (s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, i.e. Explanation of Benefits, denial letter, receipts, etc.



Eligibility

Education Achievement Authority of Michigan is pleased to offer its employees an excellent benefit program. These health and welfare benefits are designed to protect you and your family while you are an active employee.

Eligibility: Health and welfare plans are available to all employees who work 20 or more hours per week.

Dependent Eligibility: If you wish, your dependents may also be covered under the medical and dental plans. Eligible dependents include:

- Legal spouse, as defined by Federal Law; and
- Children under age 26; and
- MEDICAL, DENTAL & VISION - Your children up to age 26 regardless of marital status, financial dependency, residency with the Eligible Employee, student status, employment status, or eligibility for other coverage.
- It is your responsibility to provide the Human Resources Department with proof of your dependents' eligibility, in the form of:
(a) your most recent Federal Income Tax Return, (b) Court Order specifying your responsibility to provide "group health care coverage" to your dependent children, (c) copy of birth certificate or (d) copy of marriage certificate.

New Hire Coverage: As a new hire, your plan eligibility date is your Date of Hire. Once the necessary enrollment materials have been completed, benefits are effective on that date.

New employees have up to 30 days after their eligibility date to enroll. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period.

Annual Elections: It is important that you make your choices carefully, since changes to those elections can generally only be made during the annual open enrollment period. Exceptions will be made for changes in family status during the year, allowing you to make a mid-year benefit change. A family status change includes:

- Marriage
- Divorce
- Birth or adoption
- Death of a dependent
- Change in your spouse's employment or
- Loss of coverage by a spouse

If you have a family status change, you must change your benefit elections within 30 days of the qualifying event, or you will need to wait until the next annual open enrollment period.

COBRA Continuation Coverage: When you or any of your dependents no longer meet the eligibility requirements for health and welfare plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.



Medical Plans At A Glance

Healthcare benefits are one of the most important and necessary parts of your benefit package. The following is a summary of your benefits offered through Blue Cross Blue Shield and Blue Care Network. For a more detailed explanation of benefits, please refer to your certificate of coverage. You may access a list of participating providers at www.bcbsm.com or www.mibcn.com.

	BCBSM PPO		BCN HMO
	In-Network <i>What you pay</i>	Out-of-Network <i>What you pay</i>	In-Network ONLY <i>What you pay</i>
Doctors Office Visits			
Primary Care Physician	\$20 Copay	40% after Deductible	\$25 Copay
Specialist	\$20 Copay	40% after Deductible	\$35 Copay
Preventive Care Services	Covered at 100% Copay May Apply	Not Covered	Covered at 100% Copay May Apply
Urgent Care	\$20 Copay	40% after Deductible	\$35 Copay
Emergency Room	\$150 Copay—Copay Waived if Admitted		\$100 Copay—Copay Waived if Admitted
Deductible/Basis	Calendar Year Deductible		Calendar Year Deductible
Individual	\$500	\$1,000	None
Family	\$1,000	\$2,000	None
Co-Insurance	Plan Pays 80% You Pay 20%	Plan Pays 60% You Pay 40%	Plan Pays 80% You Pay 20%
Out of Pocket Maximum	Includes Deductible		Includes Deductible
Individual	\$2,000	\$4,000	\$1,500
Family	\$4,000	\$8,000	\$3,000
Hospitalization	20% after Deductible	40% after Deductible	20% Co-Insurance
Outpatient Surgery	20% after Deductible	40% after Deductible	20% Co-Insurance
Diagnostic Labs & X-Rays	20% after Deductible	40% after Deductible	20% Co-Insurance
Prescription Drugs			
Pharmacy Filled			
Generic	\$7 Copay	Copay plus an additional 25% of the BCBSM approved amount for the drug	\$10 Copay
Preferred Brand	\$35 Copay		\$40 Copay
Non-Preferred Brand	\$70 Copay		Not Covered
Mail Order (90 Day Supply)			
Generic	\$14 Copay	Not Covered	\$20 Copay
Preferred Brand	\$70 Copay		\$80 Copay
Non-Preferred Brand	\$140 Copay		Not Covered

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Dental & Vision Plans At A Glance

The dental coverage is provided by Blue Cross Blue Shield of Michigan. With BCBSM you have access to an extensive network of dentist's utilizing the Dental Network of America. To see a list of participating providers go to: www.bcbsm.com. The vision coverage is provided by Blue Cross Blue Shield of Michigan. With BCBSM you have access to an extensive network of dentist's utilizing VSP. To see a list of participating providers go to www.bcbsm.com or www.vsp.com.

	Dental Plan
	In-Network
Type I: Preventive Services (Oral Exams, X-Rays, Teeth Cleaning, Fluoride Treatment, Space Maintainers)	100% of Approved Amount
Type II: Basic Services (Fillings, Oral Surgery, Root Canal, General Anesthesia, IV Sedation, Tissue Conditioning)	75% of Approved Amount
Type III: Major Services (Onlays, Crowns, veneer Restorations, Removable Dentures, Bridges, Endosteal Implants)	50% after deductible
Deductible (Waived for Preventive)	Calendar Year Deductible
Individual	None
Family	None
Maximum Annual Benefit	\$1,500 Per Member
Orthodontics (Lifetime Maximum)	50% of Approved Amount
<i>Dependents under age 19 only</i>	\$1,500 Lifetime Maximum

	Vision Plan
	In-Network
Eye Exams (covered once every 12 months)	\$10 Copay
Lenses (covered once every 12 months)	\$25 Combined Lens & Frame Copay Allowances Apply
Frames (covered once every 24 months)	\$25 Combined Lens & Frame Copay Allowances Apply
Contact Lenses (covered once every 12 months)	Medically Necessary: \$25 Copay

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Voluntary Life and Disability Coverage

Life/AD&D Insurance

Employees have the opportunity to elect voluntary term life and accidental death & dismemberment insurance available through Unum. This will provide a death benefit for yourself, your spouse and/or your dependent child(ren) while you are employed at Education Achievement Authority Contributions for these premiums are 100% employee paid. *If you waive voluntary life coverage when you are initially eligible you will be required to provide Evidence of Insurability when enrolling at a later date.* Please allow 4 to 6 weeks for underwriting review. Claims incurred prior to the approval of your coverage will not be covered. Benefits may be limited and/or denied based on the EOI results. It is important to keep your beneficiary information up-to-date.

Plan Features	Benefit Amount
Employee Life/AD&D Insurance	Amounts in \$10,000 increments as applied for by the employee and approved by Unum Maximum: Up to the lesser of 5X Annual Earnings or \$500,000
Spouse Life/AD&D Insurance	Amounts in \$5,000 increments as applied for by the employee and approved by Unum Maximum: Up to the lesser of Employee Amount or \$500,000
Child Life/AD&D Insurance	Amounts in \$2,000 increments as applied for by the employee and approved by Unum
Age Reduction Schedule	Life Benefit Reduces to 65% at Age 70; and 50% at Age 75

Long Term Disability Insurance

Employees have the opportunity to elect voluntary long term disability insurance available through Unum. Long Term Disability Insurance provides income protection in the event you become disabled and are unable to work for an extended period of time. *If you waive voluntary disability coverage when you are initially eligible you will be required to provide Evidence of Insurability when enrolling at a later date.* Please allow 4 to 6 weeks for underwriting review. Claims incurred prior to the approval of your coverage will not be covered. Benefits may be limited and/or denied based on the EOI results.

Plan Features	Benefit Amount
Monthly Benefit	60% of Monthly Earnings to a Maximum Benefit of \$5,000 per Month
Elimination Period	90 Days
Benefit Duration	To Age 65
Pre-Existing Condition Limitation	A "Pre-Existing Condition" means the employee: 1.) received medical treatment, consultation, care or services including diagnostic measures or took prescribed drugs or medicines in the 12 months just prior to his/her effective date of coverage; and 2.) the disability begins in the first 24 months after the employee's effective date of coverage unless they have been treatment free for 12 months after

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Monthly Employee Contributions

	<i>Employee Only</i>	<i>Employee & Spouse or Employee & Child</i>	<i>Employee & Family or Employee & Children</i>
Medical Plan			
<i>BCBSM PPO</i>	\$224.06	\$537.75	\$672.19
<i>BCN HMO</i>	\$127.00	\$292.11	\$330.21
Dental Plan			
	\$17.54	\$42.09	\$52.61
Vision Plan			
	\$2.40	\$5.77	\$7.21
Voluntary Life Plan			
<i>See Age Banded Rates in the Benefit Summary section of this Benefit Guide</i>			
Voluntary Long Term Disability Plan			
<i>See Age Banded Rates in the Benefit Summary section of this Benefit Guide</i>			



Meet HRconnection®

HRconnection® gives you a direct line to company information in one secure and convenient location that can be viewed from any computer with internet access. It provides you with a comprehensive resource for company and benefits information, any time of the day or night.

Getting started

1. Navigate to www.hrconnection.com.
2. Enter your **user name** and **password**.
3. Click **Time to Enroll!** from the upper left corner.

Forgotten your password or user name?

Forgotten your password? Don't remember your user name? Click **I forgot my login information** to reset your password and retrieve your user name.

Protect your password

Your unique user name and password grants you access to your personal information. This electronic signature carries the same authority as your handwritten signature: it authorizes all of your elections and their corresponding deductions from payroll. *Keep this information confidential.*

What Web browsers can I use?

HRconnection® supports both Microsoft® Internet Explorer® 7.0 and 8.0 as well as Mozilla Firefox 3.

Is your information up-to-date?

After you log in, but before you make your benefit elections, take a moment to make sure that your personal and dependent information is correct.

Check your personal information

1. Navigate to **My Information > Personal Information**.

2. Confirm that all required information is provided, and that any additional information is correct.

3. Click **Save**.

Check your dependents and contacts

Go to **My Information > My Family and Contacts**.

- To add dependents, beneficiaries, or emergency contacts, click **Add Contact**.
- To update an existing relationship, click **Edit** .
- To remove a relationship, click **Delete** .

Time to enroll?

You're here either for open enrollment, or because you've recently had a life event.

Time to enroll! 

Click **Time to Enroll!**, or go to **My Information > My Elections**.

- **Open enrollment** is a period of time, usually once a year, when you can make additions or changes to your benefit options.
- A **life event** is an occasion that could potentially affect your employee data or benefit elections.

Time to Enroll

Current Elections

Life event and open enrollment

1. Your selections appear in the appropriate section of the **Time to Enroll** tab.

Life Event - Marriage	
Make Your Life Event Elect	
Status	Plan Ty
Pending	Life
Action Required	Medical

2. Click **Edit** .

Note: Your administrator may require that you confirm your

family and contact information as a part of the election confirmation process.

3. Select the coverage you want to elect, or choose **Waived** if you want to decline a particular coverage.
4. Click **Elect and Continue** to move to the next plan that requires an election, if applicable.
5. The status of elected plans moves to **Pending**.

Tip: If you need to make changes to what you choose here, you still can. Your elections aren't final until you confirm them.

Employer-sponsored plans

Employer-sponsored plans are benefit plans your company makes available to you at no cost.

1. Your selections appear in the appropriate section of the **Time to Enroll** tab.

Make Your Employer-Sponsored Elections	
Status	Action Required
	

2. Click **Edit** .
3. Select the coverage you want to elect.
4. If you need to include your dependents or beneficiaries in the plan, select them from the appropriate section.
5. To add dependents or beneficiaries, click **Add dependents** or **Add beneficiaries**.

Tip: If you need to make changes to what you choose here, you still can. Your elections aren't final until you confirm them.

Looking back at previous selections

If you've been through open enrollment before, click **View election history**  to view your past activity for a specific plan.





Can I compare healthcare plans?

Do you have more than one plan option available to you?



The plan comparison feature of HRconnection® is designed to help you make informed decisions about your health care options during the enrollment process.

1. Click **Edit**.
2. Find the plans you want to examine then select **Compare** for each.
3. Click **Compare**. HRconnection generates a side-by-side comparison in a new browser window.

Tip: Want to print this page to review later? Click **Print plan comparison**.

Confirming your elections

Once you have selected your benefit options, it's time to lock them down until the next enrollment period. The deadline for enrollment appears at the bottom of the page.

Please confirm your election by 07/31/2011

1. When you have completed your selections, click **Confirm**.
Note: Your administrator may require that you confirm your family and contact information as a part of the election confirmation process.

Confirm

Confirmation Summary - Clark

Name: Donald F. Brown Jr
Address: 10700 W. First Ave.
Address 2:
City, State, ZIP: Milwaukee, WI 53226
Phone: 414-555-0980
Date of hire: 11/04/2010

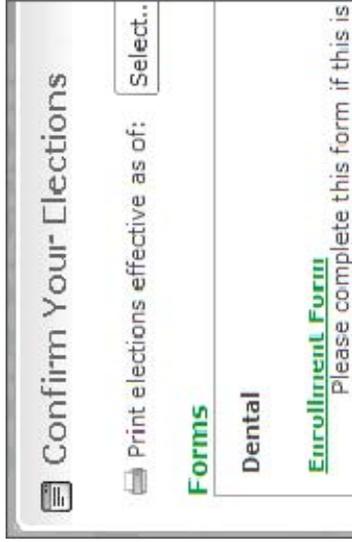
2. Review the elections you have made and click **Confirm** to stamp your elections with an electronic signature.

Tip: As part of the election confirmation process, you will be prompted to and it is recommended that you print your confirmation summary.

Complete the paperwork

After you've confirmed your elections, the last step in the process requires you to complete any applicable forms. The **Forms** page appears immediately after the confirmation step.

1. Read the form descriptions carefully to determine if you need to complete any of them.
2. Click a link to open a form, then print it, complete it, and return it to your Human Resources representative.



Tip: As part of the election confirmation process, you do have the option to print your election summary. To do so, select the correct **elections effective as of** date.

3. After you've completed this process, click **Done**. The **Time to Enroll** tab will be removed and your elections will now appear on the **Current Elections** tab.

Make a mistake?

Keep in mind that once you've confirmed your elections, you generally won't be able to change them until the next enrollment period.

However, if you need to make a correction or addition, you can submit an **Error Correction Life Event**. Doing so will enable your administrator to briefly reopen the enrollment period, allowing you to make your changes.

1. Go to **My Information > Life Events**.
2. Select **Error Correction** from the **Event Type** list.

Event type: Error Correction

3. Provide a **date** (the current date is acceptable).
4. Type a **short comment** about the error you want to correct.

5. Click **Save**.

You'll be contacted by Human Resources if additional information is required.



Hylant Script Navigator

<http://www.hylantscriptnavigator.com>

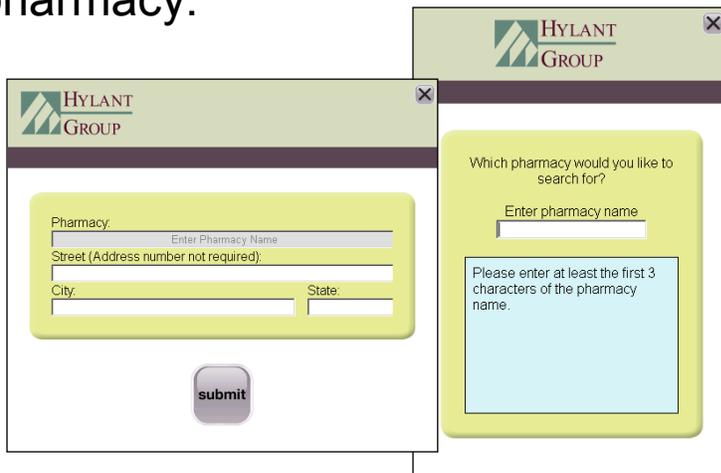
The ultimate pharmacy search engine for discounted generic drug programs available at pharmacies throughout the USA.

It's as easy as

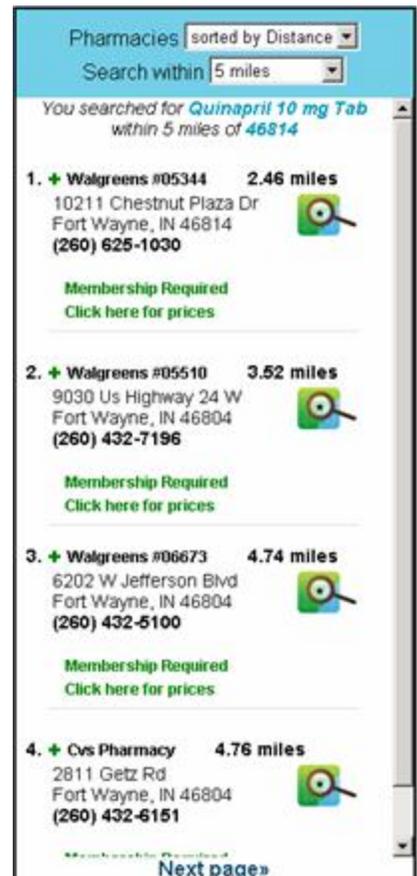


Enter the drug name, dosage, and your zip code to find the best deal for your generic prescription...

You can also find therapeutic alternatives, search at a specific pharmacy or suggest a pharmacy.



The screenshot shows the Hylant Group search interface. It features a search form with fields for Pharmacy, Street, City, and State, and a submit button. A modal dialog is open, asking "Which pharmacy would you like to search for?" and providing a text input field for the pharmacy name. A note below the input field states: "Please enter at least the first 3 characters of the pharmacy name."



The screenshot shows the search results page for "Quinapril 10 mg Tab" within 5 miles of zip code 46814. The results are sorted by distance and include the following information for each pharmacy:

Rank	Pharmacy Name	Distance	Address	Phone
1.	Walgreens #05344	2.46 miles	10211 Chestnut Plaza Dr Fort Wayne, IN 46814	(260) 625-1030
2.	Walgreens #05510	3.52 miles	9030 Us Highway 24 W Fort Wayne, IN 46804	(260) 432-7196
3.	Walgreens #06673	4.74 miles	6202 W Jefferson Blvd Fort Wayne, IN 46804	(260) 432-5100
4.	Cvs Pharmacy	4.76 miles	2811 Getz Rd Fort Wayne, IN 46804	(260) 432-6151

Each result includes a magnifying glass icon and a note: "Membership Required Click here for prices". The page also features a "Next page" link at the bottom.

Hylant Script Navigator

Today, pharmacies all across the U.S. have implemented **\$4 generic drugs programs**. The question many people ask themselves is, "which pharmacy has my prescription on their **\$4 generic drugs program**?" Medtipster.com was designed to answer that question, without sending users through a multiple step process to obtain the answer.

Cheap prescription drugs are available for more than 70% of written prescriptions. **Generic drugs** are distributed as the bioequivalent to the brand name, and today are more commonly distributed to consumers when and where available. Talk to your doctor if you have specific questions about your prescription and the alternative of a generic equivalent.

Finding the **cheapest prescriptions** is as easy as 1-2-3 with Medtipster.com's proprietary technology. You will never again have to wonder which pharmacy's generic program has your prescription drug. Have your healthcare and afford it, too.

Other search types include...

-  Flu Shots
-  Immunizations
-  Health Screenings
-  Mini clinics



The world of healthcare is both confusing and expensive. Hylant Script Navigator provides access to [pharmasueann](#). She posts a blog designed to clear things up. To tell it to you straight. To help you navigate through the morass with a little savvy and a lot less stress. From time to time, perhaps even to evoke a smile.

You will get some very concrete advice. Discover steps you can take to avoid the Medicare donut hole. Get tips for managing your care in the hospital. Learn about the background on some of the issues in drug trials.

Healthcare is a mess in this country. Every little bit of knowledge helps! PharmaSueAnn is here to serve you.



Important Disclosures

NOTE TO ALL EMPLOYEES:

Certain State and Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with all of the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator as follows:

Education Achievement Authority of Michigan
Human Resources Department
3022 W. Grand Blvd., Suite 14-652 Detroit, MI 48202
313-456-3010

THIS DOCUMENT IS FOR INFORMATION PURPOSES ONLY

This communication is intended for illustrative and information purposes only. The plan documents, insurance certificates, and policies will serve as the governing documents to determine plan eligibility, benefits, and payments.

LIMITATIONS AND EXCLUSIONS

Insurance and benefit plans always contain exclusions and limitations. Please see benefit booklets and/or contracts for complete details of coverage and eligibility.

ALL RIGHTS RESERVED

Education Achievement Authority of Michigan reserves the right to amend, modify, or terminate its insurance and benefit plans at any time, including during treatment.

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan, except as otherwise provided below.

(a.) If you decline enrollment because you or your dependent had other group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Medical Program within **30 days** of the loss of that coverage. Your enrollment will become effective on the date you enroll in the Medical Program. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other medical plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Medical Program within **30 days** of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption.

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within **60 days** after either:

(1.) Your or your Eligible Dependent's Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or

(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

(d.) You are eligible to enroll yourself and your Eligible Dependents in the Plan during an Open Enrollment Period. Your enrollment will become effective on the 1st day of the Plan Year following the Open Enrollment Period.

(e.) You may enroll in the Plan an Eligible Dependent child for whom you are required to provide medical coverage pursuant to a Qualified Medical Child Support Order (as defined under ERISA Section 609). This enrollment of an Eligible Dependent will become effective as of the Plan Administrator's qualification and acceptance of the Qualified Medical Child Support Order.

(f.) You are eligible to enroll yourself and your Eligible Dependents in the Plan under any other special circumstances permitted under the applicable Benefits Guide (and subject to the Cafeteria Plan rules outlined in Section 125 of the Internal Revenue Code).

NOTE: You will not be allowed to enroll yourself and/or Eligible Dependents for coverage in the Plan for a Plan Year unless you timely and affirmatively complete the enrollment process by the deadlines set forth above (i.e. within 30 days for loss of coverage or new dependents; within 60 days for Medicaid or CHIP circumstances; within 30 days of receipt of this notice for a dependent under the age of 26; or within the deadline established by the Plan Administrator for Open Enrollment Period).

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

EDUCATION ACHIEVEMENT AUTHORITY OF MICHIGAN
Human Resources Department
3022 W. Grand Blvd., Suite 14-652 Detroit, MI 48202
313-456-3010

Important Disclosures

NOTICE REGARDING PRE-EXISTING CONDITIONS

The Education Achievement Authority of Michigan Group Health Plan (the "Plan") does not impose a pre-existing condition limitation as detailed in the Benefit Guide issued by the insurance carrier. Please review the Benefits Guide carefully (you can obtain another copy of it by contacting the Plan Administrator). The following provides an overview of the preexisting condition limitation that is allowed under the Health Insurance Portability and Accountability Act (HIPAA) as well as protections provided under the Patient Protection and Affordable Care Act of 2010 (PPACA). If the Plan does not impose a pre-existing condition limitation, much of this information does not apply to you; however, this information is provided to make you aware of this important legislation.

The Plan complies with the changes set forth in the PPACA of 2010 and does not impose pre-existing condition exclusions with respect to eligible dependent children who are under 19 years of age. In accordance with PPACA, this change was effective as of the first day of the Plan Year beginning on or after September 23, 2010; and will apply to all other covered individuals on the first day of the Plan Year beginning on or after January 1, 2014.

Pre-existing condition exclusion means that if you have a medical condition before enrolling in the medical program, you might have to wait a certain period of time before the medical program will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month look-back period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a new hire waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the medical program or who has other creditable coverage within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. **To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should promptly give the Plan Administrator a copy of any certificate of creditable coverage (HIPAA Certificates) you have.** If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or insurer. There are also other ways that you can show that you have creditable coverage. Please contact the Plan Administrator if you need help

demonstrating creditable coverage.

Each HIPAA Certificate (or other evidence of creditable coverage) will be reviewed by the Plan Administrator (with the assistance of the prior plan administrator or insurer) to determine its authenticity. Submission of a fraudulent HIPAA Certificate would be considered a federal health care crime under HIPAA and may be punishable by fine and/or imprisonment, and may result in a loss of coverage under this Plan and other employment disciplinary action.

HOW TO REQUEST A CERTIFICATION OF CREDITABLE COVERAGE FROM THIS PLAN:

HIPAA also requires any medical program offered by the Employer to provide certificates of creditable coverage to you after you lose coverage under such medical program. This certificate allows you to use your coverage under the medical program to reduce or eliminate any pre-existing condition exclusion period that might otherwise apply to you when you change health care plans. You also may request a certificate of creditable coverage for periods of coverage on and after July 1, 1996, within 24 months of your loss of coverage. To request a HIPAA Certificate of Creditable Coverage, please contact the insurance company customer service department by calling the phone number on your healthcare identification card. If you are unable to obtain the certificate of coverage through the carrier, or have other questions regarding Pre-existing Conditions, please contact the Plan Administrator for assistance at the address or phone number below.

Date: August 14, 2012

Name of Entity/Sender: Education Achievement Authority of Michigan

Contact: Human Resources Department

Address: 3022 W. Grand Blvd., Suite 14-652 Detroit, MI 48202

Phone Number: 313-456-3010

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT (JANET'S LAW)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. Under the Women's Health and Cancer Rights Act, group health plans and insurers offering mastectomy coverage must also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These services are payable to a patient who is receiving benefits in connection with a mastectomy and elects reconstruction. The physician and patient determine the manner in which these services are performed.

The plan may apply deductibles and copayments consistent

Important Disclosures

with other coverage within the plan. This notice serves as the official annual notice and disclosure of that the fact that the company's health and welfare plan has been designed to comply with this law. This notification is a requirement of the act.

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Services Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

NOTICE REGARDING MICHELLE'S LAW

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law become effective for plan years beginning on or after October 9, 2009.

NOTICE REGARDING NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers offering group health insurance may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer to prescribe a length of stay not in excess of the above periods.

MEDICARE NOTICE

You must notify Education Achievement Authority of Michigan when you or your dependents become Medicare eligible. Education Achievement Authority of Michigan is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll free number to Medicare Coordination of Benefits is 1-800-999-1118.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Non-Creditable Coverage Notice.

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

Date: August 14, 2012

Plan Administrator: Education Achievement Authority of Michigan

Contact: Human Resources Department

Address: 3022 W. Grand Blvd., Suite 14-652 Detroit, MI 48202

Phone Number: 313-456-3010

NOTICE REGARDING PATIENT PROTECTION RIGHTS

The Education Achievement Authority of Michigan group health plan does require members to designate a Primary Care Physician. The following paragraphs outline certain protections under the PPACA and only apply when the Plan requires the designation of a Primary Care Physician.

One of the provisions in the PPACA of 2010 is for plans and insurers that require or allow for the designation of primary care providers by participants to inform the participants of their rights beginning on the first day of the first plan year on or after September 23, 2010.

You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network. The health care professional, however, may be required to comply with certain procedures, including obtain-

Important Disclosures

ing prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals or notifying primary care provider or Plan of treatment decisions.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology health care professionals, please contact the insurer.

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

Date: August 14, 2012

Plan Administrator: Education Achievement Authority of Michigan

Contact: Human Resources Department

Address: 3022 W. Grand Blvd., Suite 14-652 Detroit, MI 48202

Phone Number: 313-456-3010

IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please note that the following notice only applies to individuals who are eligible for Medicare.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to End Stage Renal Disease (ESRD)

If you are covered by 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 Education Achievement Authority of Michigan 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 pro-

vide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Education Achievement Authority of Michigan has determined that the prescription drug coverage offered by their carrier's Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. If 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 through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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 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 pre-

Important Disclosures

mium. 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 your HR Representative. 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 your company 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, visit Social Security at www.socialsecurity.gov, or call 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 (penalty).

Date: August 14, 2012

Name of Entity/Sender: Education Achievement Authority of Michigan

Contact: Human Resources Department

Address: 3022 W. Grand Blvd., Suite 14-652 Detroit, MI 48202

Phone Number: 3131-456-3010



Important Disclosures

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

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, 2011. You should contact your State for further information on Eligibility:

ALABAMA – Medicaid

Website: <http://www.medicaid.alabama.gov>

Phone: 1-800-362-1504

ALASKA – Medicaid

Website: <http://health.hss.state.ak.us/dpa/programs/medicaid/>

Phone (Outside of Anchorage): 1-888-318-8890

Phone (Anchorage): 907-269-6529

ARIZONA – CHIP

Website: <http://www.azahcccs.gov/applicants/default.aspx>

Phone (Outside Maricopa County): 1-877-764-5437

Phone (Maricopa County): 602.417.5437

ARKANSAS – CHIP

Website: <http://www.arkidsfirst.com/>

Phone: 1-888-474-8275

COLORADO – Medicaid and CHIP

Medicaid Website: <http://www.colorado.gov/>

Medicaid Phone (In State): 1-800-866-3513

Medicaid Phone (Out of State): 1-800-221-3943

CHIP Website: <http://www.CHPplus.org>

CHIP Phone: 303-866-3243

CALIFORNIA – Medicaid

Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx

Phone: 1-866-298-8443

FLORIDA – Medicaid

Website: <http://www.flmedicaidtprecovery.com>

Phone: 1-877-357-3268

MAINE – Medicaid

Website: <http://www.maine.gov/dhhs/OIAS/publicassistance/index.html>

Phone: 1-800-572-3839

MASSACHUSETTS – Medicaid and CHIP

Medicaid & CHIP Website: <http://www.mass.gov/MassHealth>

Medicaid & CHIP Phone: 1-800-462-1120

GEORGIA – Medicaid

Website: <http://dch.georgia.gov/>

Click on Programs, then Medicaid

Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP

Medicaid Website: www.accesstohealthinsurance.idaho.gov

Medicaid Phone: 1-800-926-2588

CHIP Website: www.medicaid.idaho.gov

CHIP Phone: 1-800-926-2588

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/

Phone: 1-888-346-9562

INDIANA – Medicaid

Website: <http://www.in.gov/fssa/2408.htm>

Phone: 1-800-889-9948

KANSAS – Medicaid

Website: <https://www.kdheks.gov/hcf>

Phone: 800-792-4884

KENTUCKY – Medicaid

Website: <http://chfs.ky.gov/dms/default.htm>

Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: <http://www.lahipp.dhh.louisiana.gov>

Phone: 1-888-695-2447

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>

Phone: 1-800-755-2604

OKLAHOMA – Medicaid

Website: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

Important Disclosures

STATES OFFERING PREMIUM PAYMENT ASSISTANCE PROGRAMS CONTINUED

MINNESOTA – Medicaid

Website: <http://www.dhs.state.mn.us/>

Click on Health Care, then Medical Assistance

Phone (Outside of Twin City area): 1-800-657-3739

Phone (Twin City area): 651.431.2670

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml>

Telephone: 1-800-694-3084

NEBRASKA – Medicaid

Website: <http://www.dhhs.ne.gov/med/medindex.htm>

Phone: 1-877-255-3092

NEVADA – Medicaid

Medicaid Website: <http://dwss.nv.gov/>

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <http://www.dhhs.nh.gov/ombp/index.htm>

Phone: 603-271-8183

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Medicaid Phone: 1-800-356-1561

CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710

NEW MEXICO – Medicaid and CHIP

Medicaid & CHIP Website: <http://www.hsd.state.nm.us/mad/index.html>

Medicaid & CHIP Phone: 1-888-997-2583

Click on Insure New Mexico

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <http://www.nc.gov>

Phone: 919-855-4100

OREGON – Medicaid and CHIP

Medicaid & CHIP Website:

<http://www.oregon.gov/OHA/OPHP/FHIAP/index.shtml>

Medicaid & CHIP Phone: 1-888-564-9669

PENNSYLVANIA – Medicaid

Website: <http://www.dpw.state.pa.us/hipp>

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: www.dhs.ri.gov

Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: <http://www.scdhhs.gov>

Phone: 1-888-549-0820

TEXAS – Medicaid

Website: <https://www.gethipptexas.com/>

Phone: 1-800-440-0493

UTAH – Medicaid

Website: <http://health.utah.gov/upp>

Phone: 1-866-435-7414

VERMONT – Medicaid

Website: <http://www.greenmountaincare.org>

Telephone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: <http://www.dmas.virginia.gov/rcp-HIPP.htm>

Medicaid Phone: 1-800-432-5924

CHIP Website: <http://www.famis.org/>

CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid

Website: <http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtml>

Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: <http://www.dhhr.wv.gov/bms>

Phone: 304-558-1700

WISCONSIN – Medicaid

Website: <http://www.badgercareplus.org/pubs/p-10095.htm>

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <http://www.health.wyo.gov/healthcarefin/index.html>

Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/ebsa

1-866-444-EBSA (3272)

OMB Control Number 1210-0137

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Ext. 61565



Tips for a Successful Healthcare Experience

Use the following tips to ensure you have a successful healthcare experience:

- Set yourself up for a successful healthcare experience by taking the time to **find a family physician** in your network that you and your family trust. Do this before a health concern arises.
- Did you know that doctors base up to 80% of their diagnoses on what patients tell them about their symptoms, history, and lifestyle? Preparing for a trip to the doctor not only helps you to get your thoughts in order, but also helps you better understand what your doctor is talking about.
 - Bring a list of any and all medications, allergies, and other doctors you might see.
 - Be prepared to help the physician answer questions about your ailment, such as how, what, when, and where the symptoms are occurring in the body.
- **Register with your health insurance carrier's website for online claim tracking and review.**
- Periodically review your personal information to ensure your claims are being processed accurately and timely. Consider taking a Health Risk Assessment and creating a Personal Health Record.
- Ensure you have proper documentation before you see your physician. This includes your proper **medical insurance card** printed with your carrier name, policy number, claims address, and copayment amounts. It's also helpful to bring your benefit plan summary with you just in case there is a question about copays, deductibles, or coinsurance. **Pay the correct copayment every time you see your physician.** (temporary cards are available online)
- When seeing your physicians, **confirm that they have your updated information on file.** This includes:
 - Group policy number
 - Individual identification number
- If receiving a routine physical examination, remind **your physician to file it as routine preventive care** instead of with a medical diagnosis.
- If you encounter a problem regarding eligibility **make sure the provider is using your most up to date policy and individual identification numbers;** old information can cause unnecessary confusion. These problems are often easily resolved over the phone.
- **Contact the insurance company if you believe your claim has not been paid properly or in a timely manner.** Contact your health provider if you find the insurance carrier does not have the claim in question. For claim questions, please call the insurance carrier at the number on your card.
- **Keep a record of all communication** with your insurance carrier or healthcare provider. Include the date and time of any conversation and the name of the person with whom you spoke.



Choosing the Right Care Facility

With the rise of convenience care and urgent care clinics, and varying healthcare plans, it can be confusing untangling the web of care options available to you. The following should serve as a guide to help you successfully choose the right healthcare facility for your condition.

Primary Care Physician (PCP)

When you or a loved one is ill or needs medical care, but it is not an emergency situation, it is best to visit your primary care physician. Your PCP knows you and your health history and has access to your medical records. In addition, you most likely will pay the least amount of out of pocket when visiting your PCP versus a convenience care or emergency room facility.

Convenience Care Clinics

Located in retail stores such as CVS, Walgreens and Target, convenience care clinics are staffed by medical professionals and do not require an appointment. These clinics are best utilized when you have a non-emergency condition and you are not able to get an appointment with your primary care physician. Services are often provided at a lower out of pocket cost than an urgent care clinic or emergency room visit.

Typical conditions that may be treated at a Convenience Care Clinic include:

- Common infections (e.g.: bronchitis, bladder infections, ear infections, pink eye, strep throat)
- Minor skin conditions (e.g.: athlete's foot, cold sores; minor sunburn, poison ivy)
- Flu shots

This is a sample list and not all-inclusive. For a full listing of services please visit each clinic's website. To find an in-network Convenience Care Clinic near you visit www.bcbsm.com or www.mibcn.com.

Urgent Care Clinics

Urgent care clinics are a good option when you require urgent care outside your doctor's regular office hours or you are unable to be seen by your doctor immediately.

Typical conditions that may be treated at an urgent care clinic include:

- Sprains

- Small cuts
- Strains
- Sore throats
- Mild asthma attacks
- Rashes
- Minor infections

Services vary per clinic. If you choose to visit an urgent care clinic, visit www.bcbsm.com or www.mibcn.com call the toll-free number on the back of your medical card to ensure the clinic is in-network.

Emergency Room

If you or your loved one is experiencing an emergent medical condition you should go to the nearest emergency room or call 911. In an emergency, all facilities are considered in-network.

An emergent medical condition is any condition (including severe pain) which you believe that without immediate medical care may result in:

- Serious jeopardy to your or your loved one's health, including the health of a pregnant woman or her unborn child
- Serious impairment to your or your loved one's bodily functions
- Serious dysfunction of any of your or your loved one's bodily organ or part

Some examples of emergent conditions may include the following:

- Heavy bleeding
- Large open wounds
- Sudden change in vision
- Chest pain
- Sudden weakness or trouble walking
- Major burns
- Spinal injuries
- Severe head injuries
- Difficulty breathing

This list only provides examples and is not intended as an exclusive list. If you believe you or your loved one is experiencing an emergent medical condition, you should go to the nearest emergency room or call 911, even if your symptoms are not described here. We recommend that you seek routine medical care from your

Nine Ways to Exercise When Short on Time

We all know exercise can help us improve our health and lose weight. Yet, 25 percent of adults don't exercise at all and a whopping 60 percent do not get the recommend amount of exercise, according to the U.S. Surgeon General. Who has the time to exercise when juggling work, school, family and more? It's worth squeezing it in, though, because regular exercise can relieve daily stress and lift your mood. At the same time, you can reduce your risks of diabetes, high blood pressure and heart disease. Aim to be active for at least 30 minutes most days. Check with your doctor before you start or increase your activity level.

Tips for Fitting in Fitness

- **Wake up earlier.** Do stretches and jumping jacks or follow a short exercise DVD.
- **Find a workout buddy.** Exercising with a friend is more fun and a good motivator.
- **Change into exercise clothes before leaving work.** You'll be ready for a short walk as soon as you get home.
- **Schedule your fitness activities.** Put exercise on your calendar.
- **Acknowledge your successes.** Keep a log of all the times you make a healthy choice to move more and reward yourself!
- **Create a home gym.** A jump rope, a stability ball, exercise bands and dumbbells don't cost much or take up much room.
- **Move while you watch TV.** Don't sit idly - or worse, get a snack - during commercials. Do sit-ups or jog in place instead.
- **Play games with your kids.** Whether playing ball outside or tennis on the Nintendo Wii, there are lots of ways to play with your



kids and exercise.

- **Stepping it up** After you've built short periods of activity into your day, think about times when you could lengthen each burst by a few minutes.

Regular exercise will boost your energy level and, along with restricting calories, is important for weight loss and maintaining a healthy weight.

Preventing the Spread of Infection & Illness

Keeping hands clean is one of the best ways to prevent the spread of infection and illness. Handwashing is easy to do and it's one of the most effective ways to prevent the spread of many types of infection and illness in all settings—from your home and workplace to child care facilities and hospitals. Clean hands can stop germs from spreading from one person to another and throughout an entire community. Washing hands with soap and water is the best way to reduce the number of germs on them.

When should you wash your hands?

- Before, during, and after preparing food
- Before eating food
- After using the toilet
- After changing diapers

- Before and after caring for someone who is sick
- After blowing your nose, coughing, or sneezing
- After touching an animal or animal waste
- After touching garbage
- Before and after treating a cut or wound

What is the right way to wash your hands?

- Wet your hands with clean running water and apply soap.
- Rub your hands together to make a lather and scrub them well
- Continue rubbing your hands for at least 20 seconds.
- Rinse your hands well under running water.
- Dry your hands using a clean towel or air dry.



Benefit Summaries



Client: Education Achievement Sys

Community BlueSM PPO – Plan 4A

Benefits-at-a-Glance - w/CI, PCD

The information in this document is based on BCBSM's current interpretation of the Patient Protection and Affordable Care Act (PPACA). Interpretations of PPACA vary and the federal government continues to issue guidance on how PPACA should be interpreted and applied. Efforts will be made to update this document as more information about PPACA becomes available. This BAAG is only an educational tool and should not be relied upon as legal or compliance advice. Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

	In-network	Out-of-network *
Member's responsibility (deductibles, copays and dollar maximums)		
Deductibles	\$500 for one member, \$1,000 for the family (when two or more members are covered under your contract) each calendar year Note: Deductible may be waived if service is performed in a PPO physician's office.	\$1,000 for one member, \$2,000 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network deductible amounts also apply toward the in-network deductible.
Fixed dollar copays	<ul style="list-style-type: none"> \$20 copay for office visits \$150 copay for emergency room visit 	\$150 copay for emergency room visit
Percent copays Note: Copays apply once the deductible has been met.	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing 20% of approved amount for most other covered services (copay waived if service is performed in a PPO physician's office) See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing 40% of approved amount for most other covered services See "Mental health care and substance abuse treatment" section for mental health and substance abuse percent copays.
Annual copay dollar maximums – applies to copays for all covered services – including mental health and substance abuse services – but does not apply to fixed dollar copays and private duty nursing percent copays Note: For groups with 50 or fewer employees or groups that are not subject to the MHP law, mental health care and substance abuse treatment copays do not contribute to the copay dollar maximum.	\$1,500 for one member, \$3,000 for two or more members each calendar year	\$3,000 for one member, \$6,000 for two or more members each calendar year Note: Out-of-network copays also apply toward the in-network maximum.
Lifetime dollar maximum	None	

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

* Services from a provider for which there is no Michigan PPO network and services from a non-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. Cost-sharing may differ when you obtain covered services outside of Michigan. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.



In-network

Out-of-network *

Preventive care services

Health maintenance exam – includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay), one per member per calendar year	Not covered
Gynecological exam	100% (no deductible or copay), one per member per calendar year	Not covered
Pap smear screening – laboratory and pathology services	100% (no deductible or copay), one per member per calendar year	Not covered
Well-baby and child care visits	100% (no deductible or copay) <ul style="list-style-type: none"> • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit 	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay)	Not covered
Fecal occult blood screening	100% (no deductible or copay), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay), one per member per calendar year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible Note: Non-network readings and interpretations are payable only when the screening mammogram itself is performed by a network provider.
	One per member per calendar year	
Colonoscopy – routine or medically necessary	100% (no deductible or copay) for the first billed colonoscopy Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and percent copay.	60% after out-of-network deductible
	One per member per calendar year	

Physician office services

Office visits	\$20 copay per office visit	60% after out-of-network deductible, must be medically necessary
Outpatient and home medical care visits	80% after in-network deductible	60% after out-of-network deductible, must be medically necessary
Office consultations	\$20 copay per office visit	60% after out-of-network deductible, must be medically necessary
Urgent care visits	\$20 copay per office visit	60% after out-of-network deductible, must be medically necessary

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In-network

Out-of-network *

Emergency medical care

Hospital emergency room	\$150 copay per visit (copay waived if a	\$150 copay per visit (copay waived if a
Ambulance services – must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician

Prenatal and postnatal care	100% (no deductible or copay) Includes covered services provided by a certified nurse midwife	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible Includes covered services provided by a certified nurse midwife	60% after out-of-network deductible

Hospital care

Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies Note: Nonemergency services must be rendered in a participating hospital.	80% after in-network deductible	60% after out-of-network deductible
Unlimited days		
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Skilled nursing care – must be in a participating skilled nursing facility	80% after in-network deductible	80% after in-network deductible
Limited to a maximum of 120 days per member per calendar year		
Hospice care	100% (no deductible or copay)	100% (no deductible or copay)
Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods – provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)		
Home health care – must be medically necessary and provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Home infusion therapy – must be medically necessary and given by participating home infusion therapy providers	80% after in-network deductible	80% after in-network deductible

Surgical services

Surgery – includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay)	60% after out-of-network deductible
Voluntary sterilization	80% after in-network deductible	60% after out-of-network deductible

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In-network

Out-of-network *

Human organ transplants

Specified human organ transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay)	100% (no deductible or copay) – in designated facilities only
Bone marrow transplants – when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Mental health care and substance abuse treatment

Note: If your employer has **51 or more** employees (including seasonal and part-time) and is subject to the MHP law, covered mental health and substance abuse services are subject to the following copays. Mental health and substance abuse copays are included in the annual copay dollar maximums for all covered services. See “Annual copay dollar maximums” section for this amount. If you receive your health care benefits through a collectively bargained agreement, please contact your employer and/or union to determine when or if this benefit level applies to your plan.

Inpatient mental health care	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	80% after in-network deductible	60% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic • Physician’s office	80% after in-network deductible	80% after in-network deductible, in participating facilities only
	80% after in-network deductible **	60% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only	80% after in-network deductible **	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

** Mental health and substance abuse procedures that are the equivalent of an office visit (consultative services rendered in the physician’s office) will be treated and processed like an office visit, subject to the fixed dollar office visit copay.

Note: If your employer has **50 or fewer** employees (all employees, not just eligible employees), covered mental health and substance abuse services are subject to the following copay amounts. Mental health and substance abuse copays are **not** limited to a copay maximum.

Inpatient mental health care	50% after in-network deductible	50% after out-of-network deductible
	Unlimited days	
Inpatient substance abuse treatment	50% after in-network deductible	50% after out-of-network deductible
	Unlimited days	
Outpatient mental health care: • Facility and clinic • Physician’s office	50% after in-network deductible	50% after in-network deductible, in participating facilities only
	50% (no deductible)	50% after out-of-network deductible
Outpatient substance abuse treatment – in approved facilities only	50% after in-network deductible	50% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

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In-network

Out-of-network *

Other covered services

Outpatient Diabetes Management Program (ODMP) Note: Effective July 1, 2011, when you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	80% after in-network deductible for diabetes medical supplies; 100% (no deductible or copay) for diabetes self-management training	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$20 copay per office visit Limited to a combined maximum of 12 visits per member per calendar year	60% after out-of-network deductible
Outpatient physical, speech and occupational therapy – provided for rehabilitation	80% after in-network deductible Limited to a combined maximum of 60 visits per member per calendar year	60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
Durable medical equipment	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing	50% after in-network deductible	50% after in-network deductible
Prescription drugs	Not covered	Not covered

Additional Riders Selected

<p>Rider CI, contraceptive injections Rider PCD, prescription contraceptive devices</p>	<p>Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and IUDs, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered).</p> <p>Note: These riders are only available as part of a prescription drug package. Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by a network provider.) Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.</p>
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Client: Education Achievement Sys
Blue Preferred[®] Rx Prescription Drug Coverage
with \$7 Generic / \$35 Formulary (Preferred) Brand / \$70 Nonformulary
(Nonpreferred) Brand Triple-Tier Copay Open Formulary
Benefits-at-a-Glance - w/PD-CM

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible, copay and/or coinsurance. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Specialty Drugs – The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel[®] and Humira[®]) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com. Log in under *I am a Member*. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

Member's responsibility (copays)

		90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
Tier 1 – Generic or prescribed over-the-counter drugs	1 to 30-day period	\$7 copay	\$7 copay	\$7 copay	\$7 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$14 copay	No coverage	No coverage
	84 to 90-day period	\$14 copay	\$14 copay	No coverage	No coverage
Tier 2 – Formulary (preferred) brand-name drugs	1 to 30-day period	\$35 copay	\$35 copay	\$35 copay	\$35 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$70 copay	No coverage	No coverage
	84 to 90-day period	\$70 copay	\$70 copay	No coverage	No coverage
Tier 3 – Nonformulary (nonpreferred) brand-name drugs	1 to 30-day period	\$70 copay	\$70 copay	\$70 copay	\$70 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	\$140 copay	No coverage	No coverage
	84 to 90-day period	\$140 copay	\$140 copay	No coverage	No coverage

Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.

* BCBSM will not pay for drugs obtained from non-network mail order providers, including Internet providers.

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Covered services

	90-day retail network pharmacy	* Network mail order provider	Network pharmacy (not part of the 90-day retail network)	Non-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug

* BCBSM will not pay for drugs obtained from non-network mail order providers, including Internet providers.

Features of your prescription drug plan

BCBSM Custom Formulary	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the formulary is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> ▪ Tier 1 (generic) – Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay, making them the most cost-effective option for the treatment. ▪ Tier 2 (preferred brand) – Tier 2 includes brand-name drugs from the Custom Formulary. Preferred brand name drugs are also safe and effective, but require a higher copay. ▪ Tier 3 (nonpreferred brand) – Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay for these drugs.
Prior authorization/step therapy	<p>A process that requires a physician to obtain approval from BCBSM before select prescription drugs (drugs identified by BCBSM as requiring prior authorization) will be covered. Step Therapy, an initial step in the Prior Authorization process, applies criteria to select drugs to determine if a less costly prescription drug may be used for the same drug therapy. Some over-the-counter medications may be covered under step therapy guidelines. This also applies to mail order drugs. Claims that do not meet Step Therapy criteria require prior authorization. Details about which drugs require Prior Authorization or Step Therapy are available online at bcbsm.com. Log in under <i>I am a Member</i> and click on <i>Prescription Drugs</i>.</p>
Mandatory maximum allowable cost drugs	<p>If your prescription is filled by a network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay regardless of whether you or your physician requests the brand name drug. Exception: If your physician requests and receives authorization for a nonpreferred brand-name drug with a generic equivalent from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your applicable copay. Note: This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</p>



Drug interchange and generic copay waiver	BCBSM's drug interchange and generic copay waiver programs encourage physicians to prescribe a less-costly generic equivalent. If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.
Quantity limits	To stay consistent with FDA approved labeling for drugs, some medications may have quantity limits. A list of these drugs is available at bcbsm.com .

Benefits-at-a-Glance for BCN Basic Package Plan



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Client: Education Achievement Au

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Deductible, Copays, Coinsurance and Dollar Maximums

Deductible	None
Copays/Coinsurance	\$25 for PCP office visits, \$35 referral physician visit, \$35 for urgent care visits, \$50 for ambulance services, \$100 for emergency room visits and \$5 for allergy injections
• Fixed Dollar Copay	
• Coinsurance	20% and 50% for select services as noted below
Copay/Coinsurance Dollar Maximums	
• Fixed Dollar Copay	None
• Coinsurance	\$1,500 per member, \$3,000 per family per calendar year

Preventive Services

Health Maintenance Exam	Covered – 100%
Annual Gynecological Exam	Covered – 100%
Pap Smear Screening – laboratory services only	Covered – 100%
Well-Baby and Child Care	Covered – 100%
Immunizations – pediatric and adult	Covered – 100%
Prostate Specific Antigen (PSA) Screening – laboratory services only	Covered – 100%

Mammography

Mammography Screening	Covered – 100%
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Physician Office Services

Office Visits	Covered – \$25 copay*
Consulting Specialist Care – when referred for other than preventive services	Covered – \$35 copay*

Emergency Medical Care

Hospital Emergency Room – copay waived if admitted, inpatient hospital benefits apply	Covered – \$100 copay*
Urgent Care Center	Covered – \$35 copay*
Ambulance Services – medically necessary	Covered – \$50 copay applies to the annual maximum of \$1,500 per member, \$3,000 per family

Diagnostic Services

Laboratory and Pathology Tests	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit
Radiation Therapy	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit

Benefits-at-a-Glance for BCN Basic Package Plan



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Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	Covered – \$25 copay*
Delivery and Nursery Care	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family

Hospital Care

General Nursing Care, Hospital Services and Supplies	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family
Outpatient Surgery – see member certificate for specific surgical copays	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family. Office visit copay may apply per member, per visit

Alternatives to Hospital Care

Skilled Nursing Care	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family
Hospice Care	Covered – 100%
Home Health Care	Covered – 80%, limited to a 60-day period per calendar year; 20% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family

Surgical Services

Surgery – includes all related surgical services and anesthesia. See member certificate for specific surgical copays.	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family
Voluntary Sterilization	Covered – 50%* on all associated costs
Human Organ Transplants	Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care and Substance Abuse Care	Mental Health Care: Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family when authorized Substance Abuse Care: Covered – 80%; 20% coinsurance applies to the annual maximum of \$1,500 per member, \$3,000 per family when authorized
Outpatient Mental Health Care	Covered – \$25 copay*
Outpatient Substance Abuse Care	Covered – \$25 copay*

Other Services

Allergy Testing and Therapy	Covered – 50% for evaluation
Allergy Injections	Covered – \$5 copay
Chiropractic Spinal Manipulation – when referred	Covered – \$35 copay*
Outpatient Physical, Speech and Occupational Therapy – subject to significant improvement within 60 days	Covered – 50%, up to 30 visits for a 60-day period; 50% copay applies to the annual maximum of \$1,500 per member, \$3,000 per family
Infertility Counseling and Treatment (excluding In-vitro fertilization)	Covered – 50% on all associated costs*
Durable Medical Equipment	Covered – 50%*
Prosthetic and Orthotic Appliances	Covered – 50%*

*Copay/Coinsurance does not apply to Annual Maximum

BCN-BASIC, BAS25, 35RPOV, UR35, ER100, MHSAP

Mar 2012

Benefits-at-a-Glance for \$10/\$40 Prescription Drug Coverage



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Covered Drugs

Tier 1 – Formulary Preferred	Covered – \$10 copay
Tier 2 – Formulary Option	Covered – \$40 copay
Formulary Brand Name when Generic is available	Covered – Difference in cost between brand name drug and generic drug plus \$40 copay
Tier 3 – Non-Formulary Drugs	Not Covered
Sexual Dysfunction Drugs	Covered – 50%
Contraceptives	Covered – Applicable tiered copay will apply
Retail: 31-83 day supply	Not Covered
Retail: 84-90 day supply	Covered – Two times the tiered copayments defined above
Mail Order Prescription Drugs: 31-90 day supply	Covered – Two times the tiered copayments defined above

Definitions

Brand Name Drugs	Prescription drugs which are manufactured and marketed under a registered trade name or trademark.
Covered Drugs	Prescription drugs (Generic, Brand Name, Compounded Medication, or Health Habit) which are prescribed by a BCN affiliated provider and obtained through a participating pharmacy. Certain covered drugs are a benefit only if a BCN affiliated provider certifies to BCN and BCN agrees that the covered drug in question is medically necessary. Those drugs are not payable without preauthorization by BCN.
Generic Drugs	Prescription drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark.
Tier 1 Formulary Preferred	Prescription drugs that have a proven record for safety and effectiveness. Most Generic Drugs are Formulary Preferred. These drugs may have a lower copayment compared to Tier 2 Formulary Option Drugs.
Tier 2 Formulary Options	Drugs other than Tier 1 Formulary Preferred drugs that also have a proven record for safety and effectiveness. Since more cost effective therapy or a Generic alternative is available for these drugs, a higher copayment may be required.
Tier 3 Non-Formulary Drugs	Prescription Drugs not included in the BCN Formulary. These drugs may not have a proven record for safety, or their clinical value may not be as high as the BCN Formulary alternatives.

1040DC, MOPD2C



Client: Education Achievement Sys

Traditional Plus Dental Coverage – Plan 7 Benefits-at-a-Glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten or any other plan documents your group uses, if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

With Traditional Plus Dental, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Dental Network of America (DNoA) Preferred Network of PPO dentists.

DNoA Preferred Network – Blue Dental members have unmatched access to PPO dentists through the DNoA Preferred Network, which offers nearly 200,000 dentist access points* nationwide. DNoA Preferred Network dentists agree to accept our approved amount as payment in full and participate on all claims. Members also receive discounts on noncovered services when they use PPO dentists. To find a DNoA Preferred Network dentist near you, please visit BCBSM.com/bluedental or call 1-888-826-8152.

* A dentist access point is any place a member can see a dentist to receive high-quality dental care. For example, one dentist practicing in two locations would be two access points.

Blue Par SelectSM arrangement– Most dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services — members pay only applicable copays and deductibles, along with any fees for noncovered services. To find a dentist who may participate with BCBSM, please visit BCBSM.com/bluedental.

Note: Members who go to nonparticipating dentists may be billed for any difference between our approved amount and the dentist's charge.

Member's responsibility (copays and dollar maximums)

Copays	
• Class I services	None
• Class II services	25% of approved amount
• Class III services	50% of approved amount
• Class IV services	50% of approved amount
Dollar maximums	
• Annual maximum (for Class I, II and III services)	\$1,500 per member
• Lifetime maximum (for Class IV services)	\$1,500 per member

Class I services

Oral exams	100% of approved amount, twice per calendar year
A set (up to 4 films) of bitewing x-rays	
• For members age 15 and younger	100% of approved amount, once in a calendar year
• For members age 16 and older	100% of approved amount, once every 24 months
Panoramic or full-mouth x-rays	100% of approved amount, once every 84 months
Diagnostic x-rays	100% of approved amount, any combination of 6 individual or sets of films each calendar year
Dental prophylaxis (teeth cleaning)	100% of approved amount, twice per calendar year
Pit and fissure sealants – for members age 16 and younger	100% of approved amount, once per tooth every 36 months when applied to the first and second permanent molars
Palliative (emergency) treatment	100% of approved amount
Fluoride treatment – for members age 14 and younger	100% of approved amount, once per calendar year
Space maintainers – missing posterior (back) primary teeth – for members age 16 and younger	100% of approved amount, once per quadrant per lifetime

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.



Class II services

Fillings – permanent (adult) teeth	75% of approved amount, replacement fillings covered after 48 months or more after initial filling
Fillings – primary (baby) teeth	75% of approved amount, replacement fillings covered after 24 months or more after initial filling
Recementation of crowns, veneers, inlays, onlays and bridges	75% of approved amount, three times per tooth per calendar year after six months from original restoration
Oral surgery including extractions	75% of approved amount
Root canal treatment – permanent tooth	75% of approved amount, once every 36 months for tooth with one or more canals
Scaling and root planing	75% of approved amount, once every 36 months per quadrant
Limited occlusal adjustments	75% of approved amount, limited occlusal adjustments covered up to five times in a 60-month period
Occlusal biteguards	75% of approved amount, once every 60 months (repair and reline to occlusal biteguards covered once every 60 months)
General anesthesia or IV sedation	75% of approved amount, when medically necessary and performed with oral surgery
Repairs and adjustments of a partial or complete denture	75% of approved amount, six months or more after it is delivered
Relining or rebasing of a partial or complete denture	75% of approved amount, once every 36 months per arch
Tissue conditioning	75% of approved amount, once every 36 months per arch
Periodontic maintenance	75% of approved amount

Class III services

Onlays, crowns and veneer restorations – permanent teeth – for members age 12 and older	50% of approved amount, once every 84 months per tooth
Removable dentures (complete and partial)	50% of approved amount, once every 84 months
Bridges (fixed partial dentures) – for members age 16 and older	50% of approved amount, once every 84 months after original was delivered
Endosteal implants – for members age 16 and older who are covered at the time of the actual implant placement	50% of approved amount, once per tooth in a member lifetime when implant placement is for teeth numbered 2 through 15 and 18 through 31

Class IV services – Orthodontic services for dependents under age 19

Minor treatment for tooth guidance appliances	50% of approved amount
Minor treatment to control harmful habits	50% of approved amount
Interceptive and comprehensive orthodontic treatment	50% of approved amount
Post-treatment stabilization	50% of approved amount
Cephalometric film (skull) and diagnostic photos	50% of approved amount

Note: For non-urgent, complex or expensive dental treatment such as crowns, bridges or dentures, members should encourage their dentist to submit the claim to Blue Cross for predetermination **before** treatment begins.



Client: Education Achievement Sys

Blue Vision SM Choice Benefits-at-a-Glance

This is intended as an easy-to-read summary. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Cross Blue Shield of Michigan certificates and riders. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and/or copay amounts required by your plan. This coverage is provided pursuant to a contract entered into in the state of Michigan and will be construed under the jurisdiction of and according to the laws of the state of Michigan.

Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. VSP is an independent company providing vision benefit services for Blue members. To find a VSP doctor, call **800-877-7195** or log onto the VSP Web site at **vsp.com**.

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both.

	VSP network doctor	Non-VSP provider
Member's responsibility (copays)		
Eye exam	\$10 copay	\$10 copay applies to charge
Prescription glasses (lenses and/or frames)	A combined \$25 copay	Member responsible for difference between approved amount and provider's charge, less a \$25 copay
Medically necessary contact lenses	\$25 copay	Member responsible for difference between approved amount and provider's charge, less a \$25 copay

Eye exam		
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	Covered – \$10 copay	Reimbursement up to \$35, less a \$10 copay (member responsible for any difference)
One eye exam in any period of 12 consecutive months		

Lenses and frames		
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. Note: Discounts on additional prescription glasses and savings on lens extras when obtained from a VSP doctor.	Covered – \$25 copay (one copay applies to both lenses and frames)	Reimbursement up to predetermined amount based on lense type after copay (member responsible for any difference)
One pair of lenses, with or without frames, in any period of 12 consecutive months		
Standard frames Note: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	Covered – \$25 copay (one copay applies to both frames and lenses)	Reimbursement up to \$45, less a \$25 copay (member responsible for any difference)
One frame in any period of 24 consecutive months		



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VSP network doctor

Non-VSP provider

Contact lenses

Medically necessary contact lenses (requires prior authorization approval from VSP and must meet criteria of medically necessary)	Covered – \$25 copay	Reimbursement up to \$210 after a \$25 copay (member responsible for any difference)
One pair of contact lenses in any period of 12 consecutive months		
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	Covered – \$120 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance) Note: Effective 1/1/09, the allowance will increase to \$130.	Covered – \$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
One pair of contact lenses in any period of 12 consecutive months		



Voluntary Term Life Insurance

to help protect your family's financial future

This unique Term Life Insurance product will allow you to purchase valuable life insurance coverage for yourself, your spouse, and your dependent children. During this initial enrollment, if you purchase a minimum of \$10,000 in Term Life Insurance for yourself, you have the ability to increase your amount of life insurance (up to the maximum amount) at any future open enrollment period with NO HEALTH QUESTIONS ASKED, as long as you are still actively working. Employees, Spouses and Children must meet our “actively at work” criteria in order to enroll.

Yourself

- Amounts in \$10,000 increments
- Maximum amount is the lesser of 5x annual earnings or \$500,000
- Rates are based upon Employee’s age (Plan Year – Birth Year)
- **Guaranteed Issue Amount: \$40,000**

Your Spouse

- Amounts in \$5,000 increments
- Maximum amount is the lesser of 100% of the Employee Life amount or \$500,000
- Rates are based upon Spouse’s age (Plan Year – Birth Year)
- **Spouse Guaranteed Issue Amount: \$15,000**

Your Children

- Amounts in \$2,000 increments
- Maximum amount is the lesser of 100% of the Employee Life amount or \$10,000
- **Child Guaranteed Issue Amount: \$10,000**

Rates and Cost Information for Voluntary Group Term Life/AD&D

	Employee Monthly Rates per \$10,000	Spouse Rates per \$5,000	Child Monthly Rate per \$2,000
Age	Rate	Rate	\$1.00
15-24	\$0.95	\$0.55	
25-29	\$1.04	\$0.61	
30-34	\$1.21	\$0.73	
35-39	\$1.60	\$1.00	
40-44	\$2.16	\$1.36	
45-49	\$3.26	\$2.04	
50-54	\$5.02	\$3.10	
55-59	\$7.55	\$4.67	
60-64	\$11.60	\$7.88	
65-69	\$19.92	\$13.37	
70-74	\$35.30	\$23.69	
75+	\$68.90	\$47.31	

Rate Guarantee: 3 Years (subject to the policy terms)

Note: Please refer to contract for provisions and exclusions. This document provides an overview of your coverage and does not serve as a Summary Plan Description, Contract, or Plan Document. Rates attached are for illustrative purposes only.



Group Voluntary Long Term Disability

If you're sidelined, will your bank account also be disabled? Not if you have Voluntary Long Term Disability insurance with Unum. Disability insurance can pay you a percentage of your gross monthly salary if you become injured or ill due to a covered disability. You now have the ability to protect one of your biggest assets: Your Income!

Plan Details:

Benefit Percentage:	Up to 60% of monthly earnings
Maximum Benefit:	\$5,000 per month
Minimum Benefit:	Greater of \$100 or 10% of the gross disability payment
Elimination Period:	90 days
Accumulation Feature:	180 days
Benefit Duration:	To age 65/Reducing Benefit Duration (ADEA I)

Product Features:

- Guaranteed Issue opportunity with NO medical questions
- Rehabilitation and Return to Work Assistance Available
- Work-life Balance Employee Assistance Program Available
- Worldwide Emergency Travel Assistance Available
- 12/12/24 Pre-Existing Condition
- 24-month Mental Illness & Self Reported Symptoms limitation

Rate Table:

Employee Age Band	Monthly Cost Per \$100 of Covered Payroll
15-24	\$0.08
25-29	\$0.13
30-34	\$0.24
35-39	\$0.34
40-44	\$0.50
45-49	\$0.67
50-54	\$0.76
55-59	\$0.85
60-64	\$0.88
65-69	\$0.60
70+	\$0.56

Note: Please refer to contract for provisions and exclusions. This document provides an overview of your coverage and does not serve as a Summary Plan Description, Contract, or Plan Document. Rates attached are for illustrative purposes only.