2027 Taylor *Benefits Guide*



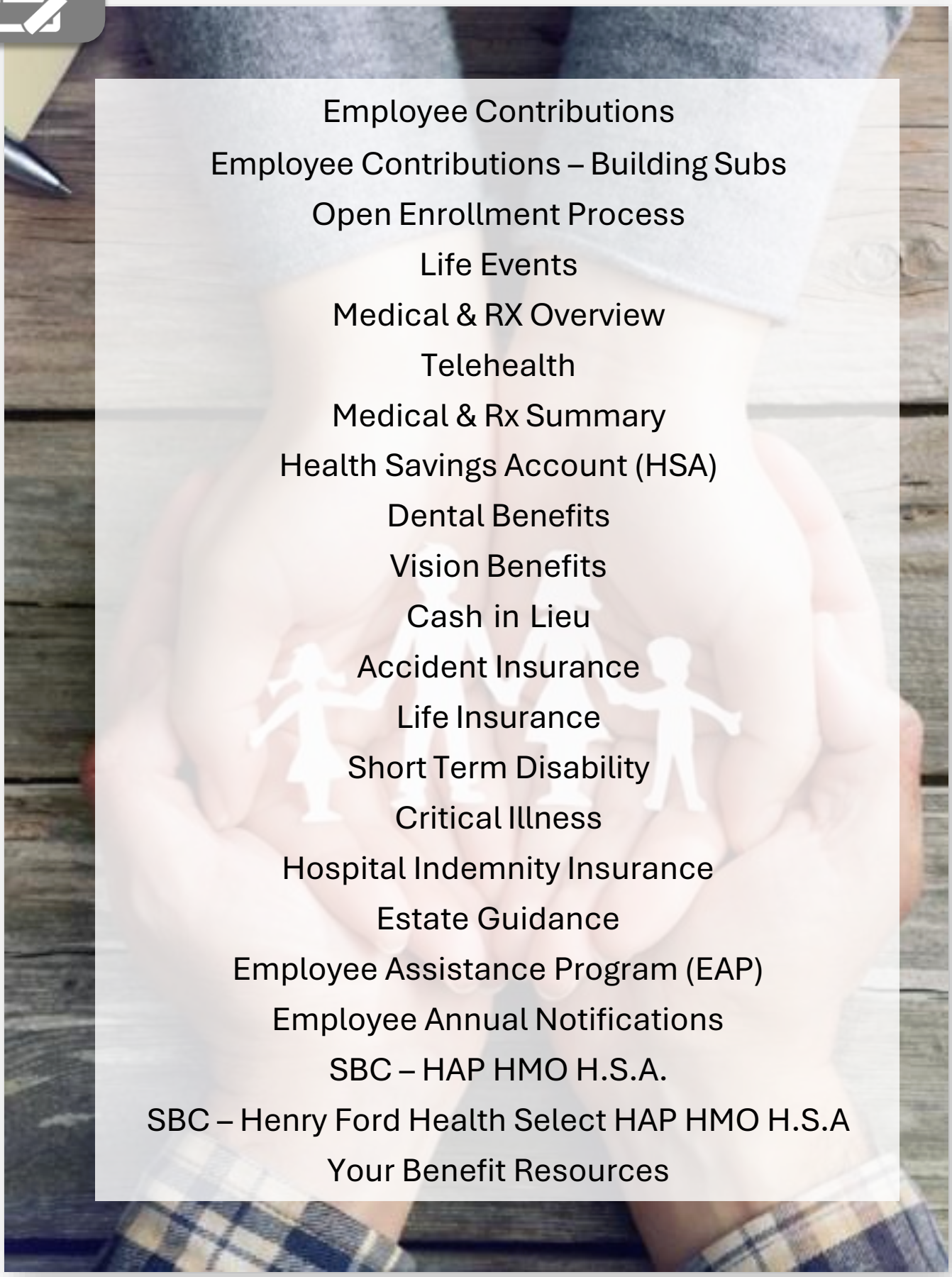




All employees must complete enrollment through the PlanSource Benefit Administration System.

Open Enrollment is November 9th - November 23rd, 2026.
Failure to enroll will result in NO BENEFITS effective January 1st, 2027!

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EMPLOYEE CONTRIBUTIONS



The below amounts in red will be deducted as premiums per pay from your check to be contributed towards your medical, dental and vision plans.
***These figures do not pertain to Building Subs. Please see next page for Building Sub Rates.**

2027 HEALTHCARE PAYROLL DEDUCTIONS

26 Pays per Year Employee

Election	HAP HMO HSA $2,500/$5,000	Henry Ford Select HMO HSA $2,500/$5,000 *	Delta Dental	NVA Vision	Cash in Lieu $1,920/year
Single	($4.62)	$0.00 Plus $500.00/year or $19.23 into your HSA Account	$0.00	($0.77)	$73.85
Two Person	($9.23)	$0.00 Plus $1,000.00/year or $38.46 into your HSA Account	$0.00	($1.45)	$73.85
Family	($18.46)	$0.00 Plus $1,000.00/year or $38.46 into your HSA Account	$0.00	($2.04)	$73.85

20 Pays per Year Employee

Election	HAP HMO HSA $2,500/$5,000	Henry Ford Select HMO HSA $2,500/$5,000 *	Delta Dental	NVA Vision	Cash in Lieu $1,920/year
Single	($6.00)	$0.00 Plus $500.00/year or $25.00 into your HSA Account	$0.00	($1.00)	$96.00
Two Person	($12.00)	$0.00 Plus $1,000.00/year or $50.00 into your HSA Account	$0.00	($1.88)	$96.00
Family	($24.00)	$0.00 Plus $1,000.00/year or $50.00 into your HSA Account	$0.00	($2.66)	$96.00

***If you are 65 or older, H.S.A. amounts will be added directly to your paycheck as federal law prohibits contributions at this age.**

2027 Maximum Employee H.S.A. Contribution - Optional

26 Pays per Year Employee

Election	HAP HMO HSA $2,500/$5,000	Henry Ford Select HMO HSA $2,500/$5,000	Catch Up Age 55 or Older
Single	($173.07)	($153.84)	($38.46)
Two Person/Family	($346.15)	($307.69)	($38.46)

20 Pays per Year Employee

Election	HAP HMO HSA $2,500/$5,000	Henry Ford Select HMO HSA $2,500/$5,000	Catch Up Age 55 or Older
Single	($225.00)	($200.00)	($50.00)
Two Person/Family	($450.00)	($400.00)	($50.00)

EMPLOYEE CONTRIBUTIONS - Building Subs ONLY



This deduction structure on this page is for Building Subs Only!

The below amounts in red will be deducted as premiums per pay from your check to be contributed towards your medical, dental and vision plans.

2027 HEALTHCARE PAYROLL DEDUCTIONS					
BUILDING SUBS ONLY - 20 Pays per Year Employee					
Election	**HAP HMO HSA $2,500/$5,000**	**Henry Ford Select HMO HSA $2,500/$5,000 ***	**Delta Dental**	**NVA Vision**	**Cash in Lieu $1,920/year**
Single	($6.00)	$0.00 Plus $500.00/year or $25.00 into your HSA Account	$0.00	($1.00)	$96.00
Two Person	($501.84)	($420.50) Plus $1,000.00/year or $50.00 into your HSA Account	($27.70)	($4.19)	$96.00
Family	($782.69)	($655.83) Plus $1,000.00/year or $50.00 into your HSA Account	($68.33)	($6.98)	$96.00

***If you are 65 or older, H.S.A. amounts will be added directly to your paycheck as federal law prohibits contributions at this age.**

2027 Maximum Employee H.S.A. Contribution - Optional			
26 Pays per Year Employee			
Election	**HAP HMO HSA $2,500/$5,000**	**Henry Ford Select HMO HSA $2,500/$5,000**	**Catch Up Age 55 or Older**
Single	($173.07)	($153.84)	($38.46)
Two Person/Family	($346.15)	($307.69)	($38.46)
20 Pays per Year Employee			
Election	**HAP HMO HSA $2,500/$5,000**	**Henry Ford Select HMO HSA $2,500/$5,000**	**Catch Up Age 55 or Older**
Single	($225.00)	($200.00)	($50.00)
Two Person/Family	($450.00)	($400.00)	($50.00)

OPEN ENROLLMENT PROCESS

Benefit Enrollment Instructions

Effective Monday, November 9, 2026

Eligibility

- **FTE –** An employee's FTE profile must be 0.65 or greater to be eligible for benefits.
- **MARRIAGE –** Employee's spouse by legal marriage if recognized under the laws of the employee's state of domicile, including any same sex marriages.
- **DEPENDENT CHILDREN** are eligible for coverage until the end of the year in which they turn 26.
- **DUAL COVERAGE –** Your plan allows for dual coverage for Medical, Dental and Vision.
- **EFFECTIVE DATE –** New hires are eligible for benefits the first day they begin work.

Enrollment Online:

Go to: https://benefits.plansource.com/



Enter your username. Your username is the first initial of your first name, the first six characters of your last name, and the last four digits of your Social Security number. *For example, if your name is John Williams, and the last four digits of your Social Security number are 1234, your username will look like this: jwillia1234.*

Enter your password. Your password is your date of birth in a number format without any punctuation, starting with the year you were born, then the month and then the date (YYYYMMDD). *For example, if your date of birth is January 5, 1970, your password will look like this: 19700105.*

Once you have logged in, you will be prompted to change your password.

Enrollment by Phone:

If you prefer to speak directly to a representative in the Benefit Center who will assist you in making your elections and with technical support, please call the Benefit Center at **(888) 222-4309**. Representatives are available between the hours of 8 a.m. and 11 p.m. EST, Monday through Friday.

When you call, the Benefit Center will ask you to verify the last four digits of your Social Security number and your date of birth. From that point, the representative will walk you through your personal information on file to confirm its accuracy. Please be prepared to first provide verbal authorization if you would like your spouse to speak with a representative on your behalf.



Open Enrollment ends at midnight on Monday, November 23rd, 2026!

Eligible Employees MUST enroll between NOVEMBER 9th - NOVEMBER 23rd to have benefits effective January 1, 2027!

If you do not enroll for 2027, you will LOSE ALL COVERAGE effective January 1, 2027!

LIFE EVENTS

Life changes that can qualify you for a Special Enrollment Period are listed below. You must notify the PlanSource Benefit call center by logging on at https://benefits.plansource.com or calling (888) 222-4309 within 30 days if you would like to exercise your special open enrollment period.

Changes in Household	Changes in Residence	Loss of Health Insurance
You may qualify for a Special Enrollment Period if you or anyone in your household **in the past 30 days:** • **Got married** • **Had a baby, adopted a child, or placed a child for foster care.** Your coverage can start the day of the event • **Got divorced or legally separated and lost health insurance. Note:** Divorce or legal separation without losing coverage doesn't qualify you for a Special Enrollment Period. • **Death—**If you are covered under your spouse's plan and they pass away you are eligible to join the DSEHP Health Plan	Household moves that qualify you for a Special Enrollment Period: • Moving to the U.S. from a foreign country or United States territory • A student moving to or from the place they attend school **Note:** Moving only for medical treatment or staying somewhere for vacation doesn't qualify you for a Special Enrollment Period. **Important:** You must prove you had qualifying health coverage for one or more days during the 30 days before your move.	You may qualify for a Special Enrollment Period if you or anyone in your household lost qualifying health coverage **in the past 30 days** Coverage losses that may qualify you for a Special Enrollment Period: • Losing job-based coverage • Losing eligibility for Medicaid or CHIP • Losing eligibility for Medicare • Losing coverage through a family member



MEDICAL & RX

Below is an overview of the copays effective January 1st.
A Summary of Benefits and Coverage is available later in this guide.

Plan Provisions	HAP HMO HSA Plan	Henry Ford Select HSA Plan
	PCP Required	PCP Required
Deductible		
Based on a Calendar Year	$2,500 / $5,000	$2,500 / $5,000
MOOP = Maximum Out of Pocket		
Based on a Calendar Year	$3,500 / $7,000	$3,500 / $7,000
Physician Office Services		
Office Visit	100% AFTER Deductible	100% AFTER Deductible
Specialist Office Visit	100% AFTER Deductible	100% AFTER Deductible
Emergency Medical Care		
Emergency Room	100% AFTER Deductible	100% AFTER Deductible
Urgent Care Visits	100% AFTER Deductible	100% AFTER Deductible
Prescription Drugs		
All Copays apply AFTER deductible		
Tier 1-Preferred Generic	Tier 1—$10	Tier 1—$10
Tier 2-Non-Preferred Generic	Tier 2—$30	Tier 2—$30
Tier 3-Preferred Brand	Tier 3—$60	Tier 3—$60
Tier 4-Non-Preferred Brand	Tier 4—$80	Tier 4—$80
Tier 5-Preferred Specialty	Tier 5—20% ($200 Max)	Tier 5—20% ($200 Max)
Tier 6-Non-Preferred Specialty	Tier 6—20% ($300 Max)	Tier 6—20% ($300 Max)

IMPORTANT!!!

To see if a Primary Care Physician (PCP) is in-network, go to https://hap.providerlookuponlinesearch.com/search and filter Insurance Plans by either *'HMO'* for the *HAP HMO HSA Plan,* or *'Henry Ford Select (Large Group) HMO'* for the *Henry Ford Select HSA Plan.*

Failure to choose and use a PCP that is not in your network can lead to unpaid medical bills and costs that may not count toward your deductible. If you do not choose a PCP in your network, Health Alliance Plan will select one for you.

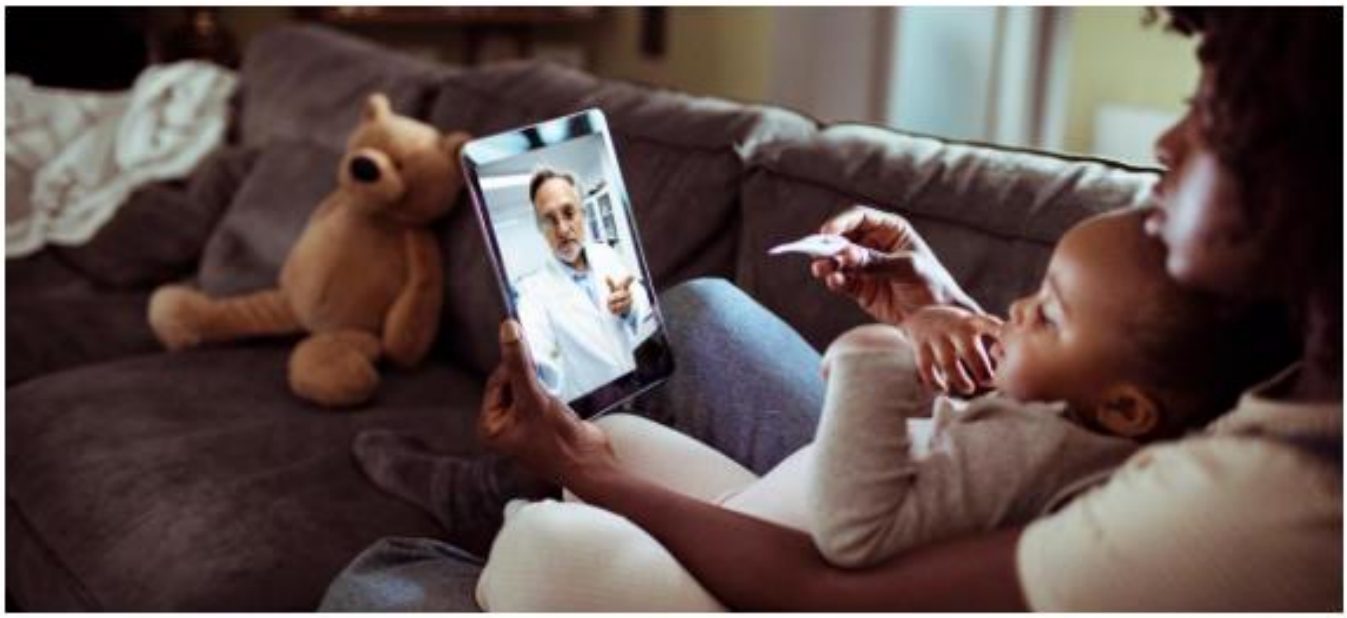
TELEHEALTH

Health Alliance Plan
by Henry Ford Health

+

Teladoc HEALTH

NEW! MEMBER BENEFIT EFFECTIVE JANUARY 1, 2027



Get ready for Teladoc Health

Health Alliance Plan members can begin registration in December 2026.
Register once so you can use your new telehealth service when the new year starts!

Multiple ways to join

- **Online:** Register at TeladocHealth.com
- **By phone:** Call 1-800-Teladoc (800) 835-2362
- **Mobile app:** Download the Teladoc Health app
- **Health Alliance Plan webpage:** Single sign-on access is coming soon (coming in December 2026)

Information you'll provide

- **Personal details:** Your name, address, date of birth and ZIP code
- **Account setup:** Your email address and a password
- **Insurance information:** Your member or health plan ID to confirm eligibility
- **Health profile:** Information that helps tailor your experience from the start

Before you register

Have your Health Alliance Plan member ID card and email address ready.

New Member?
If you are new to Health Alliance Plan, you will receive your member ID in the mail in January.

Choose the registration option that works best for you.

HAP HMO H.S.A.
$2,500/$5,000

Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits
HAP HMO Custom 2589 / Rx HMO Custom 2589 NSO

HMO

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$2,500 Self Only; $5,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts. (Aggregate)	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	0%	N/A	
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$3,500 Self Only; $7,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts. (Aggregate)	N/A	These values do not accumulate: Premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified.
Preventive Services			
Routine Well Visits	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	Covered after Deductible	N/A	
HAP Telehealth	Covered - Deductible does not apply	N/A	Through our designated telehealth partner.
Specialist Office Visit	Covered after Deductible	N/A	
Routine Audiology Exam	Covered - Deductible does not apply	N/A	One exam per benefit period. For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	N/A	One exam per benefit period. For non-routine visits see Specialist Office Visit.
Chiropractic Services	Covered after Deductible	N/A	Up to 30 visits per benefit period.
Allergy Treatment	Covered after Deductible	N/A	
Allergy Injections	Covered after Deductible	N/A	
Laboratory & Pathology	Covered after Deductible	N/A	Some services require preauthorization.
Imaging MRI, CT & PET Scans	Covered after Deductible	N/A	Services require preauthorization.
Radiology (X-ray)	Covered after Deductible	N/A	Some services require preauthorization.
Radiation Therapy & Chemotherapy	Covered after Deductible	N/A	
Dialysis	Covered after Deductible	N/A	
Outpatient Medical Drugs	Covered after Deductible	N/A	
Outpatient Surgical Services			
Outpatient Surgery	Covered after Deductible	N/A	
Ambulatory Surgical Center	Covered after Deductible	N/A	
Professional Surgical and Related Services	Covered after Deductible	N/A	
Emergency/Urgent Care			
Urgent Care	Covered after Deductible		
Emergency Room Care	Covered after Deductible		
Emergency Medical Transportation	Covered after Deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	Covered after Deductible	N/A	

HAP HMO H.S.A.
$2,500/$5,000 cont'd

Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after Deductible	N/A	
Bariatric Surgery and Related Services	Covered after Deductible	N/A	One procedure per lifetime
Maternity Services			
Routine Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services. For non-routine visits, see Specialist Office Visit.
Routine Postnatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services. For non-routine visits, see Specialist Office Visit.
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	
Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	Covered after Deductible	N/A	
Other Services			
Home Health Care	Covered after Deductible	N/A	Does not include Rehabilitation Services. Up to 100 visits per benefit period.
Hospice Care	Covered after Deductible	N/A	Unlimited.
Skilled Nursing Care	Covered after Deductible	N/A	Covered for authorized services. Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	50% Coinsurance after Deductible	N/A	Covered for approved equipment only.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	Covered after Deductible	N/A	May be rendered at home. Up to 60 combined visits per benefit period.
Habilitation Services: Physical, Occupational, and Speech Therapy	Covered after Deductible	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders. See Rehabilitation Services for non-autism Habilitation cost sharing and limits. Covered for authorized services only.
Applied Behavioral Analysis	Covered after Deductible	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders. Covered for authorized services only.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy
Infertility Services	50% Coinsurance after Deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	50% Coinsurance after Deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Tier 1	$10 Copay 30 day supply, $20 Copay 90 day supply after Deductible		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a copay or max is shown for specialty drugs, you will pay two times that amount for up to 60 days, three times that amount for up to 90 days.
Tier 2	$30 Copay 30 day supply, $60 Copay 90 day supply after Deductible		
Tier 3	$60 Copay 30 day supply, $120 Copay 90 day supply after Deductible		
Tier 4	$80 Copay 30 day supply, $160 Copay 90 day supply after Deductible		
Tier 5	20% Coinsurance ($200 max) 30 day supply at specialty pharmacy only after Deductible		
Tier 6	20% Coinsurance ($300 max) 30 day supply at specialty pharmacy only after Deductible		

QHDHP

- In case of conflict between this summary and your HMO Subscriber Contract and Riders, the terms and conditions of the HMO Subscriber Contract and Riders will govern.
- Elective hospital admissions require that HAP be notified prior to the admission. HAP must be notified within 48 hours after any emergency hospital admission. Failure to notify HAP could result in a reduction or denial of benefits.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.
- Students away at school are covered for acute illness and injury related services according to HAP criteria.
- For Outpatient Mental Health & Substance Use Disorder Services delivered via HAP Telehealth, you will pay the lower of either the Outpatient Mental Health & Substance Use Disorder Cost-Share or the HAP Telehealth Cost-Share.

HENRY FORD SELECT HMO H.S.A.
$2,500/$5,000

Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits
Henry Ford Health Select HAP HMO Custom 2411 / Rx HMO Custom 2411 NSO

HMO

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$2,500 Self Only; $5,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts. (Aggregate)	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	0%	N/A	
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$3,500 Self Only; $7,000 Family If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts. (Aggregate)	N/A	These values do not accumulate: Premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified.
Preventive Services			
Routine Well Visits	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	Covered after Deductible	N/A	
HAP Telehealth	Covered - Deductible does not apply	N/A	Through our designated telehealth partner.
Specialist Office Visit	Covered after Deductible	N/A	
Routine Audiology Exam	Covered - Deductible does not apply	N/A	One exam per benefit period. For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	N/A	One exam per benefit period. For non-routine visits see Specialist Office Visit.
Chiropractic Services	Covered after Deductible	N/A	Up to 30 visits per benefit period.
Allergy Treatment	Covered after Deductible	N/A	
Allergy Injections	Covered after Deductible	N/A	
Laboratory & Pathology	Covered after Deductible	N/A	Some services require preauthorization.
Imaging MRI, CT & PET Scans	Covered after Deductible	N/A	Services require preauthorization.
Radiology (X-ray)	Covered after Deductible	N/A	Some services require preauthorization.
Radiation Therapy & Chemotherapy	Covered after Deductible	N/A	
Dialysis	Covered after Deductible	N/A	
Outpatient Medical Drugs	Covered after Deductible	N/A	
Outpatient Surgical Services			

HENRY FORD SELECT HMO H.S.A.
$2,500/$5,000

Outpatient Surgery	Covered after Deductible	N/A	
Ambulatory Surgical Center	Covered after Deductible	N/A	
Professional Surgical and Related Services	Covered after Deductible	N/A	
Emergency/Urgent Care			
Urgent Care	Covered after Deductible		
Emergency Room Care	Covered after Deductible		
Emergency Medical Transportation	Covered after Deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	Covered after Deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after Deductible	N/A	
Bariatric Surgery and Related Services	Covered after Deductible	N/A	One procedure per lifetime
Maternity Services			
Routine Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services. For non-routine visits, see Specialist Office Visit.
Routine Postnatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services. For non-routine visits, see Specialist Office Visit.
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	
Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	Covered after Deductible	N/A	
Other Services			
Home Health Care	Covered after Deductible	N/A	Does not include Rehabilitation Services. Up to 100 visits per benefit period.
Hospice Care	Covered after Deductible	N/A	Unlimited.
Skilled Nursing Care	Covered after Deductible	N/A	Covered for authorized services. Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	50% Coinsurance after Deductible	N/A	Covered for approved equipment only.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	Covered after Deductible	N/A	May be rendered at home. Up to 60 combined visits per benefit period.
Habilitation Services: Physical, Occupational, and Speech Therapy	Covered after Deductible	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders. See Rehabilitation Services for non-autism Habilitation cost sharing and limits. Covered for authorized services only.
Applied Behavioral Analysis	Covered after Deductible	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders. Covered for authorized services only.
Voluntary Sterilizations	50% Coinsurance after Deductible	N/A	Limited to vasectomy
Infertility Services	50% Coinsurance after Deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	50% Coinsurance after Deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Tier 1	$10 Copay 30 day supply, $20 Copay 90 day supply after Deductible		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a copay or max is shown for specialty drugs, you will pay two times that amount for up to 60 days, three times that amount for up to 90 days.
Tier 2	$30 Copay 30 day supply, $60 Copay 90 day supply after Deductible		
Tier 3	$60 Copay 30 day supply, $120 Copay 90 day supply after Deductible		
Tier 4	$80 Copay 30 day supply, $160 Copay 90 day supply after Deductible		
Tier 5	20% Coinsurance ($200 max) 30 day supply at specialty pharmacy only after Deductible		
Tier 6	20% Coinsurance ($300 max) 30 day supply at specialty pharmacy only after Deductible		

HEALTH EQUITY
HEALTH SAVINGS ACCOUNT

HealthEquity

hap



HEALTH SAVINGS ACCOUNT (HSA)

Combining a HealthEquity HSA with an HSA-qualified health plan delivers incredible benefits

BUILD HEALTH SAVINGS

Choose a low premium health plan.

HSA-qualified health plans offer the lowest premiums, enabling you to unlock immediate savings. Just put the money you would have paid toward traditional premiums into your HSA. Voila! Long-term health savings.

MAXIMIZE TAX SAVINGS

Pre-tax contributions help reduce your annual taxable income.

Your HSA earns tax-free interest and you never pay taxes or penalties when you withdraw HSA dollars for qualified expenses. See a full list of qualified medical expenses at **Learn.HealthEquity.com/QME**

KEEP YOUR MONEY—FOREVER

Spend it. Save it. Invest it.[2] It's yours.

Unlike flexible spending accounts (FSA), money in your HSA rolls over year after year—even if you change employers or health plans.

HSA triple-tax advantage[1]

- Make pre-tax contributions
- Grow tax-free interest earnings
- Enjoy tax-free distributions for qualified medical expenses

SAVE FOR RETIREMENT

Your HealthEquity HSA works like a second 401(k).

Invest your HSA dollars into low-cost mutual funds, then watch your earnings grow tax-free. When you're 65, you can withdraw HSA dollars for any expense—you'll just need to pay regular income taxes. Of course, if you use that money for qualified medical expenses, you never pay taxes at all.[3]

[1]HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax deductible with very few exceptions. Please consult a tax advisor regarding your state's specific rules.

[2]Investments are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. Investing through the HealthEquity investment platform is subject to the terms and conditions of the Health Savings Account Custodial Agreement and any applicable investment supplement. Investing may not be suitable for everyone and before making any investments, review the fund's prospectus.

[3]After age 65, if you withdraw funds for any purpose other than qualified medical expenses, you will be subject to income taxes. Funds withdrawn for qualified medical expenses will remain tax-free.

DELTA DENTAL BENEFITS

DELTA DENTAL

Delta Dental PPO™ (Standard)
Summary of Dental Plan Benefits
For Group #12581-0001
Dearborn Schools Employee Healthcare Program (DSEHP)

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%
Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Minor Restorative Services – fillings and crown repair	90%	90%	90%
Endodontic Services – root canals	90%	90%	90%
Periodontic Services – to treat gum disease	90%	90%	90%
Oral Surgery Services – extractions and dental surgery	90%	90%	90%
Other Basic Services – misc. services	90%	90%	90%
Relines and Repairs – to prosthetic appliances	90%	90%	90%
Major Services			
Major Restorative Services – crowns	90%	90%	90%
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	90%	90%	90%
Orthodontic Services			
Orthodontic Services – braces	80%	80%	80%
Orthodontic Age Limit –	through age 18 and under		

* 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 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.

- 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 age 18 and under.
- Space maintainers are payable once per area per lifetime for people age 18 and under.
- Bitewing X-rays are payable once per Calendar Year and full mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any five-year period.
- Sealants are payable once per tooth per three-year period for first and second permanent molars for people age 18 and under. The surface must be free from decay and restorations.

DELTA DENTAL BENEFITS



- Composite resin (white) restorations are payable on all teeth, including posterior teeth.
- Metallic inlays are Covered Services.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.
- People with special health care needs may be eligible for additional services including exams, hygiene visits, dental case management, and sedation/anesthesia. Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

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 website or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $3,000 per Member total per Benefit Year on all services except orthodontic services. $5,000 per Member 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 Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 80% of the per month fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist. The number of orthodontic payments will be based on the type of treatment plan submitted by your Dentist (18 months for comprehensive, 10 months for interceptive and 8 months for limited) and will be calculated from the date treatment begins. If treatment begins during any applicable waiting period, Delta Dental will only be obligated to make payments for the remaining months in the approved treatment plan, and shall not be obligated to pay for any treatment months that occurred during the waiting period or that extend beyond the initial-calculated treatment plan even if all orthodontic Benefits have not been exhausted.

Deductible – None.

Waiting Period – Enrollees who are eligible for Benefits are covered on the date of hire.

Eligible People – All full-time employees of the Contractor working at least 22 hours per week who choose the dental plan and all Enrollees who are eligible for and elect Continuation Coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 or similar non-preempted state law ("COBRA").

Also eligible are your Spouse and your Children to the end of the calendar year in which they turn 26, including your Children who are married, who no longer live with you, who are not your dependents for federal income tax purposes, and/or who are not permanently disabled.

Enrollees and Dependents choosing this plan are required to remain enrolled for a minimum of 12 months. Should an Enrollee or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse's application. Your Dependent Children may be enrolled on both your and your Spouse's applications as well. Delta Dental will coordinate Benefits between your coverage and your Spouse's coverage.

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

Customer Service Toll-Free Number: 800-524-0149 (TTY users call 711)
https://www.DeltaDentalMI.com
Document Creation Date: October 9, 2026

NVA VISION BENEFITS

National Vision Administrators, L.L.C.

Your NVA Vision Benefit Summary

Taylor School District

Group Number #51393

Schedule of Vision Benefits

Benefit Frequency	*Participating Provider*	*Non-Participating Provider*
Examination Once Every 12 Months	• Covered 100%	Reimbursed Amount • Up to $35
Lenses Once Every 12 Months • Single Vision • Bifocal • Trifocal • Lenticular • Polycarbonates (under age 19)	Standard Glass or Plastic • Covered 100%	 • Up to $35 • Up to $45 • Up to $55 • Up to $80 • Up to $10
Frame Once Every 12 Months	Retail Allowance • Up to $130 (20% discount off balance)*	• Up to $45
Contact Lenses Once Every 12 Months Elective Contact Lenses Medically Necessary***	In lieu of Lenses • Up to $130 Retail① (15% discount (Conventional) or 10% discount (Disposable) off balance)** • Covered 100%	In lieu of Lenses • Up to $100 • Up to $210

How Your Vision Care Program Works

Eligible members and dependents are entitled to receive a vision examination and one pair of lenses and a frame or contact lenses once every 12 months from last date of service.

At the start of the program, if authorized by your employer you may receive identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, you must indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care professional, please visit our website at www.e-nva.com or download our mobile app by searching NVA Vision or contact NVA's Customer Service Department toll-free at 1.800.672.7723, TTY: 711 or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Enter group number 51393000001 or the group number on the identification card and enter in your search parameters. It's that easy!

*Does not apply to Wal-Mart / Sam's Club or LensCrafters locations or for certain proprietary brands or at online retailers. **Does not apply to Wal-Mart/Sam's Club, LensCrafters, Contact Fill (NVA Mail Order) or certain locations at: Target & Pearle and may be prohibited by some manufacturers. ***Subject to criteria as defined in the insurance policy.

①Additional professional services related to contact lenses (also known as fitting fees) would be included in the contact lens allowance shown above.

Fixed prices/courtesy discount do not apply at Walmart/Sam's Club and LensCrafters locations. Fixed prices listed below may differ at online retailers. Please be sure to confirm the level of service prior to placing an order.

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- $10 Solid Tint
- $12 Fashion / Gradient Tint
- $10 Standard Scratch-Resistant Coating
- $12 Ultraviolet Coating
- $40 Standard Anti-Reflective
- $20 Glass Photogrey (Single Vision)
- $30 Glass Photogrey (Multi-Focal)
- $75 Polarized
- $50 Progressive Lenses Standard
- $65 Transitions Single Vision Standard
- $70 Transitions Multi-Focal Standard
- $25 Polycarbonate (Single Vision) 19 & over
- $30 Polycarbonate (Multi-Focal) 19 & over
- $30 Blended Bifocal (Segment)
- $55 High Index
- $100 Progressive Lenses Premium

For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price. Fixed prices are available in-network only. Discounts are not insured benefits. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers. Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

NVA VISION BENEFITS

Get a Better View

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations: The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered if certain criteria are met.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Hearing Discount: You will receive up to 60% savings at participating provider locations through NationsHearing®.

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

Benefits and discounts may be different at online retailers. Please be sure to confirm the level of service prior to placing an order.

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

Your NVA EyeEssential® Plan Discount – In Network Only

Service	Participating Provider	Lens Options
	Member Cost:	
Eye Examination:	Retail Less $10	$12 Solid Tint/ Gradient Tint $50 Standard Progressive Lenses
Contact Lens Fitting:	Retail Less 10%	$75 Polarized Lenses $65 Transitions Single Vision Standard $70 Transitions Multi-Focal Standard
Lenses:	Glass or Plastic	$15 Standard Scratch Coating
Single Vision	$35.00	$12 UV Coating
Bifocal	$55.00	$35 Polycarbonate
Trifocal or Lenticular	$70.00	$45 Standard Anti-Reflective
Frame:	Retail Less 35%	
Contact Lenses*:	**Member Cost:**	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price.

Wal-Mart / Sam's Club and LensCrafters stores do not provide additional discounts.

Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

At NVA, We Work Only for Our Clients.

The proposed vision insurance program is insured through Fidelity Security Life Insurance Company (FSL) Kansas City, MO. Fidelity Security Life Insurance Company brings over 45 years of underwriting experience in the insurance industry since 1969.

Fidelity Security Life Insurance Company has been rated A (Excellent), based on an analysis of financial position and operating performance, by A.M. Best Company, an independent analyst of the insurance industry, For the latest rating, access www.ambest.com.

Some provisions benefits, exclusions or limitations listed herein may vary depending on your state of residence.

Exclusions: The following benefits are not payable under this Policy for services or materials connected with or charges arising from (unless otherwise indicated in the Proposed Schedule of Benefits): Aniseikonic Lenses; Subnormal visual aids; Orthoptics, vision training, and any associated supplemental testing; Broken, lost or stolen lenses, contact lenses, or frames will not be replaced except in the next Benefit Frequency when Vision Materials would next become available; Services or materials provide as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Services rendered after the date an insured Person ceases to be covered under the policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan; Medical and/or surgical treatment of the eye, eyes or supporting structures; Two pair of glasses in lieu of bifocals; Plano (non-prescription) lenses; non-prescription sunglasses

Limitations: Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider, such fees or materials are not covered under the Policy. For Contact Lenses, any remaining balance may be used within the same Benefit Frequency. Where the Insured Person previously utilized an In-Network Provider, the remaining balance must be used with the same or any other In-Network Provider. Where the Insured Person previously utilized an Out-of-Network Provider, the remaining balance must be used with the same or any other Out-of-Network Provider.

National Vision Administrators, L.L.C. ▫ PO Box 2187 ▫ Clifton, NJ 07015
Web: www.e-nva.com ▫ Toll-Free: 1.800.672.7723
NVA® and EyeEssential® are registered marks of National Vision Administrators, L.L.C.

This document is intended as a program overview only and is not a certified document of the individual plan parameters.

Policy Nos. VC-108, VC-109, VC-110; Form NOS. M-9142, M-9188.

051514

CASH-IN-LIEU



If you chose to decline the medical plan offered by DSEHP, you may elect to receive cash in lieu of coverage. To receive the cash in lieu credit, you must meet the credentials below. By electing the cash in lieu option, you are acknowledging that you understand you will only be allowed to change your election during the next open enrollment period or during a qualified event.

This credit is earned monthly and paid each qualifying payroll, only if the following are true:

1. You are a benefit eligible employee with an FTE of 0.65 or greater, as defined by the District, for the current school year.
2. You provide proof that you have ACA-Approved medical coverage through another source

NOTE: You **MUST** provide proof of other ACA-Approved coverage to receive the cash in lieu credit. You will need to provide this documentation to the DSEHP Benefit Center **within 30 days** of open enrollment closing or by January 15, 2027. You can reach the DSEHP Benefit Center via phone by calling (888) 222-4309. Documentation can be submitted as follows by logging into PlanSource and uploading at https://benefits.plansource.com/logon.

You will NOT receive the opt out credit until documentation is received by the DSEHP Benefit Center.

If you have questions regarding the Cash-in-Lieu Benefit, please contact the DSEHP Benefit Center at (888) 222-4309 Monday through Friday 8 am to 11 pm EST.

Medical Cash-in-Lieu		
Annually	26 Pays	20 Pays
$1,920	$73.85	$96

Dental Cash-in-Lieu		
Annually	26 Pays	20 Pays
$180	$6.92	$9

Dental Cash-in-Lieu		
Annually	26 Pays	20 Pays
$60	$2.31	$3

VOLUNTARY BENEFITS

Guardian

TAYLOR BOARD OF EDUCATION
ALL ELIGIBLE EMPLOYEES
Group Number: 00027204

Customer Service (888) 600-1600
Monday to Friday | 8am to 8:30pm ET

Welcome to

Workplace benefits

Everyone deserves a Guardian

Every day, Guardian gives 26 million Americans the security they deserve through our insurance and wealth management products and services.

We've partnered with your organization to offer you a range of employee benefits. Inside this pack, you'll find the plans your employer thinks you might benefit from.

Know your benefits

Your benefits support your physical and financial wellbeing, to help keep you and your loved ones protected.

With Guardian, you're in good hands. We've been delivering on our promises for over 150 years, and we're looking forward to doing the same for you too.

1. Read through this information.
2. Find out more about your benefits.
3. Talk to your employer if you need help or have any questions.

Your coverage options

Life insurance	Protecting your family's financial future
Short term disability insurance	Coverage if you're temporarily unable to work
Critical illness insurance	Taking care of the expenses if you're critically ill
Accident insurance	Helping you cover expenses after an accident
Hospital indemnity insurance	Covering some of your hospital stay costs

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer paid benefits or our collective bargaining agreement.

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This document is a summary of the major features of the insurance coverage that's been agreed to with your employer – it isn't your contract.

ACCIDENT

Guardian

Watch our video
How accident insurance can get you back on your feet.*

Your accident coverage

	ACCIDENT
COVERAGE - DETAILS	
Your Monthly premium	$11.79
You and Spouse	$19.76
You and Child(ren)	$20.22
You, Spouse and Child(ren)	$28.19
Accident Coverage Type	Off Job
Portability - Allows you to take your Accident coverage with you if you terminate employment.	Included
ACCIDENTAL DEATH AND DISMEMBERMENT	
Benefit Amount(s)	Employee $25,000 Spouse $12,500 Child $5,000
Catastrophic Loss	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D
Common Carrier	200% of AD&D benefit
Common Disaster	200% of Spouse AD&D benefit
Dismemberment - Hand, Foot, Sight	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit
Dismemberment - Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	25% of AD&D benefit
Seatbelts and Airbags	Seatbelts: $10,000 & Airbags: $15,000
Reasonable Accommodation to Home or Vehicle	$2,500
WELLNESS BENEFIT - Per Year Limit	$50
Child(ren) Age Limits	Children age birth to 26 years
FEATURES	
Air Ambulance	$1,000
Ambulance	$200
Blood/Plasma/Platelets	$300
Burns (2nd Degree/3rd Degree)	9 sq inches To 18 sq inches: $0/$2,000 18 sq inches To 35 sq inches: $1,000/$4,000 Over 35 sq inches: $3,000/$12,000
Burns - Skin Graft	50% of burn benefit
Child Organized Sport - Benefit is paid if the covered accident occurred while your covered child, age 18 years or younger, is participating in an organized sport that is governed by an organization and requires formal registration to participate.	25% increase to child benefits
Chiropractic Visits	$50/visit, up to 6 visits
Coma	$10,000

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer paid benefits or our collective bargaining agreement.

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ACCIDENT

Guardian

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer paid benefits or our collective bargaining agreement.

Your accident coverage

FEATURES (Cont.)	
Concussion Baseline Study	$25
Concussions	$200
Diagnostic Exam (Major)	$200
Dislocations	Schedule up to $5,000
Doctor Follow-Up Visits	$50, up to 6 treatments
Emergency Dental Work	$300/Crown, $75/Extraction
Emergency Room Treatment	$200
Epidural Anesthesia Pain Management	$100, 2 times per accident
Eye Injury	$300
Family Care—Benefit is payable for each child attending a Child Care center while the insured is confined to a hospital, ICU or Alternate Care or Rehabilitative facility due to injuries sustained in a covered accident.	$20/day, up to 30 days
Fractures	Schedule up to $6,000
Gun Shot Wound	$750
Hospital Admission	$1,000
Hospital Confinement	$250/day - up to 1 year
Hospital ICU Admission	$2,000
Hospital ICU Confinement	$500/day - up to 15 days
Initial Dr. Office/Urgent Care Facility Treatment	$100
Joint Replacement (Hip/Knee/Shoulder)	$2,500/$1,250/$1,250
Knee Cartilage	$500
Laceration	Schedule up to $400
Lodging - The hospital stay must be more than 50 miles from the insured's residence.	$125/day, up to 30 days for companion hotel stay
Medical Appliance—Wheelchair, motorized scooter, leg or back brace, cane, crutches, walker, walking boot that extends above the ankle or brace for the neck.	Schedule up to $500
Outpatient Therapies	$35/day, up to 10 days
Post-Traumatic Stress Disorder	$400
Prosthetic Device/Artificial Limb	1: $500 2 or more: $1,000
Rehabilitation Unit Confinement	$100/day, up to 15 days
Ruptured Disc With Surgical Repair	$500
Surgery (Cranial, Open Abdominal, Thoracic, Hernia) Max	Schedule up to $1,250 Hernia: $250
Surgery (Exploratory or Arthroscopic)	$400
Tendon/Ligament/Rotator Cuff	1: $500 2 or more: $1,000
Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident.	$0.50 per mile, limited to $500/round trip, up to 3 times per accident
Traumatic Brain Injury — A nondegenerative, noncongenital Injury to the brain from an external nonbiological force, requiring Hospital Confinement for 48 hours or more and resulting in a permanent neurological deficit with significant loss of muscle function and persistent clinical symptoms.	$4,000
X - Ray	$40

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ACCIDENT

Guardian

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer paid benefits or our collective bargaining agreement.

Your accident coverage

UNDERSTANDING YOUR BENEFITS:

- **Common Carrier** – Benefit is paid if an insured's death occurs due to an accident while riding as a fare-paying passanger in a public conveyance. If this is paid, we do not pay the Accidental Death benefit.
- **Common Disaster** – Benefit is paid if both you & your spouse die in a covered accident or separate covered accidents within the same 24 hour period.
- **Reasonable Accomodation** – Benefit is payable if a modification is required to an insured's place of residence or vehicle due to an Accidental Dismemberment or Catastrophic loss.
- **Emergency Room Treatment** – Benefit is paid only when an insured is examined or treated within 72 hours of a covered accident.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF ACCIDENT LIMITATIONS AND EXCLUSIONS:

Employees must be working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

This proposal summarizes the major features of the Guardian Accident benefit plan. It is not intended to be a complete representation of the proposed plan. For full plan features, including exclusions and limitations, please refer to your Policy.

This proposal is hedged subject to satisfactory financial evaluation.

We don't pay benefits for any Injury caused by or related to directly or indirectly: Sickness, disease, mental infirmity or medical or surgical treatment; the covered person being legally intoxicated; declared or undeclared war, act of war, or armed aggression; service in the armed forces, National Guard, or military reserves of any state or country; taking part in a riot or civil disorder; commission of, or attempt to commit a felony; intentionally self-inflicted Injury, while sane or insane; suicide or attempted suicide, while sane or insane; travel or flight in any kind of aircraft, including any aircraft owned by or for the policyholder, except as a fare-paying passenger on a common carrier; participation in any kind of sporting activity for compensation or profit, including coaching or officiating; riding in or driving any motor-driven vehicle in a race, stunt show or speed test; participation in hang gliding, bungee jumping, sail gliding, parasailing, parakiting, ballooning, parachuting, zorbing or skydiving; an accident that occurred before the covered person is covered by this plan; injuries to a dependent child received during birth; voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for a covered person by a doctor, and (2) it was used as prescribed. In the case of a non-prescription drug, this Plan does not pay for any Accident resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time. Job related or on the job injuries for the employee are excluded if Accident coverage is off job only.

Contract # GP-1-ACC-18

If Accident insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits.

Guardian's Accident Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides Accident insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.
IMPORTANT NOTICE – THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.
Policy Form # GP-1-AC-BEN-12, et al., GP-1-LAH-12R; GP-1-ACC-18

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TAYLOR BOARD OF EDUCATION
ALL ELIGIBLE EMPLOYEES

Kit created 10/13/2026
Group number: 00027204

LIFE INSURANCE

Guardian

Watch our video
How life insurance protects families and covers critical costs.*

Your life coverage

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer paid benefits or our collective bargaining agreement.

	VOLUNTARY TERM LIFE
Employee Benefit	Choice of 8 employer-specified amounts, from $5,000 to $150,000. See Cost Illustration page for details.
Spouse Benefit	50% of employee coverage to a max of $75,000‡
Child Benefit	Your dependent children age birth† to 26 years. 10% of employee coverage to a max of $10,000. Coverage limits are based on child age.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	We Guarantee Issue coverage up to: Employee $150,000. Spouse $40,000. Dependent children $10,000.
Premiums	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take coverage with you if you terminate employment.	Yes, with age and other restrictions
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	Yes
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
LifeAssist℠: Provides supplemental income that is calculated based off a percentage of your Life benefit to a specified dollar amount if you are ADL disabled. Benefits are paid to the lesser of 100 months or to when waiver of premium ends.	Yes
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80

Subject to coverage limits

Voluntary Life: Infant coverage is limited based on age.

Spouse coverage terminates at age 70.

The Guarantee Issue amount may be subject to reductions by percentage at the ages shown in this summary.

Annual Election Option allows employees to increase the amount of their life coverage without a medical exam when they re-enroll in their company's Voluntary Life plan. This option allows employees to step up to an amount of up to $50,000, up to the Guarantee Issue amount.

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TAYLOR BOARD OF EDUCATION
ALL ELIGIBLE EMPLOYEES

Kit created 10/13/2026
Group number: 00027204

LIFE INSURANCE

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style.

Voluntary Life Cost Illustration

		Monthly premiums displayed. Policy Election Cost Per Age Bracket								
		< 30	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69†
$5,000 Policy Election Amount										
Employee	$5,000	$.21	$.25	$.40	$.70	$1.08	$1.63	$2.55	$4.13	$6.79
Spouse	$2,500	$.11	$.13	$.20	$.35	$.54	$.81	$1.27	$2.06	$3.39
Child	$500	$.08	$.08	$.08	$.08	$.08	$.08	$.08	$.08	$.08
$10,000 Policy Election Amount										
Employee	$10,000	$.42	$.50	$.79	$1.40	$2.16	$3.25	$5.09	$8.25	$13.57
Spouse	$5,000	$.21	$.25	$.40	$.70	$1.08	$1.63	$2.55	$4.13	$6.79
Child	$1,000	$.17	$.17	$.17	$.17	$.17	$.17	$.17	$.17	$.17
$15,000 Policy Election Amount										
Employee	$15,000	$.63	$.75	$1.19	$2.10	$3.24	$4.88	$7.64	$12.38	$20.36
Spouse	$7,500	$.32	$.38	$.59	$1.05	$1.62	$2.44	$3.82	$6.19	$10.18
Child	$1,500	$.25	$.25	$.25	$.25	$.25	$.25	$.25	$.25	$.25
$25,000 Policy Election Amount										
Employee	$25,000	$1.05	$1.25	$1.98	$3.50	$5.40	$8.13	$12.73	$20.63	$33.93
Spouse	$12,500	$.53	$.63	$.99	$1.75	$2.70	$4.06	$6.36	$10.31	$16.96
Child	$2,500	$.42	$.42	$.42	$.42	$.42	$.42	$.42	$.42	$.42
$50,000 Policy Election Amount										
Employee	$50,000	$2.10	$2.50	$3.95	$7.00	$10.80	$16.25	$25.45	$41.25	$67.85
Spouse	$25,000	$1.05	$1.25	$1.98	$3.50	$5.40	$8.13	$12.73	$20.63	$33.93
Child	$5,000	$.84	$.84	$.84	$.84	$.84	$.84	$.84	$.84	$.84
$75,000 Policy Election Amount										
Employee	$75,000	$3.15	$3.75	$5.93	$10.50	$16.20	$24.38	$38.18	$61.88	$101.78
Spouse	$37,500	$1.58	$1.88	$2.96	$5.25	$8.10	$12.19	$19.09	$30.94	$50.89
Child	$7,500	$1.25	$1.25	$1.25	$1.25	$1.25	$1.25	$1.25	$1.25	$1.25
$100,000 Policy Election Amount										
Employee	$100,000	$4.20	$5.00	$7.90	$14.00	$21.60	$32.50	$50.90	$82.50	$135.70
Spouse	$50,000	$2.10	$2.50	$3.95	$7.00	$10.80	$16.25	$25.45	$41.25	$67.85
Child	$10,000	$1.67	$1.67	$1.67	$1.67	$1.67	$1.67	$1.67	$1.67	$1.67
$150,000 Policy Election Amount										
Employee	$150,000	$6.30	$7.50	$11.85	$21.00	$32.40	$48.75	$76.35	$123.75	$203.55
Spouse	$75,000	$3.15	$3.75	$5.93	$10.50	$16.20	$24.38	$38.18	$61.88	$101.78
Child	$10,000	$1.67	$1.67	$1.67	$1.67	$1.67	$1.67	$1.67	$1.67	$1.67

Refer to Guarantee Issue row on page above for Voluntary Life GI amounts.
Premiums for Voluntary Life Increase in five-year increments
Infant coverage is limited for the first two weeks of infant's life.
Spouse coverage premium is based on Employee age.
†Benefit reductions apply.
The Guarantee Issue amount may be subject to reductions by percentage at the ages shown in this summary.

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer paid benefits or our collective bargaining agreement.

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TAYLOR BOARD OF EDUCATION
ALL ELIGIBLE EMPLOYEES

Kit created 10/13/2026
Group number: 00027204

LIFE INSURANCE

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE COVERAGE:

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex.

A person is ADL-disabled if he or she is (a) physically unable to perform two or more ADLs without continuous physical assistance; or (b) cognitively impaired, and requires verbal cueing to protect himself/herself or others. ADLs are bathing, dressing, toileting, transferring, continence, and eating.

Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court order to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses his or her group coverage before an accelerated benefit is paid.

We pay no benefits if the insured employee or spouse death is due to suicide within two years from the insured employee or spouse original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. Late entrants and benefit increases require underwriting approval.

GP-1-R-EOPT-96

Guarantee Issue/Conditional Issue amounts may vary based on age and case size. See your Plan Administrator for details. Late entrants and benefit increases require underwriting approval.

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer paid benefits or our collective bargaining agreement.

Guardian Group Life Insurance underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.
Policy Form # GP-1-LIFE-15

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SHORT TERM DISABILITY

Guardian

Watch our video
How short term disability insurance can supplement your income.

Your short term disability coverage

	Short-Term Disability
Coverage amount	Choose weekly amount $200, $250, $375, $500, $750 or $1000
Maximum payment period: Maximum length of time you can receive disability benefits.	26 weeks
Accident benefits begin: The length of time you must be disabled before benefits begin.	Day 1
Illness benefits begin: The length of time you must be disabled before benefits begin.	Day 8
Evidence of Insurability: A health statement requiring you to answer a few medical history questions.	Health Statement may be required
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when applicant signs up for coverage during the initial enrollment period.	We Guarantee Issue $1000 in coverage
Minimum work hours/week: Minimum number of hours you must regularly work each week to be eligible for coverage.	Planholder Determines
Pre-existing conditions: A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months look back; 12 months after 2 week limitation
Premium waived if disabled: Premium will not need to be paid when you are receiving benefits.	Yes

UNDERSTANDING YOUR BENEFITS—DISABILITY (Some information may vary by state)

- **Earnings definition:** Your covered salary excludes bonuses and commissions.

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer paid benefits or our collective bargaining agreement.

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Group number: 00027204

SHORT TERM DISABILITY

Short-Term Disability Plan Cost Illustration:

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses.

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer paid benefits or our collective bargaining agreement.

Option 1 Benefits Begin: 1 day accident, 8 day sickness
26 week benefit duration

Policy amounts shown based on sample salary amounts only.

	< 25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60+
Option 1 premium rate	$0.898	$0.898	$1.204	$0.872	$0.646	$0.643	$0.729	$0.848	$1.006
	Election Cost Per Age Bracket								
	< 25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60+
$17,333 Minimum Annual Salary Option 1*: $200 Weekly Benefit	$17.96	$17.96	$24.08	$17.44	$12.92	$12.86	$14.58	$16.96	$20.12
$21,667 Minimum Annual Salary Option 1*: $250 Weekly Benefit	$22.45	$22.45	$30.10	$21.80	$16.15	$16.08	$18.23	$21.20	$25.15
$32,500 Minimum Annual Salary Option 1*: $375 Weekly Benefit	$33.68	$33.68	$45.15	$32.70	$24.23	$24.11	$27.34	$31.80	$37.73
$43,333 Minimum Annual Salary Option 1*: $500 Weekly Benefit	$44.90	$44.90	$60.20	$43.60	$32.30	$32.15	$36.45	$42.40	$50.30
$65,000 Minimum Annual Salary Option 1*: $750 Weekly Benefit	$67.35	$67.35	$90.30	$65.40	$48.45	$48.23	$54.68	$63.60	$75.45
$86,667 Minimum Annual Salary Option 1*: $1,000 Weekly Benefit	$89.80	$89.80	$120.40	$87.20	$64.60	$64.30	$72.90	$84.80	$100.60

*This benefit may not exceed 60% of your weekly salary.

A SUMMARY OF DISABILITY PLAN LIMITATIONS AND EXCLUSIONS

- Evidence of Insurability may be required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.
- You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.
- Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.
- For Short-Term Disability coverage, benefits for a disability caused or contributed to by a pre-existing condition are limited, unless the disability starts after you have been insured under this plan for a specified period of time. We do not pay short term disability benefits for any job-related or on-the-job injury, or conditions for which Workers' Compensation benefits are payable.
- We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane. We do not pay benefits for charges relating to legal intoxication, including but not limited to the operation of a motor vehicle, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse. We do not pay benefits during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee is receiving treatment outside of the US or Canada, and the employee's loss of earnings is not solely due to disability.
- This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", or "medical" insurance as defined by the New York State Insurance Department.
- If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. State variations may apply.
- When applicable, this coverage will integrate with NJ TDB, NY DBL, CA SDI, RI TDI, Hawaii TDI and Puerto Rico DBA, DC PFML and WA PFML.

Contract # GP-1-STD-15-1.0 et al.

Guardian's Group Short Term Disability Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Plan documents are the final arbiter of coverage.
Policy Form #GP-1-STD07-1.0, et al, GP-1-STD-15

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Group number: 00027204

CRITICAL ILLNESS

Guardian

Watch our video
How critical illness insurance helps cover the costs of treatment.*

Your critical illness coverage

	CRITICAL ILLNESS	
Benefit Amount(s)	Employee may choose a lump sum benefit of $5,000 to $10,000 in $5,000 increments.	
CONDITIONS		
Cancer	**1st OCCURRENCE**	**2nd OCCURRENCE**
Invasive Cancer	100%	50%
Carcinoma In Situ	30%	0%
Benign Brain Tumor	75%	0%
Skin Cancer	$250 per lifetime	Not Covered
Vascular		
Heart Attack	100%	50%
Stroke	100%	50%
Heart Failure	100%	50%
Coronary Arteriosclerosis	30%	0%
Other		
Organ Failure	100%	50%
Kidney Failure	100%	50%
ADDITIONAL CONDITIONS	**1st OCCURRENCE ONLY**	
Addison's Disease	30%	
ALS (Lou Gehrig's Disease)	100%	
Alzheimer's Disease	50%	
Coma	100%	
Huntington's Disease	30%	
Loss of Hearing	100%	
Loss of Sight	100%	
Loss of Speech	100%	
Multiple Sclerosis	30%	
Parkinson's Disease	100%	
Permanent Paralysis	50% for 1 limb, 100% for 2 limbs	
Severe Burns	100%	
Childhood Conditions	**1st OCCURRENCE ONLY**	
Cerebral Palsy	100%	
Cleft Lip/Palate	100%	
Club Foot	100%	
Cystic Fibrosis	100%	
Down's Syndrome	100%	
Muscular Dystrophy	100%	
Spina Bifida	100%	
Type 1 Diabetes	100%	

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer paid benefits or our collective bargaining agreement.

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CRITICAL ILLNESS

Guardian

Your critical illness coverage

	CRITICAL ILLNESS
Spouse Benefit	May choose a lump sum benefit of $2,500 to $5,000 in $2,500 increments up to 50% of the employee's lump sum benefit.
Child Benefit- children age Birth to 26 years	25% of employee's lump sum benefit
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages	50% at age 70
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period or the annual open enrollment period.	We Guarantee Issue up to: Less than age 70 $10,000 For a spouse: Less than age 70 $5,000 For a child: All Amounts **Health questions are required if the elected amount exceeds the Guarantee Issue, as well as for all applicants age 70+ regardless of elected amount.**
Portability: Allows you to take your Critical Illness coverage with you if you terminate employment.	Included
Pre-Existing Condition Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months prior, 12 months after
Cancer Vaccine Benefit	$50 per lifetime for receiving a cancer vaccine
WELLNESS BENEFIT	
Employee Per Year Limit	$50
Spouse Per Year Limit	$50
Child Per Year Limit	$50

Condition Definitions

- Stroke: Stroke must be severe enough to cause neurological deficits at least 30 days after the event.
- Heart Failure: An insured must be placed on an organ transplant list in order to be eligible for the Heart failure benefits.
- Coronary Arteriosclerosis: Coronary Arteriosclerosis must be severe enough to require a coronary artery bypass graft.
- Organ Failure: Organ failure includes both lungs, liver, pancreas or bone marrow and requires the insured to be placed on an organ transplant list.
- Kidney Failure: An insured must be placed on an organ transplant list in order to be eligible for the Kidney failure benefits.

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer paid benefits or our collective bargaining agreement.

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CRITICAL ILLNESS

Critical Illness Cost Illustration

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses and expected financial needs during a Critical Illness.

Your premium will not increase as you age.

Spouse coverage premium is based on Employee age

Child cost is included with employee election.

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer paid benefits or our collective bargaining agreement.

Monthly Premiums Displayed
Election Cost Per Age Bracket

Issue Age	< 30	30-39	40-49	50-59	60-69	70+†
Employee						
$5,000	$5.50	$7.07	$11.60	$19.45	$28.76	$53.60
$10,000	$8.60	$11.57	$20.15	$34.90	$52.41	$100.35
Benefit Amount Up To 50% of Employee Amount to a Maximum of $5,000						
Spouse						
$2,500	$2.97	$3.84	$6.35	$10.75	$15.96	$29.25
$5,000	$4.52	$6.09	$10.62	$18.47	$27.78	$52.62

†Benefit reductions may apply. See plan details.

EXCLUSIONS AND LIMITATIONS

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR CRITICAL ILLNESS:

We will not pay benefits for the First Occurrence of a Critical Illness if it occurs less than 3 months after the First Occurrence of a related Critical Illness for which this Plan paid benefits. By related we mean either: (a) both Critical Illnesses are contained within the Cancer Related Conditions category; or (b) both Critical Illnesses are contained within the Vascular Conditions category. We will not pay benefits for a Second occurrence (recurrence) of a Critical Illness unless the Covered Person has not exhibited symptoms or received care or treatment for that Critical Illness for at least 12 months in a row prior to the recurrence. For purposes of this exclusion, care or treatment does not include: (1) preventive medications in the absence of disease; and (2) routine scheduled follow-up visits to a Doctor.

We do not pay benefits for claims relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane.

Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

If the plan is new (not transferred): During the exclusion period, this Critical Illness plan does not pay charges relating to a pre-existing condition. If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. A pre-existing condition includes any condition for which an employee, in a specified time period prior to coverage in this plan, consults with a physician, receives treatment, or takes prescribed drugs. Please refer to the plan documents for specific time periods. State variations may apply.

Guardian's Critical Illness plan does not provide comprehensive medical coverage. It is a basic or limited benefit and is not intended to cover all medical expenses. It does not provide "basic hospital," "basic medical," or " medical" insurance as defined by the New York State Insurance Department.

Health questions are required on 1) late enrollees and 2) enrollees over age 69 (not applicable in FL). This coverage will not be effective until approved by a Guardian underwriter.

This policy will not pay for a diagnosis of a listed critical illness that is made before the insured's Critical Illness effective date with Guardian.

The policy has exclusions and limitations that may impact the eligibility for or entitlement to benefits under each covered condition. See your certificate booklet for a full listing of exclusions & limitations..

If Critical Illness insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits..

Contract # GP-1-CI-14

Guardian's Critical Illness Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.
Policy Form # GP-1-LAH-12R; GP-1-CI-14

HOSPITAL INDEMNITY



Guardian

The Guardian Life Insurance Company of
10 Hudson Yards, New York, NY 10001

THE FOLLOWING NOTICE ONLY PERTAINS TO HOSPITAL INDEMNITY COVERAGE

IMPORTANT: This is a fixed indemnity policy, NOT health insurance.

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer paid benefits or our collective bargaining agreement.

DISCL-2024

HOSPITAL INDEMNITY

Guardian

Watch our video
How hospital indemnity insurance can give you a comfortable stay.*

Your hospital indemnity coverage

	Hospital Indemnity
	Option I
Coverage Details	
Your Monthly premium	$10.18
You and Spouse	$17.64
You and Child(ren)	$15.96
You, Spouse and Child(ren)	$23.42
Benefits	
Hospital/ICU Admission	$500/$1,000 per admission, limited to 1 admission(s) per insured.
Hospital/ICU Confinement	$100/$200 per day, limited to 15 day(s) per insured per benefit year.
Health Screening	$50 per day, limited to 1 day(s) per insured per benefit year.
Pre-Existing Conditions Limitation - A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	Not Applicable
Portability - Allows you to take your Hospital Indemnity coverage with you if you terminate employment.	Included
Child(ren) Age Limits	Children age birth to 26 years

UNDERSTANDING YOUR BENEFITS – HOSPITAL INDEMNITY

Hospital Admission & Hospital ICU Admission benefits are not payable on the same day.

Premium will be waived if you are hospitalized for more than 30 days.

Hospital admission or confinement benefits are not payable for a newborn unless the child is admitted to the Neonatal ICU.

Hospital/ICU confinement benefits are not payable on the same day as Hospital/ICU admission benefit.

After initial enrollment, Hospital Indemnity coverage will continue as long as an insured is actively at work.

The Health screening benefit is paid for the completion of specified routine wellness screenings such as annual well visits, immunizations, mammography, chest x-ray, and many more.

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer paid benefits or our collective bargaining agreement.

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ALL ELIGIBLE EMPLOYEES

Kit created 10/13/2026
Group number: 00027204

HOSPITAL INDEMNITY

Guardian

Your hospital indemnity coverage

LIMITATIONS AND EXCLUSIONS:

In order to be eligible for coverage: Employees must be legally working: (a) in the United States or (b) outside the United States, for a US based employer, in a country or region approved by Guardian.

An applicant must enroll within 31 days of the coverage effective date. An open enrollment will occur each year during a 30 day time period specified by the policyholder. If an applicant does not enroll during their initial enrollment period, he/she may not enroll until the next open enrollment period.

This Plan will not pay benefits for:

• Treatment relating to a covered person: taking part in any war or act of war (including service in the armed forces), commission of or attempt to commit a felony, an act of terrorism, or participating in an illegal occupation, riot or insurrection.

.• Suicide or any intentionally self-inflicted injury

Elective surgery;

Surgery to correct vision or hearing, unless medically necessary surgery for glaucoma, cataracts or other sickness or injury;

Dental care, dental xrays, or dental treatment;

Gastric or intestinal bypass services including lap banding, gastric stapling, and other similar procedures to facilitate weight loss; the reversal, or revision of such procedures; or services required for the treatment of complications from such procedures. This exclusion does not apply to completion of a weight reduction program that may be payable under the Health Screening benefit ;

Rest cures or custodial care, or treatment of sleep disorders;

Cosmetic surgery. This Exclusion does not apply to reconstructive surgery:

(a) on an injured part of the body following infection or disease of the involved part;

(b) of a congenital disease or anomaly of a covered dependent newborn or adopted infant; or

(c) on a nondiseased breast to restore and achieve symmetry between two breasts following a covered Mastectomy;

Treatment or removal of warts, moles, boils, skin blemishes or birthmarks, bunions, acne, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;

Service, treatment or loss related to alcoholism or drug addiction, except for drugs prescribed by the Covered Person's Doctor and taken as prescribed;

Care or treatment for mental or nervous disorders;

Services, treatment or loss rendered in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;

Services or treatment Provided by a Doctor, Nurse or any other person who is employed or retained by a Covered Person or who is a Covered Person's Spouse, parent, brother, sister, child, Domestic Partner or partner in a civil union.

Surgery and treatment, procedures, products or services that are experimental or investigative.

Treatment of a Covered Dependent Child's Children;

Sickness or Injury sustained while on active duty in the armed forces of any country. This does not include Reserve or National Guard duty for training.

GP-1-HI-15

These benefits are available to you on an optional basis. They are not employer paid and do not affect any of the employer paid benefits or our collective bargaining agreement.

Guardian Hospital Indemnity Insurance is underwritten by The Guardian Life Insurance Company of America, New York, NY and will not be effective until approved by a Guardian underwriter. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides limited hospital insurance only. It does not provide basic medical or major medical insurance as defined by the New York State Department of Financial Services.
Policy Form # GP-1-HI-15, GP-1-LAH-12R

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ALL ELIGIBLE EMPLOYEES

Kit created 10/13/2026
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This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.

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8815485.1 (03/28)

EMPLOYEE ASSISTANCE PROGRAM

reliancematrix
A MEMBER OF THE TOKIO MARINE GROUP

The New AllOne Health **Member Portal** Is Here

The AllOne Health Member Portal has been rebuilt to work seamlessly with the AllOne Health mobile app, giving you simple, secure access to support anytime, anywhere.

HOW TO GET STARTED

1. **Sign Up for the New Member Portal**
   Visit allonehealth.com/reliance-matrix
2. **Create Your Account**
   Create your account by entering your email, password and the **Company Code** at the bottom of this flyer.
3. **Use One Login Everywhere**
   Your login works for ***both*** the online portal and the mobile app. You can download the **AllOne Health App** from the Apple App Store or Google Play.

WHAT TO EXPECT

- ✓ One login for both the portal and mobile app
- ✓ Faster access to counseling, resources, and support
- ✓ Modern, mobile-friendly experience
- ✓ Built to support your whole health

START EXPLORING

- Book Virtual Counseling Sessions
- Chat with Izzy, Your AI Mental Health Navigator
- Submit Requests and Find Resources
- Call Directly for 24/7 Live Human Support

IMPORTANT LOGIN INFORMATION

The old AllOne Health portal is being retired, and your old portal email and password will NOT work in the new portal or app.

- **If you already downloaded the new AllOne Health App** and created an account, use the same login for the portal
- **New users** will need to create a new account using their company code listed at the bottom of this flyer



Sign Up Today
Support is always within reach—built around you.
Call: 855-RSL-HELP (855-775-4357)
Visit: allonehealth.com/reliance-matrix
Company Code: RSLI859

Powered by ALLONE HEALTH

Taylor School District Healthcare Program

EMPLOYEE ANNUAL NOTIFICATIONS

PATIENT PROTECTIONS DISCLOSURE

HAP 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. Until you make this designation Health Alliance Plan (HAP) designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Health Alliance Plan (HAP) at 800-759-3436 or www.hap.org .

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Health Alliance Plan (HAP) 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 Health Alliance Plan (HAP) at 800-759-3436 or www.hap.org .

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

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

HMO Plan (Individual: 0% coinsurance and $2500 deductible; Family: 0% coinsurance and $5000 deductible)

If you would like more information on WHCRA benefits, please email support@dsehp.com

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



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

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

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

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

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

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 5/31/2029)

EMPLOYEE ANNUAL NOTIFICATIONS

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Taylor School District Healthcare Program is committed to the privacy of your health information. The administrators of the DSEHP (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting support@dsehp.com .

HIPAA Special Enrollment Rights

DSEHP Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the DSEHP (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact support@dsehp.com .

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

NOTICE OF CREDITABLE COVERAGE

Important Notice from Dearborn Schools Employee Healthcare Program

About Your Prescription Drug Coverage and Medicare

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **DSEHP has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current DSEHP coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current DSEHP coverage, be aware that you and your dependents will be able to get this coverage back.

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

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

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

EMPLOYEE ANNUAL NOTIFICATIONS

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	**January 1, 2027**
Name of Entity/Sender:	**Dearborn School Employee Healthcare Program**
Contact—Position/Office:	**support@dsehp.com**
Office Address:	**15250 Mercantile Dr.** **Dearborn, Michigan 48120-1207** **United States**
	Please notify by email:
	support@dsehp.com

EMPLOYEE ANNUAL NOTIFICATIONS

COBRA General Notice

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
-

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

EMPLOYEE ANNUAL NOTIFICATIONS

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov/**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Dearborn School Employee HealthCare Program
support@dsehp.com
Dearborn, Michigan 48120-1207
United States

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

EMPLOYEE ANNUAL NOTIFICATIONS

MARKETPLACE NOTICE

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1] [2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

EMPLOYEE ANNUAL NOTIFICATIONS



When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact support@dsehp.com .

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.

EMPLOYEE ANNUAL NOTIFICATIONS

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Dearborn Schools Employee Healthcare Program			4. Employer Identification Number (EIN) 46-5215047
5. Employer address 15250 Mercantile Dr			6. Employer phone number
7. City Dearborn	8. State Michigan	9. ZIP code 48120-1207	
10. Who can we contact about employee health coverage at this job? support@dsehp.com			
11. Phone number (if different from above)	12. Email address support@dsehp.com		

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

- As your employer, we offer a health plan to:

  x All employees. Eligible employees are employees of employers that have signed a VEBA participation agreement.

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  x We do offer coverage. Eligible dependents are all eligible dependents of the employee.

  ☐ We do not offer coverage.

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

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

EMPLOYEE ANNUAL NOTIFICATIONS

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for

employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

x **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?
Based on the participation agreement, but less than 90 days

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

x Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan?
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly
Bi-weekly for 20 payrolls beginning the last payroll in September.

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? **No changes**

☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. * (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

SBC – HAP HMO H.S.A.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage Period: 01/01/2027 - 12/31/2027**

Health Alliance Plan
by Henry Ford Health

HAP HMO Custom 2589 / Rx HMO Custom 2589 NSO

Coverage for: Individual + Family | Plan Type: HMO QHDHP

AAS03730 / XRS03298

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-422-4641 or visit http://www.hap.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-422-4641 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,500** self only coverage **/ $5,000** family coverage. If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. some Office Visits, some Pharmacy, Preventive Services	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Out-of-Pocket Limit:** **$3,500** self only coverage/**$7,000** family coverage. If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover. All other cost share accumulates unless otherwise specified in Plan Documents.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.hap.org or call 1-800-422-4641 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plans network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services
Do you need a referral to see a specialist?	Yes.	Written referrals are not required for specialist visits within the member's assigned network for selected services. Referrals or oral approvals are required in other instances. Further information on the referral process can be found at www.hap.org.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge after deductible	Not Covered	
	Specialist visit	No Charge after deductible	Not Covered	
	Other practitioner office visit	HAP Telehealth: No Charge; deductible does not apply Chiropractic Services: No Charge after deductible	Not Covered	Telehealth: Through our designated telehealth partner. Chiropractic: Up to 30 visits per benefit period.
	Preventive care/screening/immunization	No Charge; deductible does not apply	Not Covered	Coverage information available at www.hap.org. You may have to pay for services that aren't preventive services. Ask your provider if the services needed are preventive services. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge after deductible	Not Covered	Some services require preauthorization.
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	Not Covered	Services require preauthorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.hap.org	Select Generic Drugs Tier 1	$10 Copay / prescription (retail) after deductible	Not Covered	Costs shown apply to a 30-day supply of drugs. A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Applies to all Generic and Brand type drugs.
	Generic Drugs and Select Brand Name Drugs Tier 2	$30 Copay / prescription (retail) after deductible	Not Covered	
	Preferred Brand Drugs Tier 3	$60 Copay / prescription (retail) after deductible	Not Covered	
	Non-Preferred Brand and Non-Preferred Generic Drugs Tier 4	$80 Copay / prescription (retail) after deductible	Not Covered	
	Preferred Specialty drugs Tier 5	20% Coinsurance / prescription (retail) after deductible	Not Covered	All specialty drugs are limited to a 30-day supply at a specialty pharmacy only. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a Copay or max is shown, You will pay 2 times that amount for a supply up to 60 days, and 3 times that amount for a supply of up to 90 days. Other exclusions & limitations may apply. Preferred Specialty drugs : ($200 Max) 30 day supply.
	Non-preferred Specialty drugs Tier 6	20% Coinsurance / prescription (retail) after deductible	Not Covered	Non-Preferred Specialty drugs : ($300 Max) 30 day supply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center(ASC))	No Charge after deductible	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	No Charge after deductible	Not Covered	
If you need immediate medical attention	Emergency room care	No Charge after deductible	No Charge after deductible	
	Emergency medical transportation	No Charge after deductible	No Charge after deductible	Emergency transport only.
	Urgent care	No Charge after deductible	No Charge after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	No Charge after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge after deductible	Not Covered	Some services require preauthorization. Services can be accessed by calling 1-800-444-5755.
	Inpatient services	No Charge after deductible	Not Covered	Some services require preauthorization. Services can be accessed by calling 1-800-444-5755.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No Charge; deductible does not apply	Not Covered	Routine Prenatal and Routine Postnatal covered under Preventive Services. For non-routine visits, see Specialist Visit.
	Childbirth/delivery professional services	No Charge after deductible	Not Covered	
	Childbirth/delivery facility services	No Charge after deductible	Not Covered	Some services require preauthorization.
If you need help recovering or have other special health needs	Home health care	No Charge after deductible	Not Covered	Does not include Rehabilitation Services.Up to 100 visits per benefit period.
	Rehabilitation services	No Charge after deductible	Not Covered	May be rendered at home.Up to 60 combined visits per benefit period.
	Habilitation services	No Charge after deductible	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services for the treatment of Autism Spectrum Disorders. See Rehabilitation services for non-autism Habilitation cost sharing and limits. See Outpatient Mental Health for ABA cost sharing amount.
	Skilled nursing care	No Charge after deductible	Not Covered	Covered for authorized services.Up to 100 days per benefit period.
	Durable medical equipment	50% Coinsurance after deductible	Not Covered	Covered for approved equipment only.
	Hospice services	No Charge after deductible	Not Covered	Unlimited
If your child needs dental or eye care	Children's eye exam	No Charge after deductible	Not Covered	One routine eye exam per benefit period at no cost share
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Hearing Aids
- Private Duty Nursing
- Voluntary Termination of Pregnancy
- Cosmetic Surgery
- Long-Term Care
- Routine Foot Care
- Dental Care (Adult)
- Non-Emergency Care Outside the U.S.
- Vision Hardware

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Routine Eye Care (Adult)
- Chiropractic Care
- Weight Loss Programs
- Infertility Treatment

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: contact the plan at 1-800-422-4641; you may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or http://www.cciio.cms.gov.Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact the plan at 1-800-422-4641; you may also contact the Department of Insurance and Financial Services Office of Appeals, Legal Research, & Market Regulation – Appeals Section, P.O. Box 30220, Lansing, MI 48909-7720, http://michigan.gov/difs; call 1-877-999-6442 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Financial and Insurance Regulation, P.O. Box 30220, Lansing, MI 48909, phone 1-877-999-6442, website: http://michigan.gov/difs or e-mail difs-HICAP@michigan.gov.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Please see a full list of Language Access Services following the Coverage Examples at the end of the Summary of Benefits of Coverage.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

SBC – HAP HMO H.S.A.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,500
Specialist	$0
Hospital (facility)	$0
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$10
Coinsurance	$0
What isn't Covered	
Limits or exclusions	$61
The total Peg would pay is	**$2,571**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,500
Specialist	$0
Hospital (facility)	$0
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$618
Coinsurance	$0
What isn't Covered	
Limits or exclusions	$22
The total Joe would pay is	**$3,140**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,500
Specialist	$0
Hospital (facility)	$0
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,415
Copayments	$0
Coinsurance	$0
What isn't Covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,415**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Notice of Availability of Language Assistance Services and Auxiliary Aids

ENGLISH:
ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-801-1770 (TTY:711) or speak to your provider.

SPANISH:
ATENCIÓN: Si habla español, los servicios de asistencia con el idioma están disponibles para usted sin cargo. También se encuentran disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-801-1770 (TTY: 711) o hable con su proveedor.

ARABIC:
انتباه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. تتوفر أيضًا المساعدات وخدمات المساعدة مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم الآتي: 1-800-801-1770 (الهاتف النصي: 711) أو تحدث إلى مقدم الخدمة.

CHINESE TRADITIONAL:
請注意：如果您說中文，您可以免費獲得語言協助服務。另免費提供適當的輔助工具和服務並以無障礙格式提供資訊。請致電 1-800-801-1770 (TTY: 711)或聯絡您的提供者。

CHINESE SIMPLIFIED:
请注意：如果您说中文，您可以免费获得语言协助服务。另免费提供适当的辅助工具和服务并以无障碍格式提供信息。请致电 1-800-801-1770 (TTY: 711)或联系您的提供者。

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SBC – Henry Ford Health Select HAP HMO H.S.A

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage Period: 01/01/2027 - 12/31/2027**

Health Alliance Plan.
by Henry Ford Health

Henry Ford Health Select HAP HMO Custom 2411 / Rx HMO Custom 2411 NSO

Coverage for: Individual + Family | Plan Type: HMO QHDHP

AAS03731 / XRS03298

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-422-4641 or visit http://www.hap.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-422-4641 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,500** self only coverage **/ $5,000** family coverage. If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. some Office Visits, some Pharmacy, Preventive Services	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Out-of-Pocket Limit:** **$3,500** self only coverage/**$7,000** family coverage. If more than one person is covered under the plan, all family members must collectively meet the family coverage amounts.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover. All other cost share accumulates unless otherwise specified in Plan Documents.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.hap.org or call 1-800-422-4641 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plans network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services
Do you need a referral to see a specialist?	Yes.	Written referrals are not required for specialist visits within the member's assigned network for selected services. Referrals or oral approvals are required in other instances. Further information on the referral process can be found at www.hap.org.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge after deductible	Not Covered	
	Specialist visit	No Charge after deductible	Not Covered	
	Other practitioner office visit	HAP Telehealth: No Charge; deductible does not apply Chiropractic Services: No Charge after deductible	Not Covered	Telehealth: Through our designated telehealth partner. Chiropractic: Up to 30 visits per benefit period.
	Preventive care/screening/immunization	No Charge; deductible does not apply	Not Covered	Coverage information available at www.hap.org. You may have to pay for services that aren't preventive services. Ask your provider if the services needed are preventive services. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge after deductible	Not Covered	Some services require preauthorization.
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	Not Covered	Services require preauthorization.

SBC – Henry Ford Health Select HAP HMO H.S.A

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.hap.org	Select Generic Drugs Tier 1	$10 Copay / prescription (retail) after deductible	Not Covered	Costs shown apply to a 30-day supply of drugs. A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Applies to all Generic and Brand type drugs.
	Generic Drugs and Select Brand Name Drugs Tier 2	$30 Copay / prescription (retail) after deductible	Not Covered	
	Preferred Brand Drugs Tier 3	$60 Copay / prescription (retail) after deductible	Not Covered	
	Non-Preferred Brand and Non-Preferred Generic Drugs Tier 4	$80 Copay / prescription (retail) after deductible	Not Covered	
	Preferred Specialty drugs Tier 5	20% Coinsurance / prescription (retail) after deductible	Not Covered	All specialty drugs are limited to a 30-day supply at a specialty pharmacy only. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a Copay or max is shown, You will pay 2 times that amount for a supply up to 60 days, and 3 times that amount for a supply of up to 90 days. Other exclusions & limitations may apply. Preferred Specialty drugs : ($200 Max) 30 day supply.
	Non-preferred Specialty drugs Tier 6	20% Coinsurance / prescription (retail) after deductible	Not Covered	Non-Preferred Specialty drugs : ($300 Max) 30 day supply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center(ASC))	No Charge after deductible	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	No Charge after deductible	Not Covered	
If you need immediate medical attention	Emergency room care	No Charge after deductible	No Charge after deductible	
	Emergency medical transportation	No Charge after deductible	No Charge after deductible	Emergency transport only.
	Urgent care	No Charge after deductible	No Charge after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	Not Covered	Some services require preauthorization.
	Physician/surgeon fees	No Charge after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge after deductible	Not Covered	Some services require preauthorization. Services can be accessed by calling 1-800-444-5755.
	Inpatient services	No Charge after deductible	Not Covered	Some services require preauthorization. Services can be accessed by calling 1-800-444-5755.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No Charge; deductible does not apply	Not Covered	Routine Prenatal and Routine Postnatal covered under Preventive Services. For non-routine visits, see Specialist Visit.
	Childbirth/delivery professional services	No Charge after deductible	Not Covered	
	Childbirth/delivery facility services	No Charge after deductible	Not Covered	Some services require preauthorization.
If you need help recovering or have other special health needs	Home health care	No Charge after deductible	Not Covered	Does not include Rehabilitation Services.Up to 100 visits per benefit period.
	Rehabilitation services	No Charge after deductible	Not Covered	May be rendered at home.Up to 60 combined visits per benefit period.
	Habilitation services	No Charge after deductible	Not Covered	Limited to Applied Behavior Analysis (ABA) and Physical, Speech, and Occupational Therapy services for the treatment of Autism Spectrum Disorders. See Rehabilitation services for non-autism Habilitation cost sharing and limits. See Outpatient Mental Health for ABA cost sharing amount.
	Skilled nursing care	No Charge after deductible	Not Covered	Covered for authorized services.Up to 100 days per benefit period.
	Durable medical equipment	50% Coinsurance after deductible	Not Covered	Covered for approved equipment only.
	Hospice services	No Charge after deductible	Not Covered	Unlimited
If your child needs dental or eye care	Children's eye exam	No Charge after deductible	Not Covered	One routine eye exam per benefit period at no cost share
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency Care Outside the U.S.
- Private Duty Nursing
- Routine Foot Care
- Vision Hardware
- Voluntary Termination of Pregnancy

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Routine Eye Care (Adult)
- Weight Loss Programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: contact the plan at 1-800-422-4641; you may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or http://www.cciio.cms.gov.Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact the plan at 1-800-422-4641; you may also contact the Department of Insurance and Financial Services Office of Appeals, Legal Research, & Market Regulation – Appeals Section, P.O. Box 30220, Lansing, MI 48909-7720, http://michigan.gov/difs; call 1-877-999-6442 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Michigan Health Insurance Consumer Assistance Program (HICAP), Michigan Department of Financial and Insurance Regulation, P.O. Box 30220, Lansing, MI 48909, phone 1-877-999-6442, website: http://michigan.gov/difs or e-mail difs-HICAP@michigan.gov.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Please see a full list of Language Access Services following the Coverage Examples at the end of the Summary of Benefits of Coverage.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
The plan's overall deductible	$2,500
Specialist	$0
Hospital (facility)	$0
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$10
Coinsurance	$0
What isn't Covered	
Limits or exclusions	$61
The total Peg would pay is	**$2,571**

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The plan's overall deductible	$2,500
Specialist	$0
Hospital (facility)	$0
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$618
Coinsurance	$0
What isn't Covered	
Limits or exclusions	$22
The total Joe would pay is	**$3,140**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible	$2,500
Specialist	$0
Hospital (facility)	$0
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,415
Copayments	$0
Coinsurance	$0
What isn't Covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,415**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Notice of Availability of Language Assistance Services and Auxiliary Aids

ENGLISH:
ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-801-1770 (TTY:711) or speak to your provider.

SPANISH:
ATENCIÓN: Si habla español, los servicios de asistencia con el idioma están disponibles para usted sin cargo. También se encuentran disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-801-1770 (TTY: 711) o hable con su proveedor.

ARABIC:
انتباه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. تتوفر أيضًا المساعدات وخدمات المساعدة مدفوعة بالتسهيلات يمكن الوصول إليها مجانًا. اتصل على الرقم الآتي: 1-800-801-1770 (الهاتف النصي: 711) أو تحدث إلى مقدم الخدمة.

CHINESE TRADITIONAL:
請注意：如果您說中文，您可以免費獲得語言協助服務。另免費提供適當的輔助工具和服務並以無障礙格式提供資訊。請致電 1-800-801-1770 (TTY: 711)或聯絡您的提供者。

CHINESE SIMPLIFIED:
请注意：如果您说中文，您可以免费获得语言协助服务。另免费提供适当的辅助工具和服务并以无障碍格式提供信息。请致电 1-800-801-1770 (TTY: 711)或联系您的提供者。

ARAMAIC:
1-800-801-1770 (TTY:711) :ܠ

VIETNAMESE:
CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Các dịch vụ và sự hỗ trợ bổ sung thích hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng được cung cấp miễn phí. Hãy gọi 1-800-801-1770 (TTY:711) hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.

ALBANIAN:
VËMENDJE: Nëse flisni shqip, ju ofrohen shërbime falas për ndihmë gjuhësore. Gjithashtu, ofrohen falas ndihma dhe shërbimet ndihmëse përkatëse për të ofruar informacione në formate të aksesueshme. Telefononi në numrin 1-800-801-1770 (TTY:711) ose flisni me ofruesin tuaj të shërbimit.

KOREAN:
주의 사항: 한국어를 구사하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 액세스 가능한 형식으로 정보를 제공하기 위해 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 1-800-801-1770 (TTY: 711)으로 전화하거나 서비스 제공자에게 문의하십시오.

BENGALI:
মনোযোগ: আপনি যদি বাংলা ভাষায় কথা বলেন তবে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সাহায্য এবং পরিষেবাগুলিও বিনামূল্যে পাওয়া যায়। 1-800-801-1770 (TTY:711) নম্বরে কল করুন বা আপনার প্রদানকারীর সাথে কথা বলুন।

POLISH:
UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Odpowiednie materiały pomocnicze i usługi zapewniające informacje w dostosowanych formatach są również dostępne bezpłatnie. Należy zadzwonić pod numer 1-800-801-1770 (TTY: 711) lub porozmawiać z lekarzem prowadzącym.

GERMAN:
HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie unter 1-800-801-1770 (TTY:711) an oder sprechen Sie mit Ihrem Dienstleister.

ITALIAN:
ATTENZIONE: Se parli italiano, sono a tua disposizione servizi gratuiti di assistenza linguistica. Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-800-801-1770 (TTY:711) o parla con il tuo fornitore.

JAPANESE:
ご案内: 日本語を話される方の場合、無料で言語支援サービスをご利用いただけます。また、情報をわかりやすい形式でご提供するための補助機器やサービスも無料でご利用いただけます。詳しくは、1-800-801-1770（TTY: 711）までお電話いただくか、担当の医療提供者にご相談ください。

RUSSIAN:
ВНИМАНИЕ: Если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также можно получить бесплатно. Позвоните по номеру 1-800-801-1770 (TTY:711) или обратитесь к своему врачу.

SERBIAN:
PAŽNJA: Ako govorite srpski, dostupne su vam besplatne usluge jezičke pomoći. Odgovarajuća pomoćna sredstva i usluge za pružanje informacija u pristupačnim formatima takođe su dostupni besplatno. Pozovite 1-800-801-1770 (TTY:711) ili se obratite pružaocu usluga.

TAGALOG:
PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo sa tulong sa wika. Makukuha rin nang libre ang mga naaangkop na pantulong na suporta at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-801-1770 (TTY: 711) o makipag-usap sa iyong provider.

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YOUR BENEFIT RESOURCES



Coverage Type	Carrier	Contact Information
Medical & Prescription Drug	Health Alliance Plan	(800) 422-4641 www.hap.org
H.S.A. (Health Savings Accounts)	Health Equity, Serviced by PlanSource	(888) 222-4309, Option #5 https://benefits.plansource.com/logon
Dental	Delta Dental	(800) 524-0149 www.deltadentalmi.com
Vision	National Vision Administrators (NVA)	(800) 672-7723 www.e-nva.com
Voluntary Life Insurance Short Term Disability Critical Illness Accident Coverage Hospital Indemnity	Guardian	(888) 600-1600 www.guardianlife.com
Telehealth	Teladoc by Health Alliance Plan	(800) 835-2362
EAP	AllOne Health	(855) 775-4357 www.allonehealth.com/reliance-matrix

Questions or Changes In Eligibility - Call PlanSource at (888) 222-4309.

Taylor Website

The latest enrollment information and benefits guides can be found at taylorsd.com

Other Questions, email support@dsehp.com

Translation Services Available!

For assistance in any other language, call PlanSource at (888) 222-4309. At the first automated menu, choose option 5 for 'All Other Questions'. At the next menu, choose Option 5 'To Speak with a Representative'. Then ask the Representative for a translator in your desired language.

*The content of this booklet is intended for use as an easy-to-read summary only. It does not constitute a contract. Additional limitations and exclusions may apply. For an official description of benefits, please refer to each carrier's official certificate/benefit guide.