Detroit Public Schools Community District

2018 Employee Benefit Guide

DPSCD

Plan Year January 1, 2018 through December 31, 2018

Table of Contents

*** Medicare Part D Notice**

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 40 for more details.

* This booklet is intended to describe the essential features of your health plans in general terms. It is not intended to be a full description of coverage. All efforts have been made to correctly summarize the level of benefits, however, if an error has been made in the summary description, the Certificate of Coverage issued by the provider will supersede this document.

Enrollment Guide

This benefit guide is designed to help you understand your 2018 benefits and assist in keeping you and your family healthy. Please read it carefully and keep a copy for future reference.

Benefit Eligibility

DPSCD provides medical coverage to eligible employees and dependents. There are five possible coverage status levels:

- Employee Only
- Employee + Child or DPSCD Spouse
- Employee + Non-DPSCD Spouse
- Employee + Family with DPSCD Spouse
- Employee + Family with Non-DPSCD Spouse

Please note: For medical only, children are covered until the end of the month in which they reach age 26, whether or not a full-time student. For vision and dental, the plan will terminate at the end of the month of the dependents' 19th birthday. Children who are full-time students may stay on their parent's dental and vision plans until the end of the month in which they turn age 25 so long as the employee provides proof of the dependent's full-time enrollment.

A dependent is defined as a person who is related to you by blood or marriage or considered a legal dependent through a court appointed guardianship, foster children, etc. Please review your dependent information thoroughly. You will be responsible for keeping this information current. You will need the following information to enroll each dependent:

- Name
- Relationship
- Date of Birth
- Gender
- Social Security Number
- Disability Status, if applicable
- Birth Certificate (First Time Enrolling Child)
- Proof of Marriage* (If First Time Enrolling Spouse)

*Proof of Marriage = Official Tax Documents or Marriage Certificate.

Coverage Change Rules

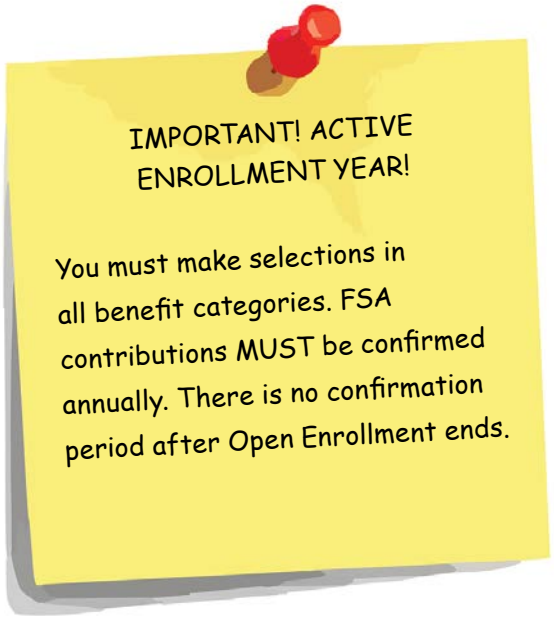
The IRS provides strict regulations about changes to pre-tax elections during the plan year. If you experience a qualified IRS family status change midyear, you are permitted to make a change, provided the change request occurs within 30 days of the event.

If the change request is not completed within 30 days of the event, you will not be able to change your health elections until the following year's benefits Open Enrollment period, typically held in November.

A mid-year change request must be consistent with the qualified life event, and some require documentation be provided within 30 days of the event. For a detailed list of mid-year changes, please refer to the Qualified Life Event chart on page 45. Please contact the DPSCD Benefits Solution Center at (888) 447-9038 with any questions.

Enrollment Contacts

DPSCD ONLINE BENEFIT CENTER
(Health, Dental, Vision)
www.detroitk12.bswift.com
Benefit Solution Center: (888) 447-9038
Monday – Friday: 8:30am to 5:00pm
Email: *servicecenter@kapnick.com*



Enrollment Information

Open Enrollment

Open Enrollment is your opportunity to elect or waive medical, dental, vision, and employee supplemental life insurance coverage, and participate in the Flexible Spending Accounts.

- Open Enrollment will take place from **Monday, November 27 – Sunday, December 10, 2017.** All benefit eligible employees including those electing "no coverage" must log onto the DPSCD Online Benefit Center and make their benefit selections for 2018 during this timeframe.
- Benefit elections will be effective January 1, 2018.
- There is NO confirmation period after the open enrollment period has ended. You will not be able to make any changes to your elections until the next Open Enrollment, unless you have a qualified life event. See page 45 for more details.
- DPSCD Benefit Solution Center – Get answers to your benefits questions Monday-Friday 8:30am-5:00pm (888) 447-9038.
- DPSCD Online Benefit Center - Enroll in your benefits online at *www.detroitk12.bswift.com*.
- Enhanced Flexible Spending Account tools including MyBenny debit card and Kapnick FSA1mobile app.

New Hire Enrollment

This is your opportunity to elect or waive medical, dental, vision, and employee supplemental life insurance coverage and participate in the Flexible Spending Accounts.

- You must submit your enrollment online within 30 days of your hire date. If you do not complete your enrollment during this period, you will have NO COVERAGE for the remainder of the plan year.
- You will not be able to make any changes to your elections until the next Open Enrollment, unless you have a qualified life event. See page 45 for more details.
- Your elected benefits will be effective the 1st day of the month following your hire date. For example, if you are hired November 3rd, your benefits will be effective on December 1st.

DPSCD Email

1. Open your web browser and go to *https://outlook.office365.com.*
2. Enter the user name and password you use to log onto the computer.
3. If you cannot access your account, please call the DPSCD Help Desk at (313) 576-0100 to obtain your temporary password. (It may take several minutes for your password to become effective).
4. Upon your initial login, you will be required to reset your password. Please note: All passwords must be reset from a DPSCD computer that is connected to the DPSCD Network.
5. Your new password must be at least 8 characters and include at least 1 capital letter, 1 lower case letter, and at least 1 number and not used in the last 18 months.

New for 2018

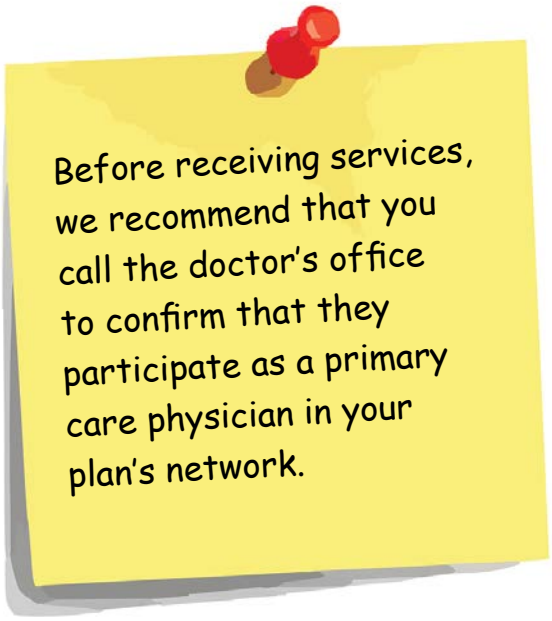
For 2018, DPSCD will be offering pharmacy benefit coverage through BCN. You will have only one insurance card for both medical and pharmacy benefits. A new card will be sent to you in the mail. Please see pages 9 and 10 for more information about your new pharmacy benefits with BCN.

Detroit Public Schools Community District (DPSCD) continues its' partnership with Blue Cross Blue Shield of Michigan's Blue Care Network (BCN) for Health Insurance for 2018. DPSCD will continue to offer three different health engagement HMO plans: Core, Core Plus, and Premium. All three BCN plans will provide excellent care for our employees and their families while promoting an atmosphere of health and wellness. Each employee can select the most appropriate coverage based on their individual needs. As all plans are HMO's, they will still require each member to select a Primary Care Physician (PCP) when you enroll. (Each family member may select a different PCP). The online healthcare feature will still be available to all BCN members. Online healthcare offers a 24/7 convenient and quick way to receive care.

- DPSCD Core Plan and Core+ Plan will utilize the BCN PCP Focus Network.
- DPSCD Premium Plan will utilize the full BCN HMO Network.
- The DPSCD voluntary benefit program (currently Allstate Benefits, Lifelock, and Hyatt Legal Voluntary Plans) will have a separate open enrollment period in 2018. Additional information, including open enrollment dates, will be communicated in 2018.
- There are no changes to your Dental and Vision plans. Delta Dental PPO Standard and EPO plans and Heritage Vision will be offered.

Successful Enrollment Tips

1. Learn about your benefits. In addition to reading this enrollment guide and the medical summary of benefits and coverage, review each plan summary as well as the associated costs of each option.
2. Review the dependent eligibility rules on page 3 and decide if you want to add dependents to your coverage or remove them.
3. Determine how much to contribute to the Health Care and Dependent Care Flexible Spending Accounts.
4. Enroll in your Medical, Dental, Vision, Life and FSA plans online at *www.detroitk12.bswift.com* (see pages 6 and 7) and confirm your elections as described.



DPSCD Online Enrollment

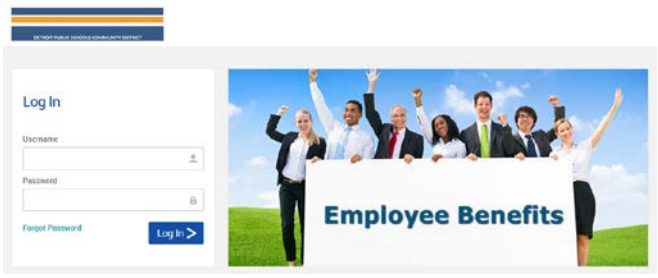
Online Benefit Center

Access to the following benefit information is available 24/7 by logging into the DPSCD Online Benefit Center:

- Enrollment Elections
- Benefit Tools (Benefit Calculator)
- Carrier Websites
- Qualified Life Events (You must report your life event to HR within 30 days to make benefit changes.)
- Review Personal Information
- View Benefit Information
- View and Print Benefit-Related Documents and Forms
- Mid-year Enrollment Changes due to Qualified Life Event (Marriage, birth, etc.)

Benefit Solution Center

- Live Benefits Support
- Monday – Friday from 8:30am – 5:00pm
- Email us at *servicecenter@kapnick.com*



www.detroitk12.bswift.com

The Online Benefit Center is the ONLY way to complete your benefits enrollment. The Benefit Solution Center staff cannot complete enrollments on your behalf.

(888) 447-9038

First Time Users

Follow these steps to complete the registration process:

1. In a web browser go to *www.detroitk12.bswift.com*
2. Enter the following information:
   - **Username:** Your name as it appears in your work email address - ex: John.Doe
   - Password: **For your initial sign-in only**, enter the last four digits of your social security number
   - Change Password: 8 characters minimum, with at least 1 number, 1 capital letter, and 1 special character (!,@,$,etc.)
   - Security Question / Answer: Click on the drop down and select a security question. Enter your answer, and click Save. (This security question will be used if you forget your password or after 3 failed attempts to sign into the DPSCD Online Benefit Center)
3. After you have completed these steps, sign in with the password you created, and begin using the DPSCD Online Benefit Center.

Returning Users

1. In a web browser go to *www.detroitk12.bswift.com*
2. Enter your username (ex: John.Doe) and the password you created.
3. If you have forgotten your password, you will be locked out after three attempts. Follow these steps to receive your Password Reset Information:
   - Click **>Forgot Password** left of the Log In icon
   - Enter your Username
   - Enter your Birthdate
   - Select the reset method you would like to use

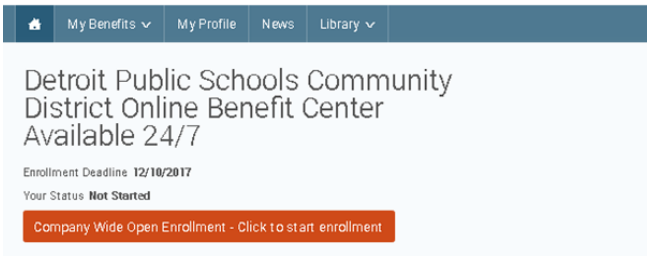
Locked Out?

If you are locked out of the Online Benefit Center, contact Kapnick support at **(888) 447-9038**.

Reminder: Your DPSCD email address is required in order to complete benefits enrollment. Contact DPSCD Help Desk at (313) 576-0100 to reactivate your email address if you are locked out. Detailed instructions can be found on page 4.

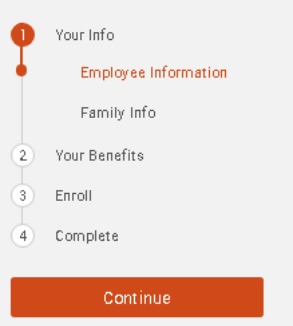
Enrollment Instructions

Once you are logged into DPSCD Online Benefit Center, you will be on the Employee Home Portal page.



To begin your enrollment process, click on the "Click to start enrollment" icon.

There are 4 steps in the enrollment process. There is a gauge on the right hand side to show your progress.



Step 1: Your Information

1. Review **Employee Information** for accuracy and complete required fields, then click 'Continue' at the bottom of the Page.
2. Review **Family Information** for accuracy and complete required fields, then click "I Agree" at the bottom of the page.

Step 2: Select Your Benefits

1. This tab displays all of the benefits that you are eligible to elect. For each benefit category, select the dependent(s) you wish to cover. ***Note: DPSCD employees who are married to each other are required to enroll together under ONE contract.*** Either spouse can choose to be the contract holder, and the other would be covered as their dependent spouse.

   If you enroll your spouse, please indicate if they are also an active DPSCD employee (employee ID required). Once verified, this will exempt you from paying the additional $50 monthly spousal access fee. (Proof of Marriage will be required if not on file.)

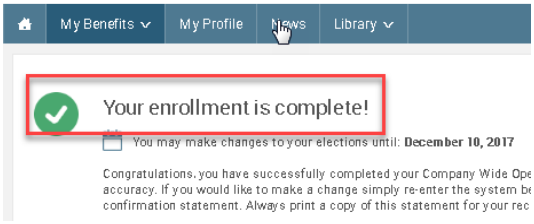
2. Each benefit category (medical, dental, etc.) will be displayed individually. If there is more than one plan option in the same benefit category, you can click on the 'Compare Plans" icon to review the options. To view additional medical options scroll down.
3. Select the orange button on the right side for the plan you wish to select.

Step 3: Enroll

1. **Beneficiary Information:** (for applicable benefits) a primary beneficiary must be specified. You may also add a secondary beneficiary if you desire. You will need the beneficiary's name, relationship, and address when making your elections.
2. **Other Insurance Information: Please enter any other group medical coverage** that any one in your family is enrolled in.
3. **Review and Confirm:** Please review all your benefit elections and Employee vs. Employer cost per pay, and use the navigation on the right side to select your benefits. You can make changes here.
4. In order to complete your enrollment, you must check the **"I agree, and I am finished with my enrollment"** statement at the bottom of the page **and click the "Complete Enrollment" icon.**

Step 4: Complete

1. This tab will be displayed when you have completed all benefit categories and your elections have been saved.



You may return to the DPSCD Online Benefit Center at any time during your enrollment period to make changes to your enrollment elections. The latest confirmed and saved enrollment will be the enrollment processed.

Congratulations! You have just successfully used the DPSCD Online Benefit Center for your enrollment.

Medical and Pharmacy Highlights

Medical Plan Highlights

DPSCD understands the importance of medical and prescription drug coverage for you and your family. We are pleased to offer three BCN medical insurance plans with pharmacy coverage also provided by BCN. As was the case in 2017, you will have the opportunity to choose the most appropriate coverage for you and your family. The table on page 11 shows a high level summary of the benefits offered by each plan. Please see pages 18 through 20 for more details of each plans' highlights.

How to Choose a Plan

Choosing the best health plan isn't always easy, careful consideration must go into your health plan selection process as every individual and family have unique needs and requirements. Employees must fully understand the differences between the Medical/Rx plan options (deductibles, coinsurance and copays) along with the plans' network access (Narrow network vs. State wide network). Employees should take all of this information into consideration as they evaluate their specific personal and family healthcare needs and evaluate which health plan option is the best fit for them and their entire family.

Per Pay Contributions

Per Pay deductions shown on page 11 include a $50 Monthly Spousal Access Fee for members who elect coverage for their spouses. This will be waived for spouses who are verified as active DPSCD employees. You will then be charged the lower rate listed on the following page. Both Medical and Rx benefits are included with this contribution amount.

Switching to Blue Care Network's Prescription Drug Coverage

Having a BCN Prescription Drug Plan Offers Value, Safety, Effectiveness and Convenience – Perfect For Keeping You Health and Your Costs Low.

Things you should know about BCN's pharmacy plans

Blue Care Network offers extensive drug coverage. But the BCN plan may differ from your previous plan. When making the switch, here's what you need to know:

- BCN maintains a list of medications approved by the U.S. Food and Drug Administration as part of your BCN drug benefit. Yours will be the Custom Drug List.
- Drugs on BCN's lists are grouped into tiers, with the least expensive drugs in the lowest tiers. The following tables shows how your copayments (or copays) connect to the tiers.

  Tier 1 **LOWEST COPAY**

  Tier 2 **HIGHER COPAY**

  Tier 3 **HIGHEST COPAY**

- Most drugs in the Tier 1 category are generics.
- Some BCN drug plans do not cover Tier 3 drugs – unless your doctor or BCN agree the drug is medically necessary based on your condition.

Some drugs need approval

BCN reviews the use of certain drugs to make sure that our members receive the most appropriate and cost-effective drug therapy. You may be required to try one or more preferred drugs to treat your health condition (step therapy), or your doctor may have to get approval (prior authorization) before a certain drug is covered. We may also limit the quantity of some drugs.

Drugs that require approval are identified in your drug list. The conditions for approval are based on current medical information and the recommendation of the Blue Cross Blue Shield of BCN Pharmacy and Therapeutics Committee, a group of doctors, pharmacists and other health experts.

If the drug isn't approved, you may have to pay for the full cost of the drug.

Preparing for the switch

When you move to a BCN prescription drug plan, we suggest that you:

- Review your drug rider because it outlines the terms and conditions of your drug coverage. To access the drug rider, log in to your account at *www.bcbsm.com*
- Work with your doctors to determine which drugs you take regularly, and try to have an ample supply during your prescription drug coverage transition.
- Review the drug section in your Member Handbook, or online at **bcbsm.com/BCNdruglists**. You'll find important coverage information that's specific to your plan.

Transition Fill

During your first three months as a new BCN member, you may qualify for a special benefit.

- If you're taking a drug that requires approval or step therapy, you may be eligible for a one-time courtesy fill of your prescription.
- Up to a 30-day prescription is available for most drugs for one copay.

BCN Pharmacy Highlights

Not all drugs are covered

Every drug plan has certain drugs that aren't covered. To learn more about what's not covered, check your drug rider. You'll find it online when you log in to your account at www.bcbsm.com.

Going generic

- **Prescription drugs can be costly.** BCN works to keep costs down while maintaining quality care by promoting generic versions of brand-name drugs.
- **Generic drugs deliver.** Generic drugs work the same as brand-name drugs. The main difference between the two is price.
- **You'll pay more if you take the brand-name drug** instead of the generic version.

Durable medical equipment

Medical equipment, such as glucose monitors, and supplies, such as lancets and strips, are considered durable medical equipment. These items may be covered by your medical coverage; they aren't included in your pharmacy benefits.

Specialty drugs have special coverage

Specialty drugs are used to treat complex conditions, such as cancer, multiple sclerosis, or rheumatoid arthritis. These drugs usually need special handling or monitoring. They also may need special approval, and you may have to order them through a specialty pharmacy.

Specialty drugs are limited to a 30-day supply. Certain specialty drugs are limited to a 15-day supply. Members pay half their copay for a 15-day supply.

Filling a prescription – There are several ways to fill a prescription:

- At a BCN participating retail pharmacy
- By mail from Express Scripts* mail order pharmacy
- By mail from Walgreens Specialty Pharmacy** for specialty prescriptions

Save on prescriptions

- We've placed select insulin products in the generic copay tier to help you save money while managing your diabetes.
- You can get up to a 30-day supply of medication for one copay. You can also get up to a three-month (90-day) supply of most prescription medications from most retail pharmacies or by mail order. To ensure the drug and dosage are right for you, an initial 30-day trial period is required for eligible brand-name medications.

Online resources

- After you've enrolled with BCN, you can find useful information about your prescription drug benefit by logging in to your account at www.bcbsm.com. Access the Prescription Drug pages to review your drug riders.
- To learn more about our drug lists, visit www.bcbsm.com/BCNdruglists, or refer to the "Your Drug Benefit" section in your Member Handbook.

More information

Call the Customer Service number on the back of your ID card.

*Express Scripts is an independent company that provides pharmacy benefit management services for Blue Care Network of Michigan.

**Walgreens Speciality Pharmacy is an independent company that provides speciality pharmacy services for Blue Care Network of Michigan.

Plan Design and Per Pay Contribution

		Core Plan PCP FOCUS Network		Core+ Plan PCP FOCUS Network		Premium Plan Full BCNNetwork	
		Enhanced	**Standard**	**Enhanced**	**Standard**	**Enhanced**	**Standard**
Medical (BCN)		**BCN HBL HMO Core**		**BCN HBL HMO Core+**		**BCN HBL HMO Premium**	
Health Engagement		Healthy Blue Living		Healthy Blue Living		Healthy Blue Living	
Network	General Care	BCN PCP Focus Network		BCN PCP Focus Network		Blue Care Network	
	OB/GYN (Routine)	Blue Care Network		Blue Care Network		Blue Care Network	
	Pediatrician	BCN PCP Focus Network		BCN PCP Focus Network		Blue Care Network	
	Urgent / Emergency	Anywhere		Anywhere		Anywhere	
Deductible		$500 Individual $1,000 Family	$2,000 Individual $4,000 Family	None	$500 Individual $1,000 Family	$500 Individual $1,000 Family	$2,000 Individual $4,000 Family
Coinsurance (employee pays)		10%	20%	N/A*	N/A*	10%	20%
Coinsurance Maximum		$1,500 Individual $3,000 Family	$2,000 Individual $4,000 Family	N/A*	N/A*	$1,500 Individual $3,000 Family	$2,000 Individual $4,000 Family
Out of Pocket Maximum		$6,600 Individual $13,200 Family	$6,600 Individual $13,200 Family	$6,600 Individual $13,200 Family	$6,600 Individual $13,200 Family	$6,600 Individual $13,200 Family	$6,600 Individual $13,200 Family
Physician Office Visit (PCP) / Online Office Visit		$20 Copay	$30 Copay	$20 copay	$20 copay	$20 Copay	$30 Copay
Specialist Office Visit		$40 Copay	$45 Copay	$20 copay	$20 copay	$40 Copay	$45 Copay
Emergency Room Visit		$100 Copay	$150 Copay	$100 copay	$100 copay	$100 Copay	$150 Copay
Urgent Care Facility		$40 Copay	$45 Copay	$50 copay	$50 copay	$40 Copay	$45 Copay
Pharmacy (BCN)		**BCN Rx**		**BCN Rx**		**BCN Rx**	
Retail (Up to 30 Days Supply)		$7 / $25 / $50 Copay	$15 / $30 / $60 Copay	$5 / $25 / $40 Copay	$5 / $25 / $40 Copay	$7 / $25 / $50 Copay	$15 / $30 / $60 Copay
Mail Order & Retail (31-90 Day Supply)		$14 / $50 / $100 Copay	$30 / $60 / $120 Copay	$10 / $50 / $80 Copay	$10 / $50 / $80 Copay	$14 / $50 / $100 Copay	$30 / $60 / $120 Copay
Contribution		**Employee Cost Per Pay - 22 Pays**					
Employee Only		$49.23		$116.24		$171.03	
Employee + Child or DPSCD Spouse		$105.38		$245.62		$360.89	
Employee + Non-DPSCD Spouse		$132.65		$272.90		$388.17	
Employee + Family with DPSCD Spouse		$131.62		$306.76		$450.71	
Employee + Family with Non-DPSCD Spouse		$158.90		$334.03		$477.98	
Contribution		**Employee Cost Per Pay - 26 Pays**					
Employee Only		$41.66		$98.35		$144.72	
Employee + Child or DPSCD Spouse		$89.17		$207.84		$305.37	
Employee + Non-DPSCD Spouse		$112.25		$230.91		$328.45	
Employee + Family with DPSCD Spouse		$111.37		$259.56		$381.37	
Employee + Family with Non-DPSCD Spouse		$134.45		$282.64		$404.45	

*For most services see Benefits at a Glance for plan details.

Health Blue Living

All three DPSCD BCN HMO plans offer a unique opportunity to save on out-of-pocket health care costs, while improving health status, through the Healthy Blue Living program. This program rewards employees who meet a few wellness participation requirements. (There is no measure of outcomes, only participation). There are two levels of benefits under each DPSCD Plan with Healthy Blue Living (HBL); their deductible and coinsurance are noted below (Enhanced or Standard). All plans include coverage for recommended preventive services at 100% with no copay once every calendar year. Please see the Benefits-At-A-Glance documents for additional cost comparisons.

	Core Plan PCP FOCUS Network		Core+ Plan PCP FOCUS Network		Premium Plan BCN Full Network	
	Enhanced	*Standard*	*Enhanced*	*Standard*	*Enhanced*	*Standard*
Deductible	$500 / $1,000	$2,000 / $4,000	None	$500 / $1,000	$500 / $1,000	$2,000 / $4,000
Coinsurance	10% to $1,500 / $3,000	20% to $2,000 / $4,000	None*	None*	10% to $1,500 / $3,000	20% to $2,000 / $4,000

All new DPSCD employees will be enrolled in the Enhanced benefit level. DPSCD employees currently enrolled will begin the new year in their current benefit level. They must meet the HBL requirements for the new benefit year to qualify to stay in the Enhanced benefit level for 2018, or to be moved from the Standard to Enhanced benefit level in 2018. Each employee, within **the first 90 days** following January 1st, must visit your Primary Care Physician (PCP) and complete your Blue Care Network Qualification Form. You will also need to complete the online health assessment.

Please note: the employee must be active on the plan in order for the participating PCP to send the form. For example, if there's a new employee that went to the doctor today – that doctor couldn't send the form until after the member's status reflects active. **Employees can schedule a visit as early as July 15th for the upcoming plan year; the PCP can use information from that visit to complete and submit the BCN qualification form. If your PCP recommends you be seen for another health maintenance exam, the preventive care visit and preventive lab work is covered at 100%.**

Failure to complete these items within the first 90 days (by March 31st) will result in your benefits being reduced from Enhanced to Standard. You will be receiving communications from Blue Care Network. The below table is information you can expect to receive:

Communication	Content	Date	Recipients
Welcome Letter	Benefit and Requirement Book and Qualification Form	January (at Enrollment)	Subscriber
Reminder Letter	Qualification Form and/or Health Assessment Not Complete	Mid-February (If Still Missing)	Subscriber As Applicable
Reminder Phone Call	Qualification Form and/or Health Assessment Not Complete	Early March (If Still Missing)	Subscriber As Applicable
Tobacco Cessation Coaching Information	Brochure and Information About Tobacco Cessation Coaching Requirement	Within 5 Days of Receipt of Qualification Form Indicating Member Uses Tobacco	Subscriber As Applicable
Weight Management Information	Brochure and Information About Weight Management Requirement	Within 5 Days of Receipt of Qualification Form Indicating Member Has a BMI of 30 or More	Subscriber As Applicable
Final Notice Standard	Information About Missing Requirements and Move to Standard	Within 21 Days of Occurrence	Subscribers Who Did Not Meet Requirement
Benefit Change Kit	Information About Changes To Out of Pocket Costs Regarding Standard Level	Within 21 Days of Occurrence	Subscribers Who Did Not Meet Requirement

Participation Requirements

There are two easy steps to complete in order to maintain enhanced benefits. ONLY employee(s) must qualify for the Enhanced Benefits for themselves and their dependents each year by completing these steps within the **first 90 days** of the plan year (by March 31st). Please note additional action may be required if you do not meet the tobacco use and weight management requirements.

1. See your Primary Care Physician (PCP) for a Blue Care Network Qualification Form visit. After your exam, your doctor needs to electronically submit your qualification form to us.
2. Log in at *www.bcbsm.com* and complete your health assessment or call (855) 326-5098 to request a paper copy.

Copays For Healthy Blue Living (HBL) Qualification Form Visits

A visit to complete your HBL Qualification Form is considered preventive, and you will not be charged a copay. However, if you receive non-preventive care during the visit or additional lab work that is not required for completing the Qualification Form, there will be a charge for those services. For example, if you decide to have vitamin D testing during your visit, you will be billed for that test. Any fees that are not considered preventive may be applied toward meeting your deductible. In addition, if your doctor recommends a follow-up visit based on your Qualification Form visit, you may be charged a copay for that visit.

Tobacco Use and Weight Management

To be in the Enhanced level, all employees must meet the requirements as it relates to tobacco use and weight management.

- Tobacco will be tested for during your Blue Care Network Qualification Form visit. Continued testing is required in the first year of enrollment. Once a negative test is received, we don't require it again. Should your Qualification Form show that you use tobacco, you must enroll in Tobacco Cessation Coaching, powered by WebMD (at no extra cost to you). If you aren't ready to set a quit date within 30 days, you'll be required to enroll in Lifestyle Coaching and participate until the end of your plan year or until you quit using tobacco. **If this requirement applies to you, BCN will send you a letter with more details and enrollment instructions.**
- If your body mass index is 30 or more, you're required to enroll in a BCN-sponsored weight-management program within the first 120 days of the plan year (no additional cost to you). You will receive communications from BCN should your BMI be at or above 30. Members must participate in the weight management program until their BMI is under 30 as evidenced by their PCP's submission of an updated Qualification Form.

  Members with a BMI of 30 or above must join either Weight Watchers® or the Steps program powered by WebMD®, within 120 days of the enrollment/renewal date to maintain Enhanced benefits Members must stay in selected program until BMI is less than 30 and a new qualification form from the PCP confirms BMI. Members may not switch weight management programs mid-plan year.

Are you a new hire? Follow these steps for your Healthy Blue Living requirements:

Hired in first or second quarter	Hired in third quarter	Hired in fourth quarter
Employee has enhanced benefits for 90 days. The employee must complete the plan requirements within the first 90 days of his or her effective date for everyone on the contract to keep enhanced benefits.	Employee has enhanced benefits for 90 days. The employee must complete the plan requirements within the first 90 days of his or her effective date for everyone on the contract to keep enhanced benefits. Primary care physician does not need to submit the qualification form for the employee at the start of the new plan year.	Employee has enhanced benefits for the remainder of the plan year. At the start of the new plan year, the employee must complete the plan requirements within the first 90 days of his or her effective date for everyone on the contract to keep enhanced benefits.

6 Key Health Measures

Healthy Blue Living focuses on six areas of health that increase the likelihood of a person developing a chronic or disabling condition. These six health measures also affect health care costs. One of the goals of Healthy Blue Living is to help employees achieve these wellness targets to avoid illness and higher health care costs.

TOBACCO	Target: No tobacco use	CHOLESTEROL	Target: LDL-C is below target (based on risk factors: <100, <130 or <160)
DEPRESSION	Target: Any depression is in full remission	BLOOD PRESSURE	Target: Below 140/90
BLOOD SUGAR	Target: Your fasting blood sugar or A1c at or below target	WEIGHT	Target: BMI below 30

The ABCs of the Blue Care Network Qualification Form

Each health measure on the qualification form tracks an employee's status using a simple "A, B, C" grading system. A's and B's will earn an employee enhanced benefits and one or more C's moves everyone on his or her contract to standard benefits. C's mean that an employee hasn't met a wellness target and hasn't committed to treatment to improve a condition.

A	**You're meeting the wellness target**	**B**	**You have a health condition that might not be controlled, but you are participating in treatment to improve the condition.**	**C**	**You're not meeting the wellness target and you haven't committed to treatment to improve your condition**

Key Dates For Completing Healthy Blue Living Requirements

90 days

30 more days

Jan 1

Plan year begins

March 31 – The employee must:

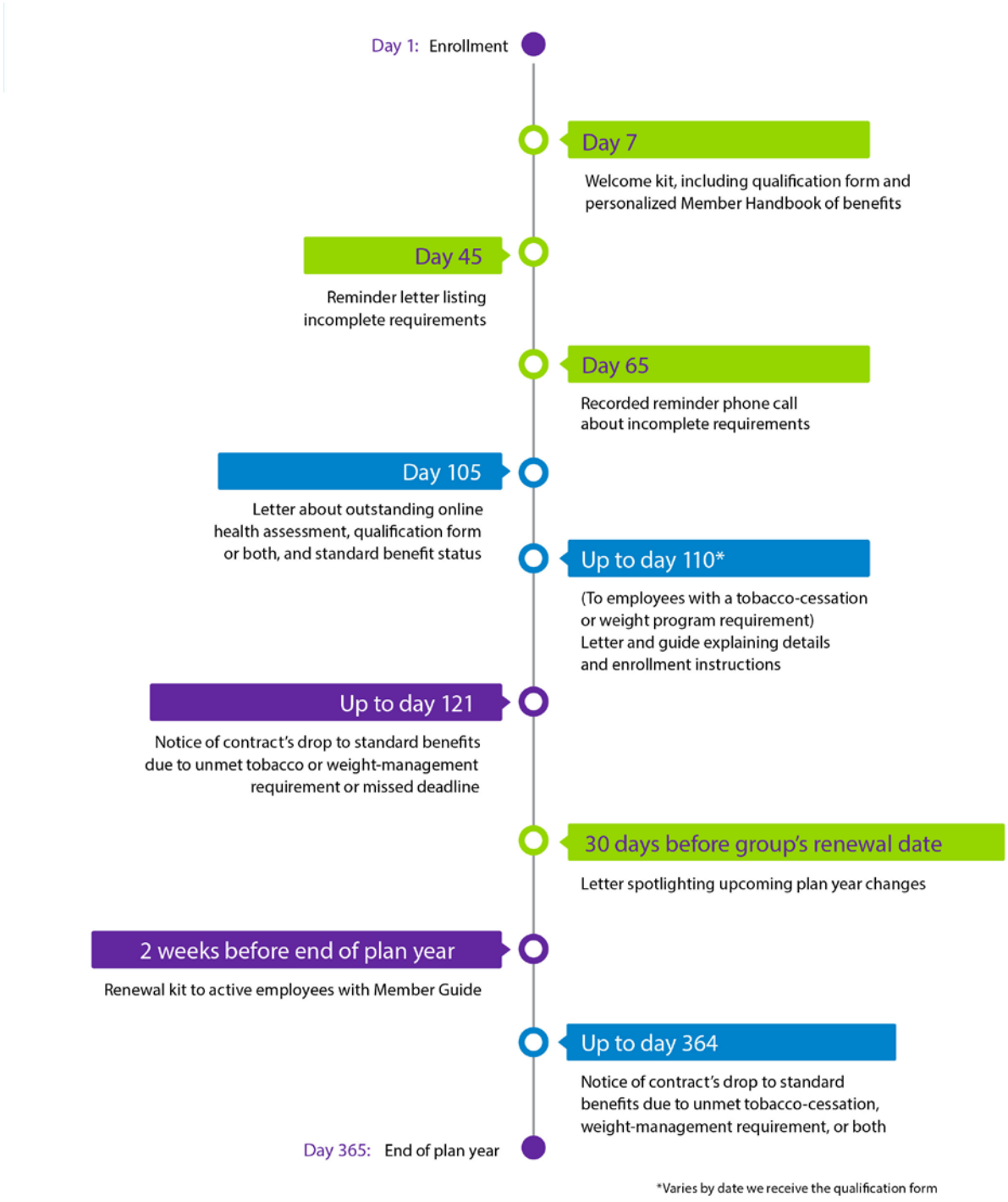
- ✓ Visit a Blue Care Network primary care physician and have the doctor complete and electronically submit to us a Blue Care Network Qualification Form.
- ✓ Meet six health measures or commit to the doctor's treatment plan to improve his or her health. See the next page.
- ✓ Complete a health assessment by logging in to their account at bcbsm.com. A paper copy can be requested by calling 1-855-326-5098.

April 30 – If the employee:

- ✓ Is a tobacco user, and he or she is ready to set a quit date, he or she must enroll, at no extra cost, in Tobacco Cessation Coaching, powered by WebMD. If he or she isn't ready to set a quit date, then participating in Lifestyle Coaching is required until the end of the plan year or until the employee quits using tobacco. This must be confirmed by a new qualification form showing a negative Nicotine test.
- ✓ Has a body mass index of 30 or more, confirmed through his or her qualification form, then he or she must enroll and participate at no extra cost in our weight-management program until his or her BMI falls below 30.

Member Communications Timeline

We send information and periodic reminders to new employees about what they need to do to earn and keep enhanced benefits. Steps are similar for renewing employees.



Blue Cross Blue Shield Online Enrollment Tools

Provider Lookup

For medical coverage, you must select a Primary Care Physician (PCP). A PCP must be selected for you and each family member that will be covered on your plan. A different PCP can be selected for each family member. If a PCP is not selected, Blue Care Network will assign an in-network PCP to each individual. PCPs can be changed at anytime throughout the year.

Prior to selecting which BCN HMO plan to enroll in, it is important to check to see if the doctors you currently are seeing are in the network. To do this, call BCN at (800) 662-6667 or follow the online instructions below:

1. Go to *www.bcbsm.com* and select the Find a Doctor button on the left side of the home screen.
2. Click on Search without logging in.
3. Click to Your Plan, click the link All Plans.
4. Then select Employer Group Plans from the menu.
5. Scroll down to HMO Plans (includes Auto Actives and Retirees) and select:
   - For the premium plan option: Blue Care Network (HMO).
   - For the core and core plus plans: Blue Care Network PCP Focus Network (HMO).
6. You may select a category of providers to search from, or simply click the magnifying glass icon.
7. Once the search results are displayed, click on any of the links for each provider listed for more details.

Register at BCBSM.com

There's a lot waiting for you at www.bcbsm.com. All you have to do is register. Once you get your ID card, locate your ID number from your card and follow these steps:

1. Go to *www.bcbsm.com*
2. Click Login in the upper right corner of the blue bar; then click Register Now.
3. Carefully read the information on the Verify Your Eligibility screen before beginning the registration process.
4. Fill out all fields; when complete, check the box in the middle of the page to verify your identity; click continue.
5. Carefully read the questions on the following page and click the appropriate answers; click continue.
6. Create a User Name and Password.

PCP Focus vs. BCN Full Network Comparison

PCP Focus Network

Both the Core Plan and Core+ Plan use the BCN PCP Focus network. PCP Focus is a primary care physician HMO network serving 20 counties in Michigan. The doctors you choose from this network have shown they can provide quality care and a high level of efficiency.

Core and Core+ members must select a primary care physician from the PCP Focus network. PCP Focus provides you with access to thousands of primary care physicians throughout select Michigan counties, as well as the flexibility to see almost any of BCN's more than 21,200 specialists and access to 134 Michigan hospitals.

Members have access to our award-winning care management programs along with innovative, cost efficient and helpful tools to manage their health. These tools include Blue Cross® Health & Wellness, powered by WebMD®, a tobacco cessation program, Blue 365® discounts, online resources and more. As part of the BlueCard® program, the Core and Core+ plans provides access to Blue Plan physicians and hospitals nationwide.

BCN HMO Network

The Premium Plan uses Blue Care Network's broad network that includes all 83 Michigan counties. BCN offers Michigan's largest HMO service area with access to 30 percent more leading doctors and specialists than our closest competitor. BCN contracts with more than 5,770 primary care physicians, over 21,200 specialists and 134 hospitals in Michigan.

Premium members must select a primary care physician to coordinate all care and services they may need.

Members have access to our award-winning care management programs along with innovative, cost efficient and helpful tools to manage their health. These tools include Blue Cross® Health & Wellness, powered by WebMD®, a tobacco cessation program, Blue 365® discounts, online resources and more. As part of the BlueCard® program, your Premium Plan provides access to Blue Plan physicians and hospitals nationwide.

Care Outside the Network

No matter which DPSCD BCN plan or doctor you choose, you'll have access to exceptional care when you need it. BCN plans also allow for flexibility and coverage outside the network in several instances. Please see the information below as well as information on the BlueCard® program on the following page. **Out-of-network providers** aren't part of the network. You can choose to get care from an out-of-network provider, but you'll pay more. Certain out-of-network services must also be authorized by BCN before you receive them. Otherwise, you'll be responsible for the entire cost of the service.

If your doctor is not in the BCN network...
To continue care with a doctor who's not in the BCN network, one of these situations must apply to you:

- You're receiving an ongoing course of treatment and changing doctors would interfere with recovery (care may continue through the current course of treatment—up to 90 days).
- You're in the second or third trimester of pregnancy (care may continue through delivery).
- You have a terminal illness (care may continue for the remainder of your life). This continuity of care may also apply when your BCN doctor leaves the network. Authorization from BCN is required.

PCP FOCUS and BCN Members on any plan can change PCPs by logging on to *www.bcbsm.com* or contacting Customer Service at (800) 662-6667.

Blue Care Network
Health Maintenance Organization (HMO) Healthy Blue Living Plan
Summary of Benefits for Detroit Public Schools Community District
January 1st – December 31st, 2018

Core Plan
PCP FOCUS Network

Health Care Services	Enhanced	Standard	Limitations* (Enhanced and Standard)
Benefit Period / Annual Deductibles & Maximums:			
Benefit Period:	Calendar Year	Calendar Year	
Annual Deductible (Individual / Family)	$500 / $1,000	$2,000 / $4,000	
Co-insurance (amount member pays)	10%	20%	
Annual Co-insurance Maximum (Individual / Family)	$1,500 / $3,000	$2,000 / $4,000	Services that DO NOT apply to Annual Co-Insurance Max: Deductible, Flat Dollar Copays, Infertility, Male Mastectomy, Reduction Mammoplasty, Male Sterilization, Elective Abortion, TMJ, Orthognathic Surgery, Weight Reduction, DME, P&O, Diabetic Supplies, Prescription Drugs
Annual Out-of-Pocket Maximum (Individual / Family)	$6,600 / $13,200	$6,600 / $13,200	Medical Cost Sharing Only - applies to deductibles, copays, coinsurance amounts for all covered services
Preventive Services:			
Health Maintenance Exam	Plan Pays 100%	Plan Pays 100%	
Annual Gynecological Exam	Plan Pays 100%	Plan Pays 100%	
Pap Smears and Mammograms	Plan Pays 100%	Plan Pays 100%	
Well-Baby and Child Care	Plan Pays 100%	Plan Pays 100%	
Immunizations	Plan Pays 100%	Plan Pays 100%	
Prostate Specific Antigen (PSA) Screening	Plan Pays 100%	Plan Pays 100%	
Voluntary Female Sterilization	Plan Pays 100%	Plan Pays 100%	
Breast Pumps	Plan Pays 100%	Plan Pays 100%	DME guidelines apply
Maternity Pre-Natal Care	Plan Pays 100%	Plan Pays 100%	
Routine Colonoscopy	Plan Pays 100%	Plan Pays 100%	
Physician Office Services:			
Primary Care Physician Office Visit	$20 Copay	$30 Copay	
Consulting Specialist Care	$40 Copay	$45 Copay	
Online Visits	$20 Copay	$30 Copay	
Emergency / Urgent Care:			
Emergency Room Services	$100 Copay	$150 Copay	Copay will be waived if admitted
Urgent Care Facility Services	$40 Copay	$45 Copay	
Emergency Ambulance Services	Plan Pays 90%	Plan Pays 80%	After Deductible
Diagnostic Services:			
Laboratory and Pathology Tests	Plan Pays 100%	Plan Pays 100%	
Diagnostic Tests and X-Rays	Plan Pays 90%	Plan Pays 80%	After Deductible
High Technology Radiology Imaging	Plan Pays 90%	Plan Pays 80%	After Deductible; Includes MRI, MRA, CAT, PET
Maternity Services:			
Post-Natal and Non-Routine Pre-Natal Care	$20 Copay	$30 Copay	See Preventive Services section for routine Pre-Natal care)
Delivery and Nursery Care	Covered	Covered	100% For Professional Services after Deductible
Hospital Care:			
General Nursing Care, Hospital Services and Supplie	Plan Pays 90%	Plan Pays 80%	After Deductible
Outpatient Surgery	Plan Pays 90%	Plan Pays 80%	After Deductible; Included all related surgical services and anesthesia
Alternatives to Hospital Care:			
Skilled Nursing Care	Plan Pays 90%	Plan Pays 80%	After Deductible; Up to 120 Calendar Days
Hospice Care	Plan Pays 100%	Plan Pays 100%	Must be authorized from Blue Cross/Blue Shield Blue Care Network; After Deductible
Home Health Care	$40 Copay	$45 Copay	
Surgical Services:			
Surgery	Plan Pays 90%	Plan Pays 80%	After Deductible; Includes all related surgical services and anesthesia
Voluntary Male Sterilization	Plan Pays 90%	Plan Pays 80%	After Deductible
Elective Abortion	Not Covered	Not Covered	
Human Organ Transplants	Plan Pays 90%	Plan Pays 80%	After Deductible
Weight Reduction Procedures	Plan Pays 90%	Plan Pays 80%	After Deductible; Limited to once per lifetime
Mental Health Care and Substance Abuse Treatment:			
Inpatient Mental Health Care and Substance Abuse	Plan Pays 90%	Plan Pays 80%	After Deductible
Outpatient Mental Health Care and Substance Abuse	$20 Copay	$30 Copay	
Autism Spectrum Disorders, Diagnoses, and Treatment:			
Applied behavioral analyses (ABA) treatment	$20 Copay	$30 Copay	
Outpatient Therapy	$40 Copay	$45 Copay	Includes physical, speech, occupational, nutritional counseling for autism spectrum disorder through age 18
Other Covered Services	Includes mental health services for autism spectrum - see outpatient mental health and medical office visit benefit		
Other Services:			
Allergy Testing and Therapy	Plan Pays 100%	Plan Pays 100%	After Deductible
Allergy Injections	100%	100%	
Chiropractic Spinal Manipulation	$40 Copay	$45 Copay	When Referred (up to 30 visits per calendar year)
Outpatient Physical, Speech, Occupational Therapy	$40 Copay	$45 Copay	Up to 60 visits per calendar year for any combination of therapy
Infertility Counseling and Treatment	Plan Pays 90%	Plan Pays 80%	After Deductible; Excludes In-vitro fertilization
Durable Medical Equipment (DME)	Plan Pays 90%	Plan Pays 80%	
Prosthetic and Orthotic Appliances (P&O)	Plan Pays 90%	Plan Pays 80%	
Diabetic Supplies	Plan Pays 90%	Plan Pays 80%	
Prescription Drugs (BCN Rx)	$7 / $25 / $50	$15 / $30 / $60	
Mail Order Prescription Drugs	2x Rx Copay	2x Rx Copay	
Prescription Drugs Deductible	None	None	
Hearing Aid	Not Covered	Not Covered	

This booklet is intended to describe the essential features of your health plans in general terms. It is not intended to be a full description of coverage. All efforts have been made to correctly summarize the level of benefits, however, if an error has been made in the summary description, the Benefits At A Glance issued by the plan will supersede this document.

Blue Care Network
Health Maintenance Organization (HMO) Healthy Blue Living Plan
Summary of Benefits for Detroit Public Schools Community District
January 1st – December 31st, 2018

Core+ Plan
PCP FOCUS Network

Health Care Services	Enhanced	Standard	Limitations* (Enhanced and Standard)
Benefit Period / Annual Deductibles & Maximums:			
Benefit Period:	Calendar Year	Calendar Year	
Annual Deductible (Individual / Family)	None	$500 / $1,000	
Co-insurance (amount member pays)	*N/A	*N/A	*For select services; some services have a 50% coinsurance level. Please see below.
Annual Co-insurance Maximum (Individual / Family)	None	None	
Annual Out-of-Pocket Maximum (Individual / Family)	$6,600 / $13,200	$6,600 / $13,200	Medical Cost Sharing Only - applies to deductibles, copays, coinsurance amounts for all covered services
Health Maintenance Exam	Plan Pays 100%	Plan Pays 100%	
Annual Gynecological Exam	Plan Pays 100%	Plan Pays 100%	
Pap Smears and Mammograms	Plan Pays 100%	Plan Pays 100%	
Well-Baby and Child Care	Plan Pays 100%	Plan Pays 100%	
Immunizations	Plan Pays 100%	Plan Pays 100%	
Prostate Specific Antigen (PSA) Screening	Plan Pays 100%	Plan Pays 100%	
Voluntary Female Sterilization	Plan Pays 100%	Plan Pays 100%	
Breast Pumps	Plan Pays 100%	Plan Pays 100%	DME guidelines apply
Maternity Pre-Natal Care	Plan Pays 100%	Plan Pays 100%	
Routine Colonoscopy	Plan Pays 100%	Plan Pays 100%	
Physician Office Services:			
Primary Care Physician Office Visit	$20 Copay	$20 Copay	
Consulting Specialist Care	$20 Copay	$20 Copay	
Online Visits	$20 Copay	$20 Copay	
Emergency / Urgent Care:			
Emergency Room Services	$100 Copay	$100 Copay	Copay will be waived if admitted
Urgent Care Facility Services	$50 Copay	$50 Copay	
Emergency Ambulance Services	Plan Pays 100%	*Plan Pays 100%	*After Deductible
Diagnostic Services:			
Laboratory and Pathology Tests	Plan Pays 100%	Plan Pays 100%	
Diagnostic Tests and X-Rays	Plan Pays 100%	*Plan Pays 100%	*After Deductible
High Technology Radiology Imaging	Plan Pays 100%	*Plan Pays 100%	*After Deductible; Includes MRI, MRA, CAT, PET
Maternity Services:			
Post-Natal and Non-Routine Pre-Natal Care	$20 Copay	$20 Copay	See Preventive Services section for routine Pre-Natal care)
Delivery and Nursery Care	Covered	Covered	100% For Professional Services after Deductible
Hospital Care:			
General Nursing Care, Hospital Services and Supplies	Plan Pays 100%	*Plan Pays 100%	*After Deductible
Outpatient Surgery	Plan Pays 100%	*Plan Pays 100%	*After Deductible; Included all related surgical services and anesthesia
Alternatives to Hospital Care:			
Skilled Nursing Care	Plan Pays 100%	*Plan Pays 100%	*After Deductible; Unlimited Days
Hospice Care	Plan Pays 100%	*Plan Pays 100%	Must be authorized from Blue Cross/Blue Shield Blue Care Network; *After Deductible
Home Health Care	Plan Pays 100%	*Plan Pays 100%	*After Deductible
Surgical Services:			
Surgery	Plan Pays 100%	*Plan Pays 100%	*After Deductible; Includes all related surgical services and anesthesia
Voluntary Male Sterilization	Plan Pays 100%	*Plan Pays 100%	*After Deductible
Elective Abortion	Not Covered	Not Covered	One procedure per two year period of membership
Human Organ Transplants	Plan Pays 100%	*Plan Pays 100%	*After Deductible
Weight Reduction Procedures	$1,000 Copay or 50% of the BCN approved amount, whichever is less, on all associated costs		
Mental Health Care and Substance Abuse Treatment:			
Inpatient Mental Health Care and Substance Abuse	Plan Pays 100%	*Plan Pays 100%	When authorized by BCN; *After Deductible
Outpatient Mental Health Care and Substance Abuse	$20 Copay	$20 Copay	
Autism Spectrum Disorders, Diagnoses, and Treatment:			
Applied behavioral analyses (ABA) treatment	$20 Copay	$20 Copay	
Outpatient Therapy	$20 Copay	$20 Copay	Includes physical, speech, occupational, nutritional counseling for autism spectrum disorder through age 18
Other Covered Services	Includes mental health services for autism spectrum - see outpatient mental health and medical office visit benefit		
Other Services:			
Allergy Testing and Therapy	Plan Pays 100%	*Plan Pays 100%	*After Deductible
Allergy Injections	100%	100%	
Chiropractic Spinal Manipulation	$20 Copay	$20 Copay	When Referred (up to 30 visits per calendar year)
Outpatient Physical, Speech, Occupational Therapy	Plan Pays 100%	*Plan Pays 100%	Up to 60 visits per calendar year for any combination of therapy; *After Deductible
Infertility Counseling and Treatment	Plan Pays 50%	*Plan Pays 50%	*After Deductible; Excludes In-vitro fertilization
Durable Medical Equipment (DME)	Plan Pays 100%	Plan Pays 100%	
Prosthetic and Orthotic Appliances (P&O)	Plan Pays 100%	Plan Pays 100%	
Diabetic Supplies	Plan Pays 50%	Plan Pays 50%	
Prescription Drugs (BCN Rx)	$5 / $25 / $40	$5 / $25 / $40	
Mail Order Prescription Drugs	2x Rx Copay	2x Rx Copay	
Prescription Drugs Deductible	None	None	
Hearing Aid	Not Covered	Not Covered	

This booklet is intended to describe the essential features of your health plans in general terms. It is not intended to be a full description of coverage. All efforts have been made to correctly summarize the level of benefits, however, if an error has been made in the summary description, the Benefits At A Glance issued by the plan will supersede this document.

Blue Care Network
Health Maintenance Organization (HMO) Healthy Blue Living Plan
Summary of Benefits for Detroit Public Schools Community District
January 1st – December 31st, 2018

Premium Plan
Full BCNNetwork

Health Care Services	Enhanced	Standard	Limitations* (Enhanced and Standard)
Benefit Period / Annual Deductibles & Maximums:			
Benefit Period:	Calendar Year	Calendar Year	
Annual Deductible (Individual / Family)	$500 / $1,000	$2,000 / $4,000	
Co-insurance (amount member pays)	10%	20%	
Annual Co-insurance Maximum (Individual / Family)	$1,500 / $3,000	$2,000 / $4,000	Services that DO NOT apply to Annual Co-Insurance Max: Deductible, Flat Dollar Copays, Infertility, Male Mastectomy, Reduction Mammoplasty, Male Sterilization, Elective Abortion, TMJ, Orthognathic Surgery, Weight Reduction, DME, P&O, Diabetic Supplies, Prescription Drugs
Annual Out-of-Pocket Maximum (Individual / Family)	$6,600 / $13,200	$6,600 / $13,200	Medical Cost Sharing Only - applies to deductibles, copays, coinsurance amounts for all covered services
Preventive Services:			
Health Maintenance Exam	Plan Pays 100%	Plan Pays 100%	
Annual Gynecological Exam	Plan Pays 100%	Plan Pays 100%	
Pap Smears and Mammograms	Plan Pays 100%	Plan Pays 100%	
Well-Baby and Child Care	Plan Pays 100%	Plan Pays 100%	
Immunizations	Plan Pays 100%	Plan Pays 100%	
Prostate Specific Antigen (PSA) Screening	Plan Pays 100%	Plan Pays 100%	
Voluntary Female Sterilization	Plan Pays 100%	Plan Pays 100%	
Breast Pumps	Plan Pays 100%	Plan Pays 100%	DME guidelines apply
Maternity Pre-Natal Care	Plan Pays 100%	Plan Pays 100%	
Routine Colonoscopy	Plan Pays 100%	Plan Pays 100%	
Physician Office Services:			
Primary Care Physician Office Visit	$20 Copay	$30 Copay	
Consulting Specialist Care	$40 Copay	$45 Copay	
Online Visits	$20 Copay	$30 Copay	
Emergency / Urgent Care:			
Emergency Room Services	$100 Copay	$150 Copay	Copay will be waived if admitted
Urgent Care Facility Services	$40 Copay	$45 Copay	
Emergency Ambulance Services	Plan Pays 90%	Plan Pays 80%	After Deductible
Diagnostic Services:			
Laboratory and Pathology Tests	Plan Pays 100%	Plan Pays 100%	
Diagnostic Tests and X-Rays	Plan Pays 90%	Plan Pays 80%	After Deductible
High Technology Radiology Imaging	Plan Pays 90%	Plan Pays 80%	After Deductible; Includes MRI, MRA, CAT, PET
Maternity Services:			
Post-Natal and Non-Routine Pre-Natal Care	$20 Copay	$30 Copay	See Preventive Services section for routine Pre-Natal care)
Delivery and Nursery Care	Covered	Covered	100% For Professional Services after Deductible
Hospital Care:			
General Nursing Care, Hospital Services and Supplies	Plan Pays 90%	Plan Pays 80%	After Deductible
Outpatient Surgery	Plan Pays 90%	Plan Pays 80%	After Deductible; Included all related surgical services and anesthesia
Alternatives to Hospital Care:			
Skilled Nursing Care	Plan Pays 90%	Plan Pays 80%	After Deductible; Up to 120 Calendar Days
Hospice Care	Plan Pays 100%	Plan Pays 100%	Must be authorized from Blue Cross/Blue Shield Blue Care Network; After Deductible
Home Health Care	$40 Copay	$45 Copay	Deductible does not apply????
Surgical Services:			
Surgery	Plan Pays 90%	Plan Pays 80%	After Deductible; Includes all related surgical services and anesthesia
Voluntary Male Sterilization	Plan Pays 90%	Plan Pays 80%	After Deductible
Elective Abortion	Not Covered	Not Covered	
Human Organ Transplants	Plan Pays 90%	Plan Pays 80%	After Deductible
Weight Reduction Procedures	Plan Pays 90%	Plan Pays 80%	After Deductible; Limited to once per lifetime
Mental Health Care and Substance Abuse Treatment:			
Inpatient Mental Health Care and Substance Abuse	Plan Pays 90%	Plan Pays 80%	After Deductible
Outpatient Substance Abuse Care and Substance Abuse	$20 Copay	$30 Copay	After Deductible
Autism Spectrum Disorders, Diagnoses, and Treatment:			
Applied behavioral analyses (ABA) treatment	$20 Copay	$30 Copay	
Outpatient Therapy	$40 Copay	$45 Copay	Includes physical, speech, occupational, nutritional counseling for autism spectrum disorder through age 18
Other Covered Services	Includes mental health services for autism spectrum - see outpatient mental health and medical office visit benefit		
Other Services:			
Allergy Testing and Therapy	Plan Pays 100%	Plan Pays 100%	After Deductible
Allergy Injections	100%	100%	
Chiropractic Spinal Manipulation	$40 Copay	$45 Copay	When Referred (up to 30 visits per calendar year)
Outpatient Physical, Speech, Occupational Therapy	$40 Copay	$45 Copay	Up to 60 visits per calendar year for any combination of therapy
Infertility Counseling and Treatment	Plan Pays 90%	Plan Pays 80%	After Deductible; Excludes In-vitro fertilization
Durable Medical Equipment (DME)	Plan Pays 90%	Plan Pays 80%	
Prosthetic and Orthotic Appliances (P&O)	Plan Pays 90%	Plan Pays 80%	
Diabetic Supplies	Plan Pays 90%	Plan Pays 80%	
Prescription Drugs (BCN Rx)	$7 / $25 / $50	$15 / $30 / $60	
Mail Order Prescription Drugs	2x Rx Copay	2x Rx Copay	
Prescription Drugs Deductible	None	None	
Hearing Aid	Not Covered	Not Covered	

Healthy Blue Living FAQs

1. I misplaced the Blue Care Network Member Handbook I got in the mail when I enrolled. How can I get another one?
   Request a copy by calling the Customer Service number on the back of your Blue Care Network ID card.

2. My plan year is about to start. How soon can I go to my doctor for my qualification form visit?
   You don't need to wait for the start of your plan year. However, the qualification form your doctor submits must be less than 180 days old.

3. How long will it take to fill out the health asessment online?
   It usually takes about 10 minutes to complete. If you don't have internet access, ask for a paper copy by calling 1-855-326-5098.

4. Why should I take a paper copy to my appointment if my doctor must submit the qualification form electronically?
   We provide a paper qualification form only as a sample of the information your doctor submits electronically. It may be helpful for you to take this with you to remind your doctor that you're a Healthy Blue Living member. We don't accept paper qualification forms from members or doctors.

5. It's been less than 12 months since my last physical. Can I have another one so soon?
   We don't limit the number of times you can visit your doctor to have a qualification form completed. There's no copay for your qualification form visit, even if you're returning to your primary care physician after a recent physical.

6. I quit smoking and lost weight. How can I stop participating in the tobacco-cessation and weight-management programs?
   Return to your primary care physician for another qualification form visit. Once we receive a qualification form showing a negative nicotine test, you'll no longer need to participate in our tobacco-cessation program. Once we receive a qualification form showing your BMI is below 30, you'll no longer need to participate in our weight-management program.

BCBS Care Guide– Where To Go For Care

You can go here:	To receive care for symptoms, conditions or situations such as:	Advantages:	Cost:	Average time for care:	How to find:
24-Hour Nurse Line	• Deciding if you can self-treat a condition or need to see a doctor, visit an urgent care center or an emergency room • Discussing treatment options for nonemergency situations • Other general medical questions	• No cost • Available 24/7 • Staffed with registered nurses	$0	12 minutes	Talk to a registered nurse for free: Blue Cross members can call: 1-800-775-BLUE (2583) Blue Care Network members can call: 1-855-624-5214
Blue Cross Online Visits℠	• Sore throat and cough • Painful urination • Low-grade fever • Earache • Colds and flu • Mild allergy symptoms • Skin rash • Eye irritation or redness • Minor burns, cuts and scrapes • Sprains and strains • Minor asthma issues	• Available anytime your doctor isn't available • No appointments or waiting rooms • Care is delivered by smart phone, tablet or computer • You can send a visit summary to your primary doctor • New for 2018 behavioral health online visists with mental health professionals are available	$	3 to 10 minutes	If your health care plan covers this service sign up for your online account at www.bcbsmonlinevisits.com or sign up with the BCBSM Online Visits℠ app. (Link will be active in 2018) Call: 1-844-606-1608 for help or questions
Doctor's office		• Some extended hours • Trusted, ongoing relationship • Can generally be reached after hours by phone	$	60 minutes	Visit your primary care doctor: if you don't have one, find a primary care doctor near you using Find a Doctor at www.bcbsm.com
Urgent care center		• Evening and weekend hours • Walk-in appointments available • Convenient locations	$$	60 to 90 minutes	Ask your primary care doctor to recommend a nearby urgert care center or find one using Find a Doctor at www.bcbsm.com
Emergency room	• Life-threatening conditions • Chest pain • Possible broken bones • Sudden blurred vision • Poisoning • Unconscious state	• Available 24/7 • Suitable for emergency situations	$$$	4 hours	Call 9-1-1 or visit your local hospital.

Know where to go.

Visit www.bcbsm.com/wheretogo for more information.

The website and app use the American Well® technology platform and provider network. American Well® is an independent company that provides online visits for Blue Cross and BCN members.

Getting health care online in 2018: What you need to know

When you use **Blue Cross Online Visits**℠ (previously called 24/7 online health care), you'll have access to online medical and behavioral health services anywhere in the U.S.

You can rest assured knowing you and your covered family members can see and talk to:

A doctor for minor illnesses such as a cold, flu or sore throat when their primary care doctor isn't available.

A behavioral health clinician or psychiatrist to help work through different challenges such as anxiety, depression and grief.

After January 1, 2018, here's what you need to do to use online visits:

- **Mobile** - Download the BCBSM Online Visits℠ app
- **Web** - Visit *www.bcbsmonlinevisits.com*
- **Phone** - Call **1-844-606-1608**

If you're new to online visits, sign up after January 1, 2018. Be sure to add your Blue Cross or Blue Care Network health plan information.

If you currently use Blue Cross' 24/7 online health care from Amwell®, use the new app, website or phone number after January 1, 2018. You don't need a service key. Your login information stays the same and will be transferred to our new site. Verify your password and your account information. You may need to re-enter some information.

Online medical care doesn't replace primary doctor relationships.

The website and app use the American Well® technology platform and provider network. American Well® is an independent company that provides online visits for Blue Cross and BCN members.

Blue Care Worldwide

" What do I do if I need medical care in a foreign country?"

To take advantage of the BlueCard Worldwide Program, whether you are traveling or living abroad, please follow these steps:

1. Before you leave, contact your Blue Plan for coverage detail. Coverage outside the United States may be different.
2. Always carry your current Blue℠ ID card.
3. In an emergency, go directly to the nearest hospital.
4. If you need to locate a doctor or hospital, or need medical assistance services, call the BlueCard Worldwide Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.
5. Call the BlueCard Worldwide Service Center at 1.800.810.2583 or collect at 1.804.673.1177 when you need inpatient care. In most cases, you should not need to pay upfront for inpatient care at BlueCard Worldwide hospitals except for the out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance) you normally pay. The hospital should submit your claim on your behalf.

   In addition to contacting the BlueCard Worldwide Service Center, call your Blue Plan for precertification or preauthorization. Refer to the phone number on the back of your Blue ID card. *Note: this number is different from the phone number listed above.*
6. You may need to pay upfront for care received from a doctor and/or hospital. Then complete a BlueCard Worldwide International claim form and send it with the bill(s) to the BlueCard Worldwide Service Center (the address is on the form). The claim form is available from your Blue Plan, online at www.BCBS.com/bluecardworldwide, or the BlueCard Worldwide Service Center.

Woman's Choice Program

Blue Care Network's Woman's Choice Program.

You choose. No referral needed. Woman's Choice is a self-referral program. This means for routine women's health services, you may visit certain Blue Care Network-contracted specialists without a referral from your primary care physician.

Find a Woman's Choice doctor at *www.bcbsm.com/index/find-a-doctor*.

Women's Health Services.

Woman's Choice health specialists include obstetricians, gynecologists, obstetrician gynecologists, gynecologic oncologists, reproductive endocrinologists, maternal and fetal medicine specialists, neonatologists, perinatologists, nurse practitioners (OB/GYN and women's health) and certified nurse midwives. Your women's health specialist may perform or order various services* without your PCP's referral.

Gynecological care – no referral needed

- Bone density studies
- Breast exams and mammograms
- Contraceptive management
- Diagnosis and in-office surgical and nonsurgical treatment of gynecological and bladder infections
- Gynecological exams, Pap smears
- Laboratory** and pathology services related to gynecological problems
- Pelvic ultrasounds

Obstetrical care – no referral needed

- Fetal nonstress tests
- Laboratory** and pathology services related to obstetrical care
- Maternity ultrasounds
- RhoGAM injections

Tip to Consider:

Consider selecting a women's health specialist who belongs to the same physician group as your PCP or has privileges at the same hospital. This makes it easier for the two to care for you as a team.

*Benefits vary by plan. To check your coverage, log in to your account on bcbsm.com.

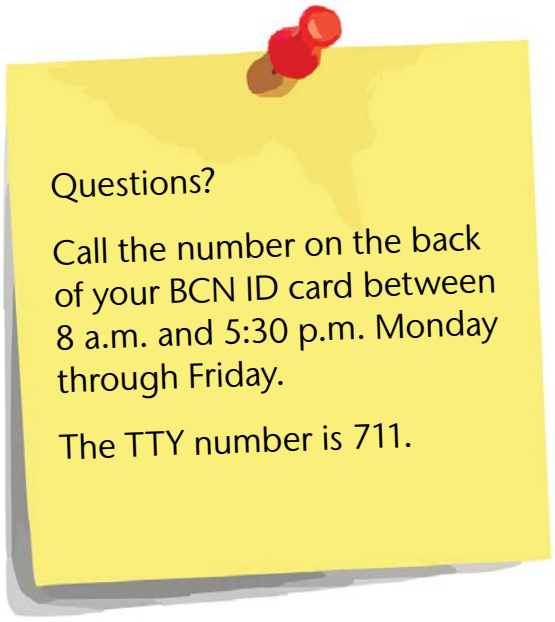
**Must be sent to Joint Venture Hospital Laboratories.

You need your PCP's referral for these services*:

- Surgical procedures performed in an outpatient facility
- Hospital admission other than infant delivery

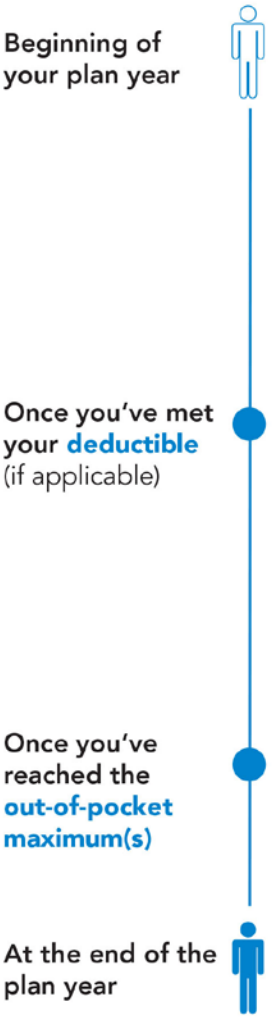
Your provider must notify BCN before performing these services*:

- Amniocentesis
- Gynecological surgical procedures
- Hospital admissions for infant delivery and other obstetric conditions
- Treatment of suspected or confirmed malignancies



How You May Share Costs With Us

As a BCN member, you have help paying for your health care.Here's how we share costs: See explanations below. For specifics about your plan, see "Your Benefits at a Glance" in this handbook.



- Depending on your plan, BCN pays for certain preventive care and wellness costs throughout the year at no cost to you.
- You pay **copayments** for certain covered services, like PCP office visits and urgent care.
- You pay for other medical costs until you meet your **deductible**, if your plan includes a deductible.

- You continue to pay **copayments** and **coinsurance** until the total you've paid for copayments, coinsurance and deductibles meets your **out-of-pocket maximum**.
- If there's more than one person on your plan, you may have to meet a family, as well as an individual, **out-of-pocket maximum**.

- BCN pays for all other covered services. You don't owe a thing. (Please note your plan may not have an out-of-pocket maximum.)

- Your **deductible** and **out-of-pocket maximum** reset for the next year.

Copayment (or copay)
A fixed dollar amount you pay each time you get certain types of care (for example, $25 for a visit to your PCP or $50 for an urgent care visit).

Coinsurance
Your share of the costs of a covered service, calculated as a percentage (for example, you pay 20 percent of the BCN approved amount, and BCN pays 80 percent).

Deductible
The amount you must pay for most health care services before BCN begins to pay. The deductible may not apply to all services.

Out-of-pocket maximum
The most you may have to pay for covered health care services during the year. The out-of-pocket maximum includes your deductible, copays and coinsurance.

*Copays do not count toward the deductible, but do count toward the out-of-pocket limit. You will continue to pay copays after you have met your deductible, until reaching your out-of-pocket limit.

**The out-of-pocket limit never includes your monthly premiums or non-covered services.

Please Note:

Your monthly premium payment is payroll deducted.

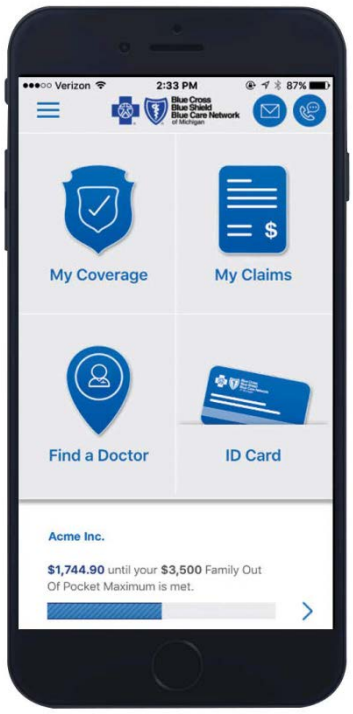
Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

ON–THE–GO Mobile App for iPhone and Android

Manage your health care plan anytime, anywhere with our mobile app

Our mobile app provides the tools and features to help you access information and make informed decisions from the convenience of your smartphone. From seeing where you stand with your deductible and out-of-pocket balances, to reviewing service claims, to finding the best doctor or place to go for treatment — count on our mobile app to give you the information you need — when and where you need it.



These are just some of the app's features:	
Benefit Details	See what your plan covers so you're more informed when you need care.
Deductible and out-of-pocket balances	Know how much you've paid toward your deductible and out-of-pocket maximum balances.
Access to pharmacy and drug information (for members with Blue Cross or Blue Care Network pharmacy coverage)	Look up drug prices, see coverage warnings and find lower cost alternatives.
View claims and EOBs	See what providers charged and why before you pay. Quickly filter and search claims by time frame, member service type or provider.
Find a Doctor	Find a doctor or hospital in your network.[1] Search by location, specialities, quality recognitions and extended office hours. Get GPS enabled directions to get there fast.
Compare cost estimates	Compare cost information for health care services to keep your health and budget in check.[2]
ID card	Show your ID card to your doctor so they have the information they need to look up your coverage.
Blue Cross® Health & Wellness powered by WebMD®	Take a health assessment, set health goals, track your health measures and find credible health infomration from WebMD®.

SEARCH BCBSM WITHIN THE APPLE® APP STORE OR GOOGLE® PLAY. LEARN MORE TODAY AT *www.bcbsm.com/app*.

1. Always call providers before visits to confirm they're in-network.
2. Health care treatment costs are available only to PPO members who aren't covered by a Medicare plan.
3. WebMD Health Services is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network by providing health and wellness services

HMO and Wellness Glossary of Terms

Cost-Sharing. The amount you pay for covered services, medications and medical supplies. These expenses are also known as out-of-pocket costs. They do not include your monthly premium (i.e., the amount you pay each month for health insurance). Your cost-sharing responsibilities reset at the beginning of the next benefit period (every January 1st).

Copay. A fixed dollar amount you pay each time for a covered service, or the purchase of prescriptions or other medical supplies. The amount can vary by the type of covered health care service.

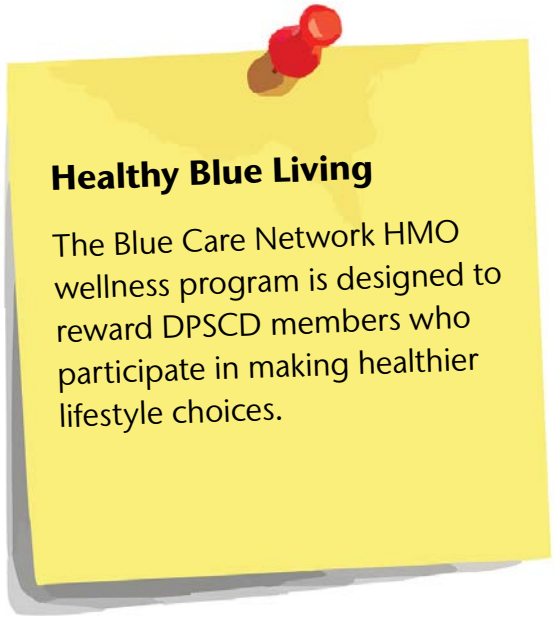
Deductible. The amount you owe for certain covered services before your health plan begins to pay for them. There are per person (individual) deductible amounts and family deductible amounts.

Coinsurance. The percentage of charges for certain covered services that you pay after your deductible has been met. Coinsurance percentages can vary by plan and some plans don't have it at all. Some plans have a "coinsurance maximum" which states a maximum dollar amount for coinsurance for which you will be responsible for during the plan year.

Out-of-pocket Maximum. The most you will pay for the combined total of all copays, coinsurance and deductibles for covered services during the plan year (calendar year). Once you meet your out-of-pocket limit, BCN will pay the allowed amount for covered services. The out-of-pocket limit never includes your monthly premium or non-covered services. Prescription drug copays will count toward the out of pocket maximum.

EOB. Explanation of Benefits – Detailed form provided by the insurance company showing how your claim was processed and benefit amounts allowed and/or paid by your insurance.

Healthy Blue Living. The Blue Care Network HMO wellness program is designed to reward DPSCD members who participate in making healthier lifestyle choices. This program is integrated into all our medical plan options. Enhanced benefits require a commitment, including a visit to your Primary Care Physician (PCP) during the first 90 days (by March 31st) of the Plan Year to get a deeper understanding of your health risks, set healthy goals, and complete an online health assessment. If you do not wish to participate in the Healthy Blue Living health engagement plan requirements, the Standard benefits provide access to the same quality care, but with higher out-of-pocked costs – in other words, by participating in this health engagement program, your Enhanced benefits can save you money on health care throughout the Plan Year. At the end of the 90 day period, if you have not completed the participation requirements, you will automatically be placed in the Standard Plan for the remaining Plan Year. You will get another chance to qualify for the Enhanced Plan during the next year's 90 day period. (See page 13-15 for more details.)



Health Maintenance Organization (HMO). A type of managed care plan that focuses on prevention and wellness. Under an HMO Plan, members are required to seek most routine covered medical care services from their Primary Care Physician (PCP). The PCP coordinates the member's care and refers the member to a specialist when medically necessary. You may select a PCP for yourself and one for each of your covered dependents. With an HMO, generally speaking, you are limited to providers within the HMO network.

In-Network. A doctor or facility that participates in the BCN PCP Focus network or the BCN HMO network, depending on the plan you choose.

Out-of-Network. A doctor or facility not part of the BCN PCP Focus or the BCN HMO network, depending on the plan you choose. Coverage is available for Urgent and Emergency Care.

BCN-Affiliated Providers. Doctors and other providers who are contracted with the BCN networks that are offered to DPSCD. The two networks offered are the BCN PCP Focus network and the BCN HMO network

Plan Year. For DPSCD, this is January 1 through December 31.

Primary Care Physician (PCP). A PCP is a contracted doctor who is usually an internist, general or family practitioner, or pediatrician. The relationship you have with your PCP is important because he or she is the person who knows your complete medical history and will make sure you get the right care you need, including care from a specialist. Select or change your PCP by calling BCN Customer Service at (800) 662-6667 or by visiting *www.bcbsm.com/find-a-doctor*.

For medical coverage, you must select a Primary Care Physician (PCP). A PCP must be selected for you and each family member that will be covered on your plan. A different PCP can be selected for each family member. If a PCP is not selected, Blue Care Network will assign an in-network PCP to each individual. PCPs can be changed at anytime throughout the year.

Health Plan FAQ's

1. **What will I be paying for my health plan in 2018?**
   There will be changes to your monthly contribution. You will see an increase in your monthly premiums for 2018. Please see page 11 for the medical contributions.

2. **For Healthy Blue Living, when will I need to have the Qualification Form and the Health Assessment completed to take advantage of the lower out-of-pocket costs?**
   Only the enrolled DPSCD employee must take part in Healthy Blue Living requirements – neither spouses nor children/dependents need to participate/complete the HBL requirements. Your Qualification Form and Health Assessment must be completed within 90 days (by March 31st) of the start of the Plan Year (January 1st). Should you fail to complete all action prior to the conclusion of the 90 days (by March 31st), you will be moved from Enhanced to Standard benefits. Stated a different way, to receive Enhanced benefits, only the DPSCD employee must meet the HBL requirements and complete all necessary steps within the 90 day window. Some employees, depending on the status of their health and results of the Qualification Form from their PCP, may be required to complete additional wellness programs (i.e. smoking cessation or weight management program) to maintain enhanced benefits.

   Please note: Employees can schedule a visit as early as July 15th for the upcoming plan year; the PCP can use information from that visit to complete and submit the BCN qualification form.

3. **What is a Deductible?**
   A Deductible is the amount you pay for certain covered services before the health plan begins to pay for services. Deductibles may not apply to all services.

4. **What services are covered in full (Deductible does not apply)?**
   Deductibles do not apply to Preventive Services as defined by the Patient Protection and Affordable Care Act (Health Care Reform) rules. Also, deductibles do not apply when a Copay is required. For a list of services, please see the Benefits-At-A-Glance documents or call BCN Customer Service at (800) 662-6667.

5. **What is Coinsurance?**
   Coinsurance is the shared portion of charges for certain covered services after the Deductible has been satisfied. For example, a member might be responsible for 20% of the charges, while the insurance plan pays 80%. The member's portion of these charges are only paid until either the Coinsurance Maximum or Out-of-Pocket Maximum is reached.

6. **What is an Out-of-Pocket Maximum?**
   This is the most you will pay "out of your pocket" for the combined total of all Deductibles, Copays (including pharmacy), and Coinsurance for covered services during the plan year. Once you meet your out-of-pocket Maximum, BCN will pay 100% of the allowed amounts for covered services. The out-of-pocket limit never includes your monthly premium or non-covered services.

7. **May I use funds from my Flexible Spending Account (FSA) to pay my Deductibles, Copays and Coinsurance amounts?**
   Yes, most Deductibles, Copays and Coinsurance charges for services covered by the plan are eligible for FSA reimbursement.

Plan Design and Per Pay Contribution

Dental Plan Highlights

Your teeth may be in great condition, but regular checkups are necessary to keep your teeth healthy. We offer two choices of dental coverage so that you can make the right choice for you and/or your family's dental needs – whether it is extensive work or just polishing your smile. There are several things to keep in mind as you work through choosing your dental option. You may consider if your spouse has a dental plan that will cover you and/or your family. Have you had a great need for dental coverage in the past, or do you foresee an increase in your dental needs in the future? Another key factor to consider is the need for orthodontia. The dental benefit comparison chart on this page does not list a full description of coverage, but serves as a quick summary to assist you in making your decision. Full plan summaries can be found on pages 32 through 36.

If you enroll in the Delta Dental's EPO, your Dental Care will only be covered if you use an EPO participating dentist.

If you choose to enroll in the Delta Dental PPO Plan, you will have access to Delta Dental's PPO and Premier Provider networks, which include over 90% of dental providers in Michigan. **If, for some reason, you choose a Nonparticipating Dentist, the percentages shown indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services.** The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference. You can find dental providers at *www.deltadentalmi.com*.

	Delta Dental EPO	Delta Dental PPO
Annual Maximum	No Limit; Copay Schedule Applies for All Services	$1,500 Per Person
I - Diagnostic / Preventive Services	100%	100% (except x-rays)
II - Restorative Services / X-Rays	100% for Most Services Copay May Apply - See EPO Schedule	PPO Provider: 85% Premier Provider: 75% Non-Par Provider: 75%
III - Prosthodontics	Copay Applies - See EPO Schedule	50%
IV - Orthodontia	Copay Applies - See EPO Schedule to age 19 No Lifetime Maximum	50% to age 19 $1,000 Lifetime Maximum
Changes for 2018:	No Plan Changes	No Plan Changes
Contribution	**Employee Cost Per Pay - 22 Pays**	
Employee Only	$3.55	$2.83
Employee + One	$7.11	$5.61
Employee + Family	$11.02	$10.15
Contribution	**Employee Cost Per Pay - 26 Pays**	
Employee Only	$3.01	$2.39
Employee + One	$6.01	$4.75
Employee + Family	$9.32	$8.59

This booklet is intended to describe the essential features of your health plans in general terms. It is not intended to be a full description of coverage. All efforts have been made to correctly summarize the level of benefits, however, if an error has been made in the summary description, the Certificate of Coverage issued by the plan will supersede this document.

Delta Dental EPO Summary of Dental Plan Benefits For Group# 7000–0001, 0099 DPSCD

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate.

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services - Please refer to the Member Copayment Schedule for a list of Covered Services and Copayments. When more than one treatment option is available, the least expensive treatment is the one covered. Copayments will be reviewed annually for adjustment. Procedure codes are subject to change to reflect current American Dental Association (ADA) procedure codes. Any changes to the Member Copayment Schedule will be effective any January 1.

You must receive dental care from a Delta Dental EPO Dentist in order to receive Benefits. If you receive services from a Non-EPO Dentist, you will be responsible for paying for those services, unless that dental care is Emergency Dental Treatment. If you require Emergency Dental Treatment and your EPO Dentist is not available, you may obtain treatment from any Dentist. You are responsible for paying for the Emergency Dental Treatment. Delta Dental will reimburse you up to the Maximum Payment for Emergency Dental Treatment.

- **Oral exams (including evaluations by a specialist) are payable twice per calendar year.**
- **Prophylaxes (cleanings) are payable twice per calendar year.**
- **People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.**
- **Fluoride treatments are payable twice per calendar year for people up to age 19.**
- **Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.**
- **Sealants are payable once per tooth per lifetime for the occlusal surface of first permanent molars up to age nine and second permanent molars up to age 14. The surface must be free from decay and restorations.**
- **Composite resin (white) restorations are Covered Services on posterior teeth.**
- **Implants and related services are not Covered Services.**
- **Limited orthodontic treatment for primary teeth, comprehensive orthodontic treatment for adult teeth, and adjustment of a removable orthodontic retainer are Covered Services.**

Maximum Payment – $125 per person total per Benefit Year for Emergency Dental Treatment from a Non-EPO Dentist. There is no annual or lifetime maximum on treatment received from an EPO Dentist.

Deductible – None.

Waiting Period – Employees who are eligible for dental benefits are covered upon determination action by the Detroit Public Schools Community District.

Eligible People – All regular employees and para-professional employees qualified under Detroit Public Schools Community District Action (0001) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees (0099). (Note: Certain bargaining units have "employee only" dental coverage while others have full family). The Contractor pays the full cost of this plan.

Also eligible are your legal spouse and your dependent children to the end of the calendar year in which they turn 19 and your dependent unmarried children to the age of 25 if a full-time student and who are eligible to be claimed by you as a dependent under the U.S. Internal Revenue code during the current calendar year.

Coordination of Benefits - If you and your spouse are both eligible for coverage under this Contract, you may be enrolled together on one application or separately on individual applications, but not both. Your dependent children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Subscribers under This Plan.

Benefits will cease on the last day of the month in which the employee is terminated.

Delta Dental EPO – Member Copayment Schedule

DIAGNOSTIC SERVICES

CLINICAL ORAL EVALUATIONS

D0120	Oral examination, periodic	$0
D0140	Oral examination, limited, problem focused (emergency)	$0
D0145	Oral evaluation for patients under age 3 and counseling with primary caregiver	$0
D0150	Oral examination, comprehensive evaluation	$0
D0160	Oral examination, detailed and extensive evaluation, problem focused, by report	$0
D0180	Oral examination, comprehensive periodontal evaluation	$0
D0190	Screening of a patient	$0

RADIOGRAPHS

D0210	Intraoral, complete series (includes bitewings)	$0
D0220	Intraoral, periapical first film	$0
D0230	Intraoral, periapical each addt'l film	$0
D0240	Intraoral, occlusal	$0
D0270	Bitewing, 1 film	$0
D0272	Bitewing, 2 films	$0
D0273	Bitewing, 3 films	$0
D0274	Bitewing, 4 films	$0
D0277	Bitewing, vertical, 7 to 8 films	$0
D0330	Panoramic film	$0

TESTS & LABORATORY

D0460	Pulp vitality	$0
D0486	Accession of brush biopsy sample, microscopic exam, prep and written report	$0

PREVENTIVE

DENTAL PROPHYLAXIS (cleaning)

D1110	Prophylaxis – adult	$0
D1120	Prophylaxis – child	$0

FLUORIDE TREATMENT

D1206	Topical fluoride varnish - child	$0
D1208	Topical application of fluoride	$0

OTHER PREVENTIVE SERVICES

D1351	Sealant - per tooth	$0
D1353	Sealant repair - per tooth	$0

SPACE MAINTAINERS

D1510	Fixed, unilateral	$0
D1515	Fixed, bilateral	$0
D1520	Removable, unilateral	$0
D1525	Removable, bilateral	$0
D1550	Recementation	$0
D1555	Removal of fixed space maintainer	$0
D1575	Distal shoe – fixed, unilateral	$0

RESTORATIVE PROCEDURES

AMALGAM RESTORATIONS

D2140	1 surface	$0
D2150	2 surfaces	$0
D2160	3 surfaces	$0
D2161	4 or more surfaces	$0

RESIN RESTORATIONS

D2330	1 surface, anterior	$0
D2331	2 surfaces, anterior	$0
D2332	3 surfaces, anterior	$0
D2335	Involving incisal angle or 4 or more surfaces, anterior	$0
D2390	Crown, anterior	$0
D2391	1 surface, posterior	$23
D2392	2 surfaces, posterior	$34
D2393	3 surfaces, posterior	$43
D2394	4 or more surfaces, posterior	$50

ONLAY RESTORATIONS[1]

D2542	Onlay, metallic, 2 surfaces	$79
D2543	Onlay, metallic, 3 surfaces	$99
D2544	Onlay, metallic, 4 or more surfaces	$119

CROWNS - SINGLE RESTORATION ONLY[1]

D2710	Resin (indirect)	$39
D2740	Porcelain/ceramic	$49
D2750	Porcelain fused to high noble metal	$73
D2751	Porcelain fused to predominantly base metal	$51
D2752	Porcelain fused to noble metal	$54
D2780	3/4 cast high noble metal	$68
D2781	3/4 cast predominantly base metal	$47
D2782	3/4 cast noble metal	$49
D2783	3/4 porcelain/ceramic	$49
D2790	Full cast high noble metal	$68
D2791	Full cast predominantly base metal	$47
D2792	Full cast noble metal	$49
D2794	Titanium	$49

OTHER RESTORATIVE SERVICES

D2910	Recement onlay or partial coverage restoration	$0
D2915	Recement cast or prefabricated post and core	$0
D2920	Recement crown	$0
D2930	Crown - prefabricated stainless steel, primary	$0
D2931	Crown - prefabricated stainless steel, permanent	$0
D2932	Crown - prefabricated resin	$0
D2940	Sedative filling	$0
D2950	Crown buildup (substructure) including any pins	$0
D2951	Pin retention - per tooth, in addition to restoration	$0
D2952	Post and core in addition to crown, indirectly fabricated	$23
D2954	Prefabricated post and core in addition to crown	$0
D2971	Additional procedures to construct new crown under existing partial denture framework	$11

ENDODONTICS

PULPOTOMY

D3220	Therapeutic pulpotomy	$0
D3221	Pulpal debridement, primary and permanent teeth	$0

ROOT CANAL THERAPY

D3310	Anterior (excludes final restoration)	$0
D3320	Premolar (excludes final restoration)	$0
D3330	Molar tooth (excludes final restoration)	$0
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$0
D3333	Internal root repair of perforation defects	$0
D3346	Retreatment, anterior	$0
D3347	Retreatment, premolar	$0
D3348	Retreatment, molar	$0

APEXIFICATION/RECALCIFICATION PROCEDURES

D3351	Initial visit	$0
D3352	Interim medication replacement	$0
D3353	Final visit	$0

APICOECTOMY/PERIRADICULAR SERVICES

D3410	Surgery - anterior	$0
D3421	Surgery - premolar, first root	$0
D3425	Surgery - molar, first root	$0
D3426	Surgery - each additional root	$0
D3430	Retrograde filling - per root	$0
D3450	Root amputation – per root	$0
D3920	Hemisection (incl any root removal), not incl root canal therapy	$0

PERIODONTIC SERVICES

SURGICAL SERVICES

D4210	Gingivectomy or gingivoplasty – 4 or more teeth per quadrant	$0
D4211	Gingivectomy or gingivoplasty – 1 to 3 teeth per quadrant	$0
D4240	Gingival flap procedure, includes root planing – 4 or more teeth per quadrant	$0
D4241	Gingival flap procedure, includes root planing, 1 to 3 teeth per quadrant	$0
D4249	Clinical crown lengthening	$0
D4260	Osseous surgery – 4 or more teeth per quadrant	$0
D4261	Osseous surgery – 1 to 3 teeth per quadrant	$0
D4263	Bone replacement graft – retained natural tooth – first site	$0
D4264	Bone replacement graft – retained natural tooth – each addt'l site in quadrant	$0
D4270	Pedicle soft tissue graft procedure	$0
D4277	Free soft tissue graft, first tooth	$0
D4278	Free soft tissue graft, each addt'l tooth	$0

NON-SURGICAL SERVICES

D4341	Periodontal scaling and root planing – 4 or more teeth per quadrant	$0
D4342	Periodontal scaling and root planing – 1 to 3 teeth per quadrant	$0
D4346	Scaling in the presence of inflammation	$0
D4355	Full mouth debridement	$0
D4910	Periodontal maintenance	$0

PROSTHODONTICS (Removable)[2]

COMPLETE DENTURES

D5110	Denture - complete, maxillary	$137
D5120	Denture - complete, mandibular	$137
D5130	Denture - immediate, maxillary	$147
D5140	Denture - immediate, mandibular	$147

PARTIAL DENTURES

D5211	Maxillary, resin base	$189
D5212	Mandibular, resin base	$189
D5213	Maxillary, cast metal framework with resin denture base	$231
D5214	Mandibular, cast metal framework with resin denture base	$231
D5221	Maxillary, immediate, resin base	$202
D5222	Mandibular, immediate, resin base	$202
D5223	Maxillary, immediate, cast metal framework with resin denture base	$247
D5224	Mandibular, immediate, cast metal framework with resin denture base	$247
D5225	Maxillary, flexible base	$309
D5226	Mandibular, flexible base	$309
D5281	Removable unilateral, 1 piece cast metal	$137

ADJUSTMENT TO DENTURES

D5410	Complete, maxillary	$0
D5411	Complete, mandibular	$0
D5421	Partial, maxillary	$0
D5422	Partial, mandibular	$0

REPAIRS TO COMPLETE DENTURES

D5511	Repair broken complete denture base, mandibular	$11

Delta Dental EPO – Member Copayment Schedule

D5512	Repair broken complete denture base, maxillary	$11
D5520	Replace missing or broken teeth (each tooth)	$8
REPAIRS TO PARTIAL DENTURES		
D5611	Repair resin partial denture base, mandibular	$11
D5612	Repair resin partial denture base, maxillary	$11
D5621	Repair cast partial framework, mandibular	$16
D5622	Repair cast partial framework, maxillary	$16
D5630	Repair or replace broken clasp (per tooth)	$15
D5640	Replace broken tooth (each)	$8
D5650	Add tooth to existing partial denture	$42
D5660	Add clasp to existing partial denture (per tooth)	$53
DENTURE REBASE PROCEDURES		
D5710	Complete maxillary denture	$33
D5711	Complete mandibular denture	$33
D5720	Maxillary partial denture	$32
D5721	Mandibular partial denture	$32
DENTURE RELINE PROCEDURES		
D5730	Complete maxillary, chairside	$0
D5731	Complete mandibular, chairside	$0
D5740	Maxillary partial, chairside	$0
D5741	Mandibular partial, chairside	$0
D5750	Complete maxillary, laboratory	$25
D5751	Complete mandibular, laboratory	$25
D5760	Maxillary partial, laboratory	$24
D5761	Mandibular partial, laboratory	$24
OTHER REMOVABLE PROSTHETIC SERVICES		
D5820	Interim partial denture, maxillary	$89
D5821	Interim partial denture, mandibular	$89
D5850	Tissue conditioning, maxillary	$0
D5851	Tissue conditioning, mandibular	$0

PROSTHODONTICS (Fixed)[1]

BRIDGE PONTICS (Per Unit)		
D6210	Cast high noble metal	$145
D6211	Cast base metal	$95
D6212	Cast noble metal	$120
D6240	Porcelain fused to high noble metal	$155
D6241	Porcelain fused to base metal	$105
D6242	Porcelain fused to noble metal	$130
D6245	Porcelain/ceramic	$225
FIXED BRIDGE RETAINERS – INLAYS/ONLAYS		
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$32
D6600	Inlay, porcelain/ceramic, 2 surfaces	$161
D6601	Inlay, porcelain/ceramic, 3 or more surfaces	$181
D6602	Inlay, cast high noble metal, 2 surfaces	$141
D6603	Inlay, cast high noble metal, 3 or more surfaces	$161
D6604	Inlay, cast predominantly base metal, 2 surfaces	$101
D6605	Inlay, cast predominantly base metal, 3 or more surfaces	$121
D6606	Inlay, cast noble metal, 2 surfaces	$121
D6607	Inlay, cast noble metal, 3 or more surfaces	$141
D6608	Onlay, porcelain/ceramic, 2 surfaces	$155
D6609	Onlay, porcelain/ceramic, 3 or more surfaces	$161
D6610	Onlay, cast high noble metal, 2 surfaces	$135
D6611	Onlay, cast high noble metal, 3 or more surfaces	$141
D6612	Onlay, cast predominantly base metal, 2 surfaces	$95
D6613	Onlay, cast predominantly base metal, 3 or more surfaces	$101
D6614	Onlay, cast noble metal, 2 surfaces	$115
D6615	Onlay, cast noble metal, 3 or more surfaces	$121
BRIDGE RETAINERS – CROWNS		
D6750	Porcelain fused to high noble metal	$124
D6751	Porcelain fused to base metal	$100
D6752	Porcelain fused to noble metal	$105
D6780	3/4 cast high noble metal	$114
D6781	3/4 cast base metal	$90
D6782	3/4 cast noble metal	$95
D6783	3/4 porcelain/ceramic	$113
D6790	Full cast high noble metal	$114
D6791	Full cast base metal	$90
D6792	Full cast noble metal	$95
OTHER FIXED PROSTHETIC SERVICES		
D6930	Recement fixed partial denture	$0
D6940	Stress breaker	$0

ORAL SURGERY

EXTRACTIONS (Simple)		
D7111	Extraction, coronal remnants - primary tooth	$0
D7140	Extraction, erupted tooth or exposed root	$0
SURGICAL EXTRACTIONS		
D7210	Surgical removal of erupted tooth	$0
D7220	Removal of impacted tooth – soft tissue	$0
D7230	Removal of impacted tooth – partially bony	$0
D7240	Removal of impacted tooth – completely bony	$0
D7241	Removal of impacted tooth – completely bony with complications	$0
D7250	Surgical removal of residual roots	$0
OTHER SURGICAL PROCEDURES		
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$0
D7280	Exposure of an unerupted tooth	$0
D7286	Biopsy of oral tissue – soft	$0
D7288	Brush biopsy	$0
ALVEOLOPLASTY (Surgical Preparation of Ridge for Dentures)		
D7310	In conjunction with extractions, 4 or more teeth or spaces per quadrant	$0
D7311	In conjunction with extraction, 1 to 3 teeth or spaces per quadrant	$0
D7320	Not in conjunction with extractions, 4 or more teeth or spaces per quadrant	$0
D7321	Not in conjunction with extraction, 1 to 3 teeth or spaces per quadrant	$0
EXCISION OF BONE TISSUE		
D7471	Removal of lateral exostosis	$0
SURGICAL INCISION		
D7510	Incision and drainage of abscess – intraoral soft tissue	$0
OTHER REPAIR PROCEDURES		
D7910	Suture of recent small wounds up to 5 cm	$0
D7960	Frenulectomy	$0
D7963	Frenuloplasty	$0
D7970	Excision of hyerplastic tissue – per arch	$0
D7971	Excision of pericoronal gingival	$0

ADJUNCTIVE GENERAL SERVICES

UNCLASSIFIED TREATMENT		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$0
ANESTHESIA		
D9222	Deep sedation/general anesthesia – first 15 minutes	$0
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$0
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	$0
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$0
PROFESSIONAL VISITS		
D9440	Office visit after regularly scheduled hours	$0
MISCELLANEOUS SERVICES		
D9610	Therapeutic parenteral drug, single administration	$0
D9612	Therapeutic parenteral drugs, multiple administration	$0
D9940	Occlusal guard	$41
D9951	Occlusal adjustment – limited	$0
D9952	Occlusal adjustment – complete	$0

ORTHODONTICS[3]

RECORDS (solely for orthodontic purposes)		
D0340	Cephalometric film	$0
D0350	Oral/facial photographic images	$0
D0470	Diagnostic casts	$0
LIMITED ORTHODONTIC TREATMENT		
D8010	Primary dentition	$1900
D8020	Transitional dentition	$1900
D8030	Adolescent dentition	$1900
D8040	Adult dentition (to age 19)	$1900
INTERCEPTIVE ORTHODONTIC TREATMENT		
D8050	Primary dentition	$650
D8060	Transitional dentition	$650
COMPREHENSIVE ORTHODONTIC TREATMENT		
D8070	Transitional dentition	$1900
D8080	Adolescent dentition	$1900
D8090	Adult Dentition (to age 19)	$1900
MINOR TREATMENT TO CONTROL HARMFUL HABITS		
D8210	Removable appliance therapy	$300
D8220	Fixed appliance therapy	$350

[1]Porcelain/ceramic on molars is considered optional treatment.

[2]Includes any adjustments for six months.

[3]Orthodontic Benefits include the initial examination, diagnosis, consultation, initial banding, monthly active treatment, de-banding, and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers, and office visits.

Summary of Dental Plan Benefits for Group# 2355-2001, 2099 Detroit Public Schools Community District

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Nonparticipating Dentist
	Plan Pays	Plan Pays*	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	85%	85%	85%
Basic Services			
Minor Restorative Services – fillings and crown repair	85%	75%	75%
Endodontic Services – root canals	85%	75%	75%
Periodontic Services – to treat gum disease	85%	75%	75%
Oral Surgery Services – extractions and dental surgery	85%	75%	75%
Other Basic Services – misc. services	85%	75%	75%
Relines and Repairs – to bridges, implants, and dentures	85%	75%	75%
Major Services			
Major Restorative Services – crowns	50%	50%	50%
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	Up to age 19	Up to age 19	Up to age 19

*** When you receive services from a Delta Dental Premier or Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's PPO Dentist Schedule (or the Nonparticipating Dentist Fee) that will be paid for those services. This amount may be less than what the dentist charges or Delta Dental approves and you are responsible for that difference.**

Delta Dental PPO Standard

Summary of Dental Plan Benefits for Group# 2355–2001, 2099
Detroit Public Schools Community District

- Oral exams (including evaluations by a specialist) are payable twice in any period of 12 consecutive months.
- Prophylaxes (cleanings) are payable twice in any period of 12 consecutive months.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice in any period of 12 consecutive months for people up to age 19.
- Bitewing X-rays are payable twice in any period of 12 consecutive months for people under age 19 and once in any period of 12 consecutive months for people age 19 and older. Full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Composite resin (white) restorations are optional treatment on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,500 per person total per Benefit Year on all services except orthodontics. $1,000 per person total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to 30% of Delta Dental's stated Copayment of the Maximum Allowed Amount for Orthodontic Services as set forth in the Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 50% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental."

Deductible – None.

Waiting Period – Employees who are eligible for dental benefits are covered upon the determination by the Detroit Public Schools Community District.

Eligible People – All regular employees and para-professional employees qualified under Detroit Public Schools Community District Action (2001) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees (2099). The Contractor pays the full cost of this plan.

Also eligible are your legal spouse and your dependent children to the end of the calendar year in which they turn 19 and your dependent unmarried children to the age of 25 if a full-time student who are eligible to be claimed by you as a dependent under the U.S. Internal Revenue code during the current calendar year.

Coordination of Benefits - If you and your spouse are both eligible for coverage under this Contract, you may be enrolled together on one application or separately on individual applications, but not both. Your dependent children may only be enrolled on one application. Delta Dental will not coordinate benefits between your coverage and your Spouse's coverage if you and your Spouse are both covered as Subscribers under This Plan.

Benefits will cease on the last day of the month in which the employee is terminated.

Save money and stay in network with Delta Dental PPO

With your Delta Dental PPOSM (Standard) plan, you may save more money and receive higher levels of coverage when visiting a Delta Dental PPO dentist. Our PPO dentists have agreed to accept lower fees as full payment for covered services. However, if you go to a dentist who doesn't participate in Delta Dental PPO, you can still save money if your dentist participates in Delta Dental Premier®. Like our PPO dentists, Delta Dental Premier dentists agree to accept reduced fees for covered services. Since the maximum allowed fees are higher for Delta Dental Premier dentists than for our PPO dentists, you may have to pay more out of pocket if you choose not to visit a Delta Dental PPO dentist.

Delta Dental PPO	▪ No balance billing on covered services ▪ Most significant network discounts with more than 287,400 office locations nationwide[1] ▪ Dentists file claims for member
Delta Dental Premier	▪ Provider charges cannot exceed the maximum allowed fee for Delta Dental Premier dentists ▪ Significant network discounts with the most office locations nationwide—363,400[1] ▪ Dentists file claims for member
Nonparticipating dentist	▪ May be balance billed ▪ No network discounts ▪ May need to file own claims

1 National network statistics: Delta Dental Plans Association, December 2015

Examples of how it works:

As shown below, your lowest out-of-pocket costs result from going to a Delta Dental PPO dentist.*

		DELTA DENTAL PPO DENTIST	DELTA DENTAL PREMIER DENTIST	NON-PARTICIPATING DENTIST
ADULT CLEANING	Submitted fee:	$90.00	$90.00	$90.00
	Maximum allowed fee:	$54.00	$77.00	$63.00
	Delta Dental PPO dentist schedule:	$54.00	$54.00	$54.00
	Coverage level:	100%	100%	100%
	Amount Delta Dental pays:	$54.00	$54.00	$54.00
	AMOUNT YOU PAY:	$0.00	$23.00	$36.00
CROWN	Submitted fee:	$950.00	$950.00	$950.00
	Maximum allowed fee:	$675.00	$898.00	$744.00
	Delta Dental PPO dentist schedule:	$675.00	$675.00	$675.00
	Coverage level:	50%	50%	50%
	Amount Delta Dental pays:	$337.50	$337.50	$337.50
	AMOUNT YOU PAY:	$337.50	$560.50	$612.50

*Payment examples above are illustrative only. Fees and reimbursements can vary by location and dentist. They do however represent how payment is determined.

Stay informed about your dental benefits with Consumer Toolkit®

Stay current on your dental benefits with Delta Dental's easy-to-use Consumer Toolkit. This secure online tool is designed to give you 24/7 access to important information regarding your dental benefits, including:

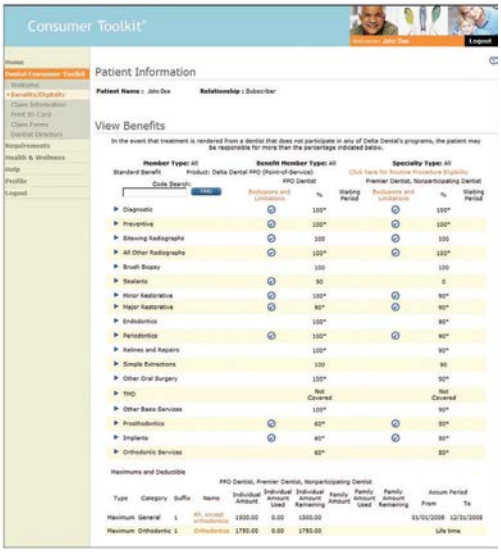
- Eligibility information
- Current benefits information (such as how much of your yearly benefit has been used to date, how much is still available to use, and levels of coverage for specific dental services, etc.)
- Specific claims information, including what has been approved and when it was paid

The site also allows you to sign up for electronic delivery of Explanation of Benefits (EOB) statements, print claim forms and identification cards, and browse oral health information.

All users must first register to gain access to the Consumer Toolkit. Privacy of your online benefit information is assured through highly secure encryption technology.

Eligibility

Up-to-date benefit information



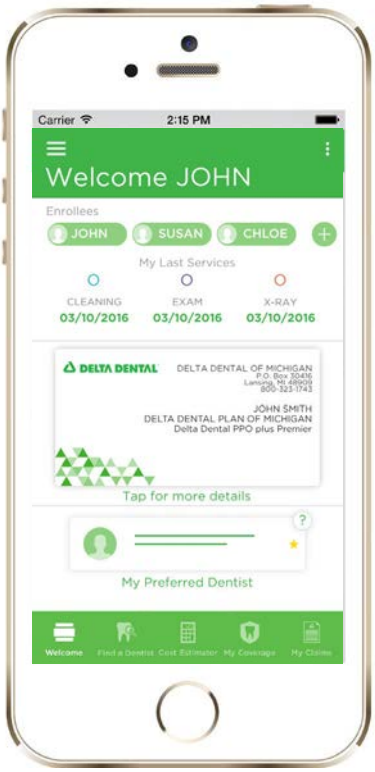
Get started today

1. To start taking advantage of this innovative tool, follow these simple steps:
2. Visit www.toolkitsonline.com.
3. Select "Consumer Toolkit" on the homepage.
4. Register as a new Toolkit user by clicking "Register here."
    - NOTE: You will need the subscriber's (the person whose name is on the benefit package) member ID. The member ID is an assigned number unique to the subscriber. In most cases, the member ID is the same as the subscriber's Social Security number.
5. Complete required fields and follow the on-screen instructions.
6. Select your own username and password to access the site.

Additional help topics can be found by selecting "Help" or clicking the ? at any time within the Toolkit. If you need further assistance, contact Toolkit support at (866) 356-0301.

Your benefits, at your fingertips!

The Delta Dental Mobile App helps you get the most out of your dental benefits anytime, anywhere. Use the dentist search or toothbrush timer without logging in, or enter your username and password to securely access your personal benefit information or estimate your dental care costs.



» Coverage and claims information

See your plan type, benefit levels, deductibles, maximums and more. Check the status of recent dental claims. Add your dependents to your account to be able to access the whole family's coverage in one spot.

» Dental Care Cost Estimator

This easy-to-use tool provides estimated cost ranges on common dental care needs for dentists in your area. You can even select your dentist for tailored cost estimates.

» Dentist search

It's easy to find a participating dentist near you! Search and compare dental offices to find one that suits your needs. Narrow the list with criteria like language spoken and specialty. After you choose a dentist, you can save the contact information and get directions.

» Mobile ID card

There's no longer a need to carry a paper ID card. Simply show the dentist's office your mobile ID card right on your screen. Easily save it to your device for quick access using Apple Passbook or Google Wallet.

» Toothbrush timer

Keep up with your oral health routine by using this handy tool. Our timer counts down for two minutes while reminding you to brush each tooth.

Get started

Delta Dental's free app is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental. Or, scan the QR code at right.

SCAN TO DOWNLOAD APP

Log in for secure access

Delta Dental subscribers can log in using the username and password used to log in to www.deltadental.com. If you haven't registered for an account yet, you can do so within the app. If you've forgotten your username or password, you can also retrieve these within the app. You must log in each time you access the secure portion of the app. No personal health information is ever stored on your device.

Plan Design and Per Pay Contribution

Vision Plan Highlights

Because DPSCD recognizes the value and overall wellness of a vision care program, comprehensive vision coverage is offered to full time employees and their dependents at no cost. Routine eye exams are important for everyone – no matter the age or physical condition. Eye exams can detect vision problems, eye disease and general health problems before you become aware a problem exists.

The Heritage Vision chart located on the next page provides an easy-to-read overview of benefits. To obtain additional information or locate a DPSCD participating vision provider, please call 800.252.2053 or log on to the Heritage Website at *www.heritagevisionplans.com*.

Vision Coverage	Heritage Vision Plans
Contact Lenses / Eye Exam	$90 towards the visit
Vision Screening / Eye Exam	One every 12 months
Eyeglasses Prescription	One every 24 months
Providers	Contact the Plan for an updated list

Heritage Vision Benefits at a Glance

Exam Benefit Frequency is once every 12 Months (from date of last service)
Eyeglasses or Contact Lens Benefit Frequency is once every 24 Months (from date of last service)*

COVERED SERVICES[1]	IN-NETWORK COVERAGE	OUT-OF-NETWORK REIMBURSEMENT[4]
Comprehensive Eye Exam for Eyeglasses	**100% Covered, No Co-Pay**	Reimbursed up to **$39.00**
Frames:		
Frames[2] Member has Choice of Frames	**$50.00** Retail Allowance Member pays retail frame cost over $50.00 less 20% preferred pricing discount[3]	Reimbursed up to **$34.00**
Lenses: Standard Plastic		
Single Vision	**100% Covered, No Co-Pay**	Reimbursed up to **$26.00**
Bifocal		Reimbursed up to **$45.00**
Trifocal		Reimbursed up to **$55.00**
Lenticular		Reimbursed up to **$65.00**
Lens Options and Upgrades:		
Tint Therapeutic Rose #1 or #2	**100% Covered, No Co-Pay**	**N/A**
1 Year Frame Warranty	**100% Covered, No Co-Pay**	**N/A**
Lens Enhancements: Thinner Lenses - Polycarbonate - U.V. Coating Anti-Reflective Coating - Transitions - Etc.	**20% Preferred Pricing Discount** granted for eyeglass lens options and up-grades not covered by the plan[3]	**N/A**
Contact Lenses: (in lieu of eyeglass exam and eyeglasses)		
The Contact Lens Benefit includes the Contact Exam and Contact Lenses		
Comprehensive Eye Exam for Contacts	**$45.00** Retail Allowance Member pays retail contact exam cost over $45.00	Reimbursed up to **$39.00**
Contact Lenses	**$45.00** Retail Allowance Member pays retail contact exam cost over $45.00	Reimbursed up to **$45.00**

[1]You are eligible for contact lenses OR eyeglasses, **not both**, in any Plan Year.
[2]In-program frames include a one year manufacturers' warranty.
[3]Preferred pricing discounts may not be available for certain frame brands, or lens options, as determined by the manufacturer or where prohibited by law.
[4]Out of area reimbursement available to members having no participating provider within 25 miles of residence. Prior approval required.
*Children (under age 19) may receive new lenses once every 12 months with a prescription change of ± .50 diopters or more.

Additional In-Network Discounts	Exclusions (Not Covered)
• 20% discount off an additional prescription Eyeglass or Sunglass (2nd pair) purchase made during the initial visit. • 15% Discount off Retail Price (or 5% off Promotional Pricing) on Lasik Refractive Surgery through the LasikPlus.	• Vision Training • Non-prescription Lenses • Two pairs of glasses instead of bifocals • Replacement of lost or broken lenses or frames • Medical or surgical treatment of the eyes • Services covered under Worker's Comp.

This is intended as an easy-to-read summary and provides a general overview of benefits. It is not a contract. Additional exclusions and limitations may apply.
To find a Heritage Vision Provider, please call **800.252.2053** or log on to the Heritage Website at *www.heritagevisionplans.com*.

Life Insurance/Discounts

Basic Life Insurance

Basic Life Insurance is provided to all eligible DPSCD employees. DPSCD provides this coverage to help protect your family's financial security in the event of your death.

Your Online Enrollment will list the amount of coverage provided to you by DPSCD.

Imputed Income: When the amount of your DPSCD-provided Employee Basic Life Insurance is greater than $50,000, you are subject to the IRS' Imputed Income rules. You will be required to pay annual federal and state income taxes as well as Social Security tax on the value of employer provided insurance over $50,000. The amount of the tax will be based on your age. Your imputed income will be reported on your W-2.

Supplemental Life Insurance

In some situations, the Basic Life Insurance may not meet all of your family needs. There are several advantages to enrolling in the Supplemental Employee Life Insurance Program. You will be a member of a large group purchasing additional insurance which can provide more affordable group rates. You may purchase up to 5x your annual salary of Supplemental Life Insurance, subject to the benefit maximum. If an employee enrolls themselves when they are initially eligible for the coverage, there will be no medical questions, Evidence of Insurability (EOI), to answer as long as the coverage election is less than the benefits Guaranteed Issue amount (which is the lesser of 2 times your annual salary or $300K). Should you choose to enroll at the next annual enrollment period or if you elect to increase your supplemental life insurance coverage, Evidence of Insurability (EOI) is required. You will need to also confirm your selection during this online enrollment.

An employee who retires from Detroit Public Schools Community District is eligible to port basic and supplemental life insurance or convert basic and supplemental life insurance. They can also port the coverage and when the port benefit ends they can convert.

Employee Discounts

As an employee of DPSCD you are eligible to receive discounts on purchases and/or services through the following companies. You can access each vendor by clicking on the logo, and following the link below:

Additional discounts may be available by using your health insurance card. Click on your plan provider logo below for a link to details and participating merchants:

DPSCD assumes no obligation or liability and does not endorse any product, service, discount or vendor listed. Discounts are subject to end at any time without notice.

403b and FSA

Retirement Planning

Retirement may be years away for some of our employees; however, there is no time like the present to plan for tomorrow. DPSCD provides access to the following programs.

MPSERS Pension / Health Care Benefits

The Michigan Public Schools Employees Retirement System (MPSERS) was developed for Michigan Public School Employees to provide a monthly pension and health care benefits for you and your family after you retire.

The MPSERS plan is administered by the State of Michigan Office of Retirement Services (ORS) and is controlled by the Michigan Public School Employees Retirement Act (Public Act 300 of 1980 as amended). If you have questions regarding this plan, you should contact ORS directly at **(800) 381-5111 or (517) 322-5103**. For written correspondence the address is: Office of Retirement Services (ORS) P.O. Box 30171 Lansing, MI 48909-7671.
If you prefer to manage your communication online, follow this link: *www.michigan.gov/orsschools*.

The OMNI Group 403(b)

All full time DPSCD employees have the opportunity to save for retirement on a pre-tax basis by participating in the Detroit Public Schools Community District 403(b) plan. DPSCD has partnered with The OMNI Group to administer these plans, and help ensure compliance with IRS regulations. We recommend that all our employees review a brief, 3-minute video presentation explaining what a 403(b) plan is, and how to contribute, at *www.403bwhyme.com*.

If you choose to participate, you will first need to set up an investment account with the 403(b) service provider of your choice. Participating providers are listed at *https://www.omni403b.com/PlanDetail.aspx?clientID=PAE4A6DVhyo=*.

Next, you will need to complete the Salary Reduction Agreement (SRA) in order to begin your contributions. A copy of the SRA can be completed electronically at *www.omni403b.com/forms_SRA_403b.aspx*.

No login information is required to complete this form. Please contact The OMNI Group at **(877) 544-6664** with any questions regarding this plan or your enrollment.

Save With An FSA

Kapnick Insurance Group is the Administrator for DPSCD Flexible Spending Accounts. **FSAs allow you to set aside pre-tax dollars to pay for various healthcare and dependent care expenses, keeping more money in your pocket. FSA's allow you to save money through contributing pre-tax dollars to your FSA account, thus decreasing your taxable income and increasing your "take home pay." Please see the Eligible Expenses section on the next page for an understanding of what you can use FSA money for.**

See savings example below:

Take Home Pay	Without FSA	With FSA
Your Annual Income	**$35,000**	**$35,000**
Contribution to FSA (before taxes)	**0**	**($2,650)**
Tax Deduction (est. 35%)	**$12,250**	**$11,322.50**
After Tax Income	**$22,750**	**$23,677.50**
Increase in Take Home Pay	**N/A**	**$921.50**

Health Care FSA

The Health Care Flexible Spending Account assists you in paying for medical expenses that are not covered by your medical insurance plan. You will simply need to determine how much to contribute to this plan for the 2018 plan year. The annual contribution for 2018 is limited to $2,650 (maximum allowed by the IRS). If you elect to participate in the Health Care FSA you will receive a ***MyBenny*** MasterCard debit card to purchase eligible services or items. Your ***MyBenny*** card will be pre-loaded with the entire annual election amount available to you the first day of the new plan year. This will eliminate the need for you to pay out of pocket and wait for reimbursement. All new participants will receive two ***MyBenny*** cards in the mail. New cards are only sent every five years. You may request an additional or replacement card for a $10 charge.

FSA Information (continued)

Eligible FSA Expenses

Eligible Medical expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments such as Deductibles, Copays, Coinsurance, etc. for services rendered by physicians, surgeons, dentists, and other medical practitioners.

Medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins or a vacation. You can generally include medical expenses you pay for yourself, as well as expenses you pay for your qualified spouse or dependent.

You can include only the medical and dental expenses you paid this year. **You cannot include medical expenses that were paid by insurance companies or other sources.** This is true whether the payments were made directly to you, to the patient, or to the provider of the medical services.

Over-the-Counter Medications

Remember that you cannot use your Health Care FSA to pay for over-the-counter medications unless you have a prescription from your health care provider. This includes, but is not limited to, antacids, cold medications, pain relievers, and allergy medications. However, insulin and over-the-counter supplies (such as bandages, contact lens solution, antibiotic ointment, etc.) are still eligible expenses. For a complete list of Eligible Medical Expenses, please refer to IRS Publication 502 at the link below:

http://www.irs.gov/pub/irs-pdf/p502.pdf

Want to Save More Money?

Learn more about the money saving benefits of a Flexible Spending Account, by visiting the DPSCD Online Benefit Center at *www.detroitk12.bswift.com*.

Calculators are available to help you set your contribution. Also visit the online FSA store at *http://www.kapnick.com/employee-benefits/kapnick-flex-account/fsaextras/* for convenient FSA shopping.

Dependent Care FSA

The Dependent Care Flexible Spending Account allows you to set aside money to pay for the care of a dependent parent, child, or disabled dependent, so that you and your spouse are able to work outside of the home. Under this plan, a dependent must be a spouse or dependent you legally claim on your year-end taxes, and must be either under 13 years old, or unable to care for themselves due to physical or mental limitations.

Enrolling in one or both of these plans is easy. All you need to do is determine how much you would like to contribute annually to the plan. That amount will be deducted from your pay checks in equal installments throughout the year. These deducted amounts will be taken before taxes are calculated. The maximum allowable contribution (by the IRS) is $5,000 annually. (This is limited to $2,500 if you are married filing separately, or to a combined maximum of $5,000 if married filing jointly.) For more information please refer to IRS publication 503 available at: *http://www.irs.gov/pub/irs-pdf/p503.pdf*.

It's important to set aside only the money you expect to use during the coming year. If you do not spend all of your money in your Flexible Spending Accounts during the year, IRS regulations require that you forfeit any remaining balance.

For questions regarding Flexible Spending Accounts Contact Kapnick Flex at (800) 550-3539 or by email at *flex@kapnick.com*.

Qualified life Events – Allowable Changes

Any employee who knowingly enrolls an ineligible dependent will risk losing medical, dental, and vision coverage, and may also be penalized by DPSCD. Penalties include disciplinary action, repayment and loss of benefits, and possible termination of employment. Audits will continue to occur throughout the year when dependent(s) are added to your plan. A letter will be sent to your home address with instructions for providing the required documentation.

The following changes are allowable, as long as the change is made within 30 days of the applicable qualifying life event with changes being effective as the life event date.

Life Event	Medical	Dental	Vision	Supplemental Life	Health FSA	Dependent Care FSA	Required Documents
Birth/Adoption	Enroll or Add coverage for new dependent only	Enroll or Add coverage for new dependent only	Enroll or Add coverage for new dependent only	Increase/Decrease Coverage	Add/Increase Coverage	Add/Increase Coverage	Copy of Hospital Record, Birth Certificate, Adoption Papers or Court Documents
Marriage	Add Spouse/ Dependent(s) Drop Coverage	Add Spouse/ Dependent(s) Drop Coverage	Add Spouse/ Dependent(s) Drop Coverage	Add/Drop/Increase/ Decrease Coverage	Increase/ Decrease Coverage	Add/Drop/Increase/ Decrease Coverage	Copy of Marriage Certificate
Divorce/Legal Separation*	Enroll or Add Dependents Drop Spouse/ Dependent(s)	Enroll or Add Spouse/ Dependents Drop Spouse/ Dependent(s)	Enroll or Add Spouse/ Dependents Drop Spouse/ Dependent(s)	Drop/Increase/ Decrease Coverage	Decrease Coverage	Add/Drop/ Increase/ Decrease Coverage	Entire Copy of Divorce Decree
Different Election Period-Spouse	Add/Drop Coverage Add/Delete Spouse/ Dependent(s)	Add/Drop Coverage Add/Delete Spouse/ Dependent(s)	Add/Drop Coverage Add/Delete Spouse/ Dependent(s)	Add/Drop / Increase/Decrease Coverage	No Change	Add/Drop/Increase/ Decrease Coverage	Letter of Verification from Spouse's Employer
Dependent Child Gains Eligibility	Add Dependent(s)	Add Dependent(s)	Add Dependent(s)	Increase/Decrease Coverage	Add/Increase Coverage	Add/Increase Coverage	Verification of Full-Time Student Status between ages of 19-25
Dependent Child Loses Eligibility	Drop Dependent(s)	Drop Dependent(s)	Drop Dependent(s)	Increase/Decrease Coverage	Drop/Decrease Coverage	Drop/Decrease Coverage	None
Spouse Gains Benefits	Drop Coverage Delete Spouse/ Dependent(s)	Drop Coverage Delete Spouse/ Dependent(s)	Drop Coverage Delete Spouse/ Dependent(s)	Increase/Decrease Coverage	Drop/Decrease Coverage	Add/Drop/ Increase/ Decrease Coverage	None
Spouse Loses Benefits	Enroll Spouse/ Dependent(s)	Enroll Spouse/ Dependent(s)	Enroll Spouse/ Dependent(s)	Increase/Decrease Coverage	Increase/ Decrease Coverage	Add/Increase Coverage	Proof of Loss of Coverage
Dependent(s) Gains Medicare or Medicaid	Drop Dependent(s)	No Change	No Change	Increase/Decrease Coverage	Add/Increase Coverage	Add/Increase Coverage	None
Dependent(s) Loses Medicare or Medicaid	Add Dependent(s)	No Change	No Change	Increase/Decrease Coverage	Drop/Decrease Coverage	Drop/Decrease Coverage	Proof of Loss of Coverage
Death of Spouse**	Drop Spouse, Enroll or Add Dependent(s)	Drop Spouse, Enroll or Add Dependent(s)	Drop Spouse, Enroll or Add Dependents	Drop/Increase/ Decrease Coverage	Decrease Coverage	Add/Drop/ Increase/ Decrease Coverage	Copy of Death Certificate
Death of Dependent Child(ren)	Drop Dependent(s)	Drop Dependent(s)	Drop Dependent(s)	Drop/Increase/ Decrease Coverage	Decrease Coverage	Add/Drop/Increase/ Decrease Coverage	Copy of Death Certificate
Establish Legal Guardianship	Add Dependent(s)	Add Dependent(s)	Add Dependent(s)	Increase/Decrease Coverage	Add/Drop/ Increase/ Decrease Coverage	Add/Drop/ Increase/ Decrease Coverage	Proof of Guardianship

Your Prescription Drug Coverage & 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 Detroit Public Schools Community District 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 (such as an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Detroit Public Schools Community District has determined that the prescription drug coverage offered with the Core, Core Plus and Premium Medical Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-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 Detroit Public Schools Community District coverage will not be affected. However, if you join a Medicare drug plan and drop your current Detroit Public Schools Community District coverage, be aware that you and your dependents will not be able to get this coverage back until Detroit Public Schools Community District's next Open Enrollment, which has an effective date of January 1, 2019.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Detroit Public Schools Community District 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.

Your Prescription Drug Coverage & Medicare

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 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed on this page for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Detroit Public Schools Community District 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 the telephone number)
- For personalized help, call **(800) MEDICARE / (800) 633-4227**. TTY users should call **(877) 486-2048**

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

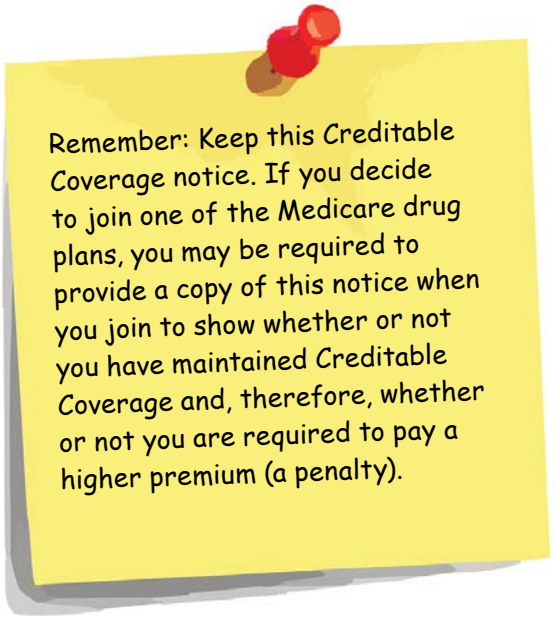
Date: November 2017

Name of Entity: Detroit Public Schools Community District

Contact: Human Resources Department

Address: 3011 West Grand Blvd. 10th Floor
Detroit, MI 48202

Phone Number: (313) 576-0080



Federal Laws

Health Insurance Portability and Accountability Act (HIPAA)

The HIPAA Act was passed in 1996 to help people maintain or obtain medical insurance coverage for employees and their families when they lose or change jobs. HIPAA also established standards for keeping your personal health information, and that of your family private so that you cannot be prevented from receiving medical benefits due to pre-existing conditions.

Michelle's Law

Michelle's Law was passed in 2010 in order to avoid interruption of coverage for dependent students experiencing a medically necessary leave of absence, in cases where student status is an eligibility requirement under the plan.

In order to qualify, the dependent child must be enrolled in the plan or coverage on the basis of student status immediately before the first day of the medically necessary leave of absence involved.

A group health plan must continue such coverage until the earlier of either one year after the first day of the medically necessary leave of absence, or through the date on which such coverage would have otherwise terminated under the terms of the plan.

The group health plan or issuer may require receipt of written certification by a treating physician of the dependent child which states that the dependent child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.

Please note under the Patient Protection and Affordable Care Act (PPACA or ACA), dependent children may stay on their parents health insurance plan until age 26 regardless of full-time student status.

Patient Protection Disclosure

BCN generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, BCN will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BCN: (800) 662-6667. You do not need prior authorization from BCN or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact BCBS: **(800) 662-6667.**

Women's Health and Cancer Rights Act

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications for all stages of a mastectomy, including lymphedema (swelling associated with the removal of lymph nodes).

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to Deductibles and Coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Federal Laws

Newborn's / Mother's Health Protection Act

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

Family Medical Leave Act (FMLA) Benefits

DPSCD will determine eligibility based on your hours worked and the documentation from you or your family's health care provider. You can receive up to 12 weeks (or up to 26 weeks of military caregiver leave to care for a covered service member with a serious injury or illness) during a 12-month period for eligible employees. The leave may be paid, unpaid, or a combination of paid and unpaid leaves. During this time, your job will be protected. This leave is provided in case you or one of your immediate family members becomes ill. You may also use this leave for the birth, adoption, or foster care of you or your immediate family. Failure to respond and/or submit your monthly premium will result in cancellation of your benefits for the applicable month. Therefore, you will be responsible for any healthcare expenses obtained during the applicable month. **The district will enforce its policy that medical leaves will not be back-dated.**

Medicaid / Children's Health Insurance Plan

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. Some 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 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 **877-KIDSNOW** or visit *www.insurekidsnow.gov* to find out how to apply. You must request coverage within 60 days of being determined eligible for premium assistance.

USERRA

Your right to continued participation in the plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the plan by paying premiums.

If you do not elect to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in the plan.

Federal Laws

Reminder of Availability of Privacy Notice

This is to remind plan participants and beneficiaries of the DPSCD and Welfare Plan (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and discloses protected health information (PHI). You can obtain a copy of the DPSCD and Welfare Plan Privacy Notice upon your written request to Human Resources, at the address below. If you have any questions, please contact the DPSCD Human Resources Office at (313) 576-0080.

Detroit Public Schools Community District
Human Resources Department
3011 West Grand Blvd, 10th Floor
Detroit, MI 48202

Notice of Health Insurance Market Place Coverage Options

This notice provides some basic information about the new Health Insurance Marketplace and employment based health coverage offered by your employer.

The Marketplace is designed to help the uninsured and underinsured find health insurance that meets the budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1.

If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace, and may wish to enroll in your employer's health plan.

However, if your employer does not offer coverage that would cost you less than 9.56% of your household income to enroll yourself only, or if the plan offered does not meet the ACA's 'Minimum Value' standard, you may qualify for a credit toward your premium, depending on your household income.

Keep in mind that when you purchase a health plan through the Marketplace, your payments for coverage would be made on an after-tax basis. You will lose any contribution from the employer toward their benefit plan, which, along with your contributions, is often excluded from your income and paid on a pre-tax basis.

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

About This Guide

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual Summary of Benefits and Coverage (SBCs) or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail.

DPSCD reserves the right to make changes at any time to the benefits, costs, and other provisions relative to benefits.

Carrier Contact Information

COVERAGE	PHONE	WEBSITE / EMAIL
Health, Dental, Vision Enrollment		
Enrollment: DPSCD Online Benefit Center	Online Only	*www.detroitk12.bswift.com*
Support: DPSCD Benefits Solution Center	(888) 447-9038	*servicecenter@kapnick.com*
Voluntary Benefits Enrollment		
Allstate Call Center	(877) 579-3635	
Allstate Online Enrollment	Online Only	*https://awd.benselect.com/enroll*
Allstate Microsite (Info Only)	Online Only	*http://www.allstatevoluntary.com/DPS/*
Medical and Rx Plans		
BCN Core Plan - with PCP Focus Network	(800) 662-6667	*www.bcbsm.com*
BCN Core+ Plan - with PCP Focus Network	(800) 662-6667	*www.bcbsm.com*
BCN Premium Plan - with BCN HMO Network	(800) 662-6667	*www.bcbsm.com*
Dental Plans		
Delta Dental EPO	(800) 524-0149	*www.deltadentalmi.com*
Delta Dental PPO	(800) 524-0149	*www.deltadentalmi.com*
Vision Plans		
Heritage Optical	(800) 252-2053	*www.heritagevisionplans.com*
Tax-Deferred Annuity Plan - 403(b)		
Omni Group - TDA Administrator	(877) 544-6664	*www.omni403b.com*
Life Insurance		
Securian	(800) 843-8358	*www.lifebenefits.com*
Flexible Spending Accounts		
Kapnick Flex	(800) 550-3539	*flex@kapnick.com*
Retirement and Group ORS		
Michigan Office of Retirement Services	(800) 381-5111	*http://www.michigan.gov/ors*

Notes

Detroit Public Schools Community District

2018 Annual Benefit Guide

This booklet is intended to describe the essential features of your health plans in general terms. It is not intended to be a full description of coverage. All efforts have been made to correctly summarize the level of benefits, however, if an error has been made in the summary description, the Certificate of Coverage issued by the plan will supersede this document.

DPSCD