AE
BENEFITS GUIDE

July 1, 2024- June 30, 2025

Medicare Part D
Prescription Drug Information

If you have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage.

WHAT'S INSIDE

IMPORTANT INFORMATION

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

Changes in Household

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 spouses plan and they pass away you are eligible to join the DSEHP Health Plan

Changes in Residence

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** SEP.

Important: You must prove you had qualifying health coverage for one or more days during the 30 days before your move.

Loss of Health Insurance

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

OPEN ENROLLMENT PROCESS

Open Enrollment for making insurance benefit changes will be from ***May 6th through May 20th***.

THIS IS AN <u>ACTIVE</u> OPEN ENROLLMENT.

Your Medical benefits WILL NOT rollover. You <u>MUST</u> elect these benefits in order to have coverage on July 1, 2024!

Your open enrollment period is May 6th through May 20th and benefit elections MUST be made during this period!

You have two different methods to enroll:

- Online
- Over the Phone

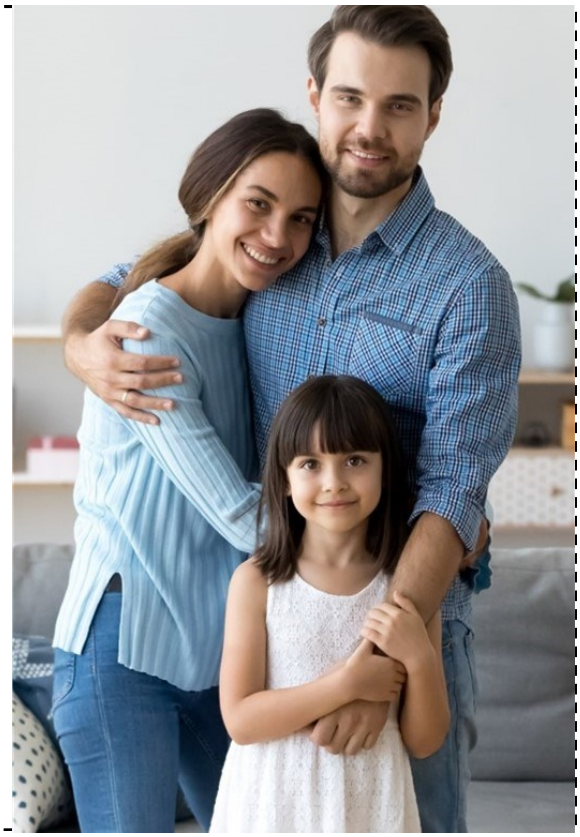
Instructions for these two enrollment methods are on page 4 of this newsletter.

Remember that the choices you make now will be effective July 1, 2024 and will remain in effect until June 30, 2025 unless you experience a qualified special enrollment event.

For those waiving coverage, you still need to make a benefit election indicating you are waiving coverage.

Eligibility

- An employee's FTE profile must be 1.0 or greater to be eligible for benefits and employed at least one year.
- 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 month in which they turn 26.
- The DSEHP plan does not allow dual coverage for Medical coverage, however dual coverage is ALLOWED for Dental and Vision.
- New hires are eligible 1st of the month following 27 days.



OPEN ENROLLMENT PROCESS

Benefit Enrollment Instructions
Effective Monday, May 6, 2024

ONLINE ENROLLMENT SYSTEM:

To access your benefits online, go to: https://benefits.plansource.com/ anytime.

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.

OVER THE 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.

Please remember that Open Enrollment will end at midnight on May 20, 2024.

MEDICAL & RX

Below is an overview of the copays effective July 1st. A full benefit summary is available on page 6 and a detailed Summary of Benefits and Coverage is available starting on page 42.

Benefit	Service Type	
Medical	Deductible	$150 single / $300 Family
	PHP/MHSA Visit	$20
	Telehealth visit	$0
	Specialist	$30
	Urgent Care	$40
	Emergency Room	$200
Prescription	Generic	$15
	Preferred	$30
	Non-Preferred	$60

EMPLOYER & EMPLOYEE CONTRIBUTIONS

AE Employees are not eligible for benefits until employed for one year or more.

Costs	Single	Two Person	Family
Full Cost of Benefits per Month	**$ 708.31**	**$ 1,481.28**	**$ 1,931.77**
Employed 1 year - 4 years 364 days			
Employer	$ 354.16	$ 740.64	$ 965.89
Employee per Month	$ 354.15	$ 740.64	$ 965.88
Employee per Pay	$ 212.49	$ 444.38	$ 579.53
Employed 5+ years			
Employer	$ 531.23	$ 1,110.96	$ 1,448.83
Employee per Month	$ 177.08	$ 370.32	$ 482.94
Employee per Pay	$ 106.25	$ 222.19	$ 289.77

MEDICAL & RX SUMMARY

Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits
AA000775 / XR000941

HMO
AA000775 / XR000941

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$150 Individual; $300 Family	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	$6,600 Individual; $13,200 Family	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			
Office Visit / Physical Exam / Well Baby Exam	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	$20 Copay - Deductible does not apply	N/A	
Telehealth Visit	Covered - Deductible does not apply	N/A	Through our contracted telehealth services provider.
Specialist Office Visit	$30 Copay - Deductible does not apply	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	$30 Copay - Deductible does not apply	N/A	Manipulation of the spine for subluxation only. Up to 35 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	$40 Copay - Deductible does not apply		
Emergency Room Care	$200 Copay - Deductible does not apply		Copay will be waived if admitted
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	$1,000 Copay 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
Routine Postnatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	

MEDICAL & RX SUMMARY

Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	$20 Copay - Deductible does not apply	N/A	
Other Services			
Home Health Care	Covered after Deductible	N/A	Does not include Rehabilitation Services. Unlimited.
Hospice Care	Covered after Deductible	N/A	Up to 210 days per lifetime
Skilled Nursing Care	Covered after Deductible	N/A	Covered for authorized services. Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	Covered after Deductible	N/A	Covered for approved equipment only.
Hearing Aid Hardware	$0 Copay per Hearing Aid for Value Technology Hearing Aids - Deductible does not apply $689 Copay per Hearing Aid for Basic Technology Hearing Aids - Deductible does not apply $989 Copay per Hearing Aid for Prime Technology Hearing Aids - Deductible does not apply $1,539 Copay per Hearing Aid for Advanced Technology Hearing Aids - Deductible does not apply $2,039 Copay per Hearing Aid for Premium Technology Hearing Aids - Deductible does not apply	N/A	Through a NationsHearing Provider only. Limited to 2 Hearing Aids per Benefit Period. Copays do not count toward the Out-of-Pocket Limit.
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 through age 18. Covered for authorized services only.
Applied Behavioral Analysis	$20 Copay - Deductible does not apply	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders through age 18. 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	Covered after Deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Preferred Generic Drugs	$15 Copay 30 day supply, $30 Copay 90 day supply		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.
Non-Preferred Generic Drugs	$15 Copay 30 day supply, $30 Copay 90 day supply		
Preferred Brand Drugs	$30 Copay 30 day supply, $60 Copay 90 day supply		
Non-Preferred Brand Drugs	$60 Copay 30 day supply, $120 Copay 90 day supply		
Preferred Specialty Drugs	$60 Copay 30 day supply at specialty pharmacy only		
Non-Preferred Specialty Drugs	$60 Copay 30 day supply at specialty pharmacy only		

Template Rev 01/2020

- 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 Telehealth, you will pay the lower of either the Outpatient Mental Health & Substance Use Disorder Cost-Share or the Telehealth Cost-Share.

EAP

Ulliance

Enhancing People. Improving Business.

No cost and completely confidential

LIFE ADVISOR EAP®

The Ulliance Life Advisor EAP® is a benefit that employers can sponsor and offer total well-being services to their employees, spouse/live-in partner and dependents under the age of 27 at no cost to the employee.

Counseling

Counseling is available in-person or telephonically with a counselor close to work, home or school. Individual, family and couples counseling are all included. Short-term, solution focused support for work-life issues such as stress, major life transitions, relationship issues, substance use, grief/loss and overwhelming emotions.

Coaching

Life Advisor Coaches offer telephonic support for individual life enhancement goals, such as education, career advancement, financial or self improvement goals.

Crisis Support

Mental health professionals are available by phone 24/7/365.

Referrals

Consultants provide recommendations for resources within the community.

Work-life Materials

Information on a wide range of work-life balance topics are easily accessed through the EAP portal. A work-life library of related books are available by calling Ulliance and as always, are free of charge.

Legal & Financial Consultations

Ulliance professionals can connect employees with resources to assist individuals regarding legal and financial issues.

Connect with us 800.448.8326 LifeAdvisorEAP.com

YOUR RIGHTS UNDER FEDERAL LAW

Change in Status or Special Enrollment -

You may qualify for a special enrollment if certain events occur in your life:

- If you decline coverage for yourself and/or your dependents (including your spouse) because you are covered under another health plan, you may be able to enroll yourself and/or your dependents in the plan if you experience an involuntary loss of that coverage (e.g., spouse loses his/her job, divorce).
- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the plan.

In either situation, you must request enrollment through the DSEHP Benefit Center within 30 days after the special enrollment event as described above. If you enroll as the result of a special enrollment event, coverage will be made effective on the date of the event.

Newborn and Mother's Health Protection Act -

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

Women's Health Cancer Rights Act Notice -

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

These services include:

- Reconstruction of the breast upon which the mastectomy has been performed;
- Surgery/reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis;
- Physical complication during all stages of mastectomy, including lymph edemas.

The plan may not:

- Interfere with a woman's right under the plan to avoid these requirements;
- Offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles and co-insurance requirements consistent with other coverage provided under the plan.

Patient Protection Notice -

HAP generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in HAP's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of participating primary care providers, contact HAP at 877-427-3678. For children you may designate a pediatrician as the primary care provider.

You do not need prior authorization from 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 HAP at 877-427-3678.

YOUR RIGHTS UNDER FEDERAL LAW

CHIPRA NOTICE

Qualified group health plans in States that provide medical assistance through either Medicaid or a Children's Health Insurance Program (CHIP or SCHIP) must provide a notice informing employees of the potential opportunity for state Medicaid or CHIP health care assistance for group health plan coverage. The notice must be provided to employees when initially eligible and during the annual enrollment. [Note: Health FSAs and qualified High Deductible Health Plans (HSA-compatible) are not qualified health plans.]

State-specific information must also be included in the notice. We have not included that information here because portions of the information such as phone numbers change. An updated model notice is available on the DOL's Employee Benefits Security Administration's ("EBSA") website at: http://www.dol.gov/ebsa

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

DSEHP

Protecting Your Health Information Privacy Rights

May 1, 2022

DSEHP 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 DSEHP Benefit Center at 888-222-4309.

HIPAA SPECIAL ENROLLMENT RIGHTS

DSEHP Initial Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the DSEHP Group Health Plan (to actually participate, you must complete an enrollmand 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 the marriage, birth, adoption, or placement for adoption.

YOUR RIGHTS UNDER FEDERAL LAW

Eligibility for 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 DSEHP Benefit Center at 888-222-4309 or email Support@dsehp.com

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 4-30-2017)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

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

MEDICARE PART D

Important Notice from Dearborn Schools Employee Healthcare Program (DSEHP) About Your CREDITABLE 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 HAP 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 coverage will not be affected.

Summary of Options for Medicare Eligible Employees (and/or Dependents):

- Continue medical and prescription drug coverage and do not elect Medicare D coverage. **Impact** – your claims continue to be paid by DSEHP health plan.
- Continue medical and prescription drug coverage and elect Medicare D coverage. **Impact** - As an active employee (or dependent of an active employee) the DSEHP health plan continues to pay primary on your claims (pays before Medicare D).
- Drop the coverage and elect Medicare Part D coverage. **Impact** – Medicare is your primary coverage. You will not be able to rejoin the DSEHP health plan unless you experience a family circumstance change or until the next open enrollment period.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will not be able to get this coverage back unless you experience a family status change or until the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with HAP 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 November to join.

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

Contact the person listed below for further information [or call Office Manager, PlanSource at [(313) 9823292]. **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: July 1, 2024
Name of Entity/Sender: DSEHP
Contact--Position/Office: Office Manager, PlanSource
Address: 15250 Mercantile Dr., Dearborn MI 48120
Phone Number: 888-222-4309

CMS Form 10182-C
Updated April 1, 2022
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 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, 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 2 1244-1850

COBRA NOTICE

General Notice Of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

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."

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 or spouse losing or gaining eligibility for coverage elsewhere), you must notify PlanSource, (the Plan Administrator) within 30 days of the qualifying event. You must provide this notice, by calling PlanSource at (888)-222-4309 and following their instructions to make changes.

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. Please call the DSEHP benefit center at 888-222-4309 if this occurs.

COBRA NOTICE

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, Medicaid, 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.

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

DSEHP Benefit Center
15250 Mercantile Drive
Dearborn, MI 48120
888-222-4309

APPENDIX - SBC

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage Period: 07/01/2023 - 06/30/2024**

AA000775 / XR000941

Coverage for: Individual + Family | Plan Type: HMO

AA000775 / XR000941

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?	**$150** individual / **$300** family	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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Chiropractic, Emergency Services, Office Visits, Pharmacy, Preventive Services, Urgent Care	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:** **$6,600** individual/**$13,200** family	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been 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.

APPENDIX - SBC

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	$20 Copay; deductible does not apply	Not Covered	
	Specialist visit	$30 Copay; deductible does not apply	Not Covered	
	Other practitioner office visit	Telehealth Visit: No Charge; deductible does not apply Chiropractic Visit: $30 Copay; deductible does not apply	Not Covered	Telehealth: Through our contracted telehealth services provider. Not Covered Out-of-Network. Chiropractic: Manipulation of the spine for subluxation only.Up to 35 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.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.hap.org	Preferred Generic drugs	$15 Copay / prescription (retail) ; deductible does not apply	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.
	Non-preferred Generic drugs	$15 Copay / prescription (retail) ; deductible does not apply	Not Covered	
	Preferred Brand drugs	$30 Copay / prescription (retail) ; deductible does not apply	Not Covered	
	Non-preferred Brand drugs	$60 Copay / prescription (retail) ; deductible does not apply	Not Covered	
	Preferred Specialty drugs	$60 Copay / prescription (retail) ; deductible does not apply	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.
	Non-preferred Specialty drugs	$60 Copay / prescription (retail) ; deductible does not apply	Not Covered	

APPENDIX - SBC

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	$200 Copay; deductible does not apply	$200 Copay; deductible does not apply	Copay will be waived if admitted
	Emergency medical transportation	No Charge after deductible	No Charge after deductible	Emergency transport only.
	Urgent care	$40 Copay; deductible does not apply	$40 Copay; deductible does not apply	
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	$20 Copay; deductible does not apply	Not Covered	Some services require preauthorization. Services can be accessed by calling 1-800-444-5755.
	Inpatient services	No Charge after deductible	Not Covered	Services require preauthorization. Services can be accessed by calling 1-800-444-5755.
If you are pregnant	Office visits	No Charge; deductible does not apply	Not Covered	Routine Prenatal and Routine Postnatal covered under Preventive Services.
	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. Unlimited
	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 associated with the treatment of Autism Spectrum Disorders through age 18. Covered for authorized services only. 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	No Charge after deductible	Not Covered	Covered for approved equipment only.
	Hospice services	No Charge after deductible	Not Covered	Up to 210 days per lifetime
If your child needs dental or eye care	Children's eye exam	$30 Copay; deductible does not apply	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	

APPENDIX - SBC

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)
- 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
- Hearing Aids
- 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, Healthcare Appeals Section, Office of General Counsel, 611 Ottawa, 3rd Floor, 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.----------

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	$150
Specialist copayment	$30
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	$150
Copayments	$10
Coinsurance	$0
What isn't Covered	
Limits or exclusions	$61
The total Peg would pay is	**$221**

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

The plan's overall deductible	$150
Specialist copayment	$30
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	$150
Copayments	$749
Coinsurance	$0
What isn't Covered	
Limits or exclusions	$22
The total Joe would pay is	**$921**

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

The plan's overall deductible	$150
Specialist copayment	$30
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	$150
Copayments	$295
Coinsurance	$0
What isn't Covered	
Limits or exclusions	$0
The total Mia would pay is	**$445**

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

APPENDIX - SBC

Language Assistance

We want you to easily get the information you need. To request assistance in a language other than English, call (800) 422-4641 (TTY: 711).

VINI RE: Nëse flisni shqip, ju ofrohen shërbime ndihme gjuhësore falas. Telefononi numrin (800) 422-4641 ose TTY: 711.

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية مجانًا. اتصل بالرقم (800) 422-4641 أو خدمة الهاتف النصي: 711.

নজর দিন: আপনি বাংলা ভাষায় কথা বললে, ভাষা সহায়তার পরিষেবা বিনামূল্যে আপনার জন্য উপলব্ধ। (800) 422-4641 বা TTY: 711 নম্বরে কল করুন।

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 422-4641 或 TTY 用户請致電 711。

HINWEIS: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufnummer: (800) 422-4641 oder TTY: 711.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.
Chiamare il numero (800) 422-4641 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。(800) 422-4641 まで、お電話にてご連絡ください。
TTY ユーザーは 711 までご連絡ください。

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-422-4641 번 또는 TTY: 711 번으로 연락해 주십시오.

UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 422-4641 lub TTY: 711.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь по номеру (800) 422-4641 (телетайп: 711).

NAPOMENA: Ako govorite hrvatski/srpski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte (800) 422-4641 ili tekstualni telefon za osobe oštećena sluha: 711.

ATENCIÓN: si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Llame al (800) 422-4641, los usuarios TTY deben llamar al 711.

ملحوظة: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية مجانًا. اتصل بالرقم (800) 422-4641 أو خدمة الهاتف النصي: 711.

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Tumawag sa (800) 422-4641 o TTY: 711.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi (800) 422-4641 hoặc TTY: 711.

YOUR BENEFIT RESOURCES

Medical & Prescription Drug	**HAP**	**888-654-0706** **www.hap.org**
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.guardiananytime.com**
Flexible Spending Accounts (FSA)	**Plan Source**	**888-222-4309** **www.plansource.com**
EAP	**Ulliance**	**800-448-8326** **www.lifeadvisorEAP.com**

Other Questions or Changes In Eligibility, Call 888-222-4309

Translation Services are Available!

For assistance in Arabic or 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.

DSEHP WEBSITE

The latest Benefit Guides and Enrollment Information can also be found at dsehp.com