Henry Ford Health System

all for you

2021 My Choice Rewards

Benefits Guide

FOR HENRY FORD OPTIMEYES EMPLOYEES

What's Inside

LOOKING FOR KEY TERMS?

Throughout this guide you'll see key terms in **bold type in bright blue**. This means you can find the definition or description in the back of the guide. See page 56 for more details.

Your 2021 Benefits

My Choice Rewards provides a competitive suite of benefit **options** for you and your family. Open enrollment for 2021 My Choice Rewards is **Monday, Nov. 2 through Monday, Nov. 16, 2020**. This is your once-a-year chance to re-enroll in your benefits and make changes. Benefit selections will be effective Jan. 1, 2021. For detailed information see page 46.

How My Choice Rewards Works

My Choice Rewards offers a variety of options under each benefit category. Each option has a different cost, depending on benefit level and who you cover. You can select a particular benefit category, such as health care or spending accounts, depending on your changing needs. Most benefits can be purchased on a pre-tax basis, with the exception of dependent life insurance and voluntary benefits.

NEW HIRES

Employees who are hired or rehired during 2021 will receive an email notification to enroll in their benefits and will have 10 days from receipt of that email to make their benefit elections.

HERE'S AN OVERVIEW OF THE BENEFIT PROGRAMS AND CHOICES AVAILABLE TO YOU DURING OPEN ENROLLMENT.

	BENEFIT	ABOUT YOUR OPTIONS
HEALTH CARE	**Medical, including Vision**	Coverage options for a broad range of medical services and prescription drugs, including: • The HFHS Advantage Tiered Access Plan – an **EPA plan** • Three **Consumer Driven Health Plan (CDHP)** options, with a **Health Savings Account (HSA)**
	Dental	Coverage options for a broad range of dental services and procedures, including preventive care: • Delta Basic • Delta Comprehensive, with higher coverage for basic services and orthodontic coverage
	Standalone Vision	Vision coverage for an annual eye exam and eyewear, such as glasses or contact lenses, for employees who opt out of HFHS medical coverage
TAX-SAVING ACCOUNTS	**Health Savings Account (HSA)**	When you choose a CDHP medical plan, the HSA provides you a triple-tax advantage: • Contributions are tax free • Investment/interest earnings grow tax free • Paying for eligible expenses is tax free
	Health Care Flexible Spending Account (FSA)	Allows you to reimburse yourself for eligible health care expenses with pre-tax dollars. You cannot participate in both the HSA and health care FSA.
	Dependent Care Flexible Spending Account	Allows you to reimburse yourself and save money by using pre-tax dollars to pay for eligible child or elder-care expenses if your spouse also works or goes to school full-time.
LIFE & DISABILITY	**Life**	Choose from: • Employee term life insurance • Dependent term life insurance • Accidental death and dismemberment (AD&D)
	Disability	• Short-term disability (STD) • Long-term disability (LTD)
VOLUNTARY BENEFITS		Choose from the following during open enrollment: • Supplemental coverage that works with your medical plan to reduce your out-of-pocket costs for certain medical needs, including critical illness insurance, accident insurance and hospital indemnity insurance • Group legal insurance • Identity theft insurance Choose from the following any time during the year: • Auto/home insurance • Pet insurance • Purchasing power

The benefits offered under My Choice Rewards are designed to conform to Section 125 of the Internal Revenue Code, and as such may provide significant tax advantages to you as well as Henry Ford Health System. To maintain its tax-qualified status, HFHS must adhere to the regulations established by the IRS. These requirements will be summarized in the appropriate sections of this guide. This guide is intended to summarize the key features of each benefit offered under My Choice Rewards. You are encouraged to consult with your financial planner or tax advisor before making your benefit selections. HFHS reserves the right to modify or discontinue any of its benefits at any time.

REVIEW YOUR BENEFITS ONLINE

Review your benefit options online, even if you don't plan to make changes for 2021. You must go online and enroll:

- If you want to choose a different plan or option.
- If you want to update your dependents.
- If you want to participate in an FSA in 2021.
- If you want to participate in an HSA in 2021.
- If you cover your spouse on a Henry Ford medical plan, you must complete an online Spouse Verification Form every year, or you will be assessed a surcharge.

DEPENDENT ELIGIBILITY AND DOCUMENTATION

Documentation for newly added dependents is required at the time you enroll. You must ensure only people who are eligible for dependent coverage are covered by your HFHS benefits. This helps keep benefit costs at reasonable levels for everyone.

MID-YEAR LIFE EVENTS

You have 30 days to make changes to certain benefits when you experience a qualified mid-year life event. For a list of life events and eligible changes, see the mid-year life event chart on pages 51-54.

Use the following guidelines to determine if your enrolled dependents meet eligibility requirements.

Eligible dependents:

- Your spouse.
- Natural children, legally adopted children (including children placed for adoption for whom legal adoption proceedings have started), step-children, alternate recipients under qualified medical child support orders (QMCSO), and any other child for whom you have obtained legal guardianship and who is in a regular parent-child relationship.
- For medical, vision and dental, young adult children through the end of the month they turn 26. They do not have to be your IRS dependent, be a full-time student or live with you. They can also be married. For Accidental Death and Dismemberment and Dependent Life insurance, young adult children must – through the end of the month they turn 26 – be your IRS dependent, be a full-time student and live with you.
- Any unmarried disabled child, regardless of age, who depends primarily on you for support, provided the physical or mental disability occurred before age 26.
- Sponsored dependents age 20 or older, related to you by blood or marriage and residing in your household and claimed as dependents on your most recent tax return.

Ineligible dependents:

- Your spouse, when he or she is no longer legally married to you.
- Your child, at the end of the month he or she reaches age 26.
- Your sponsored dependent when he or she no longer resides with you, or is no longer claimed on your income tax return.

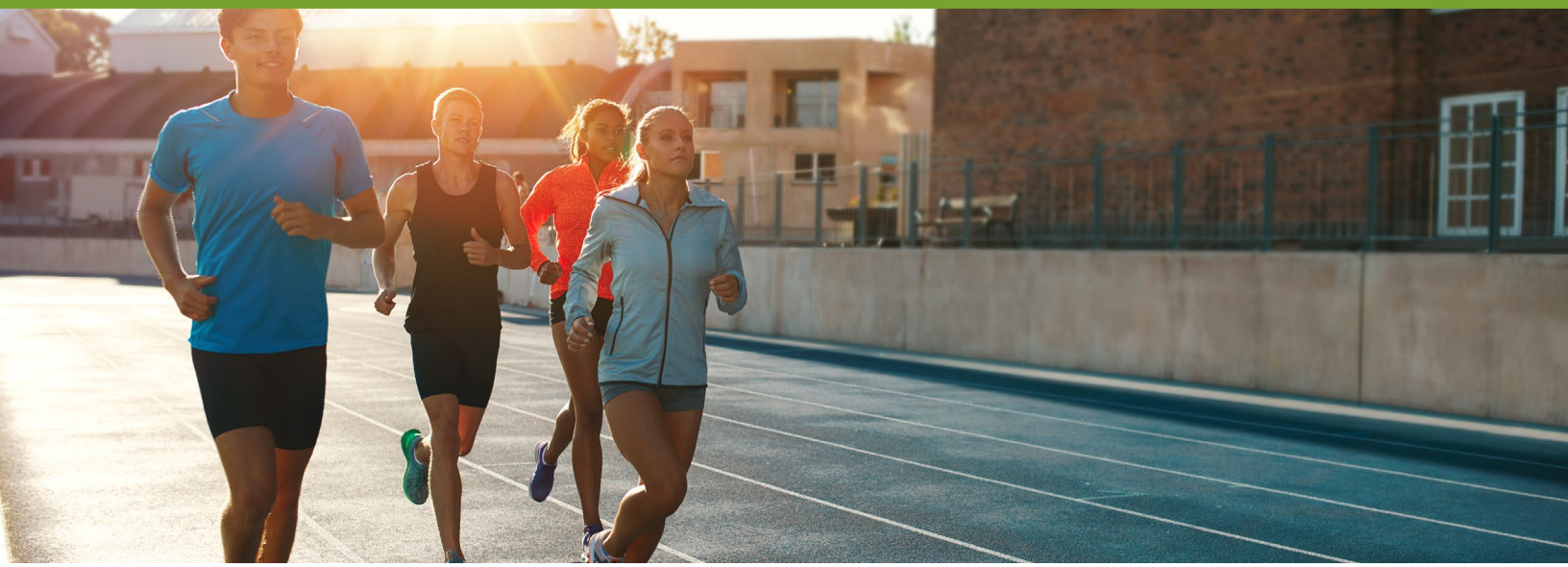
ACCEPTABLE FORMS OF DOCUMENTATION

SPOUSE	UNMARRIED, NATURAL AND LEGALLY ADOPTED CHILDREN, AND STEP-CHILDREN *(until the end of the month they reach age 26)*	SPONSORED DEPENDENT
Proof of spousal relationship from any one of the following documents: • Copy of marriage license that includes date of marriage. • Copy of legal, presently valid marriage certificate. • Copy of the first page of the most recently filed federal income tax return that indicates "married filing jointly." Financial amounts may be blocked out. • Copy of the first page of the most recently filed federal income tax return that indicates "married filing separately." Your spouse's name must appear on the tax form on the line provided after the "married filing separately" status. Financial amounts may be blocked out. • Canadian employees who do not claim dependents on their U.S. federal income tax must submit their Canadian income tax form listing eligible dependents. If an identification number is used in place of a dependent name, documentation such as the social insurance number card must be submitted that links the dependent's name to the identification number.	**Proof of parent/child relationship from any one of the following documents:** • Copy of legal birth certificate, with you listed as a parent. Canadian employees must provide the long-form birth certificate. • Copy of hospital certificate, with you listed as parent and date of birth included. • Affidavit of Parentage that is certified and filed with the state. • Copy of the first page of the most recently filed federal income tax return showing the child listed as a dependent and indicating that child lived with you. Financial amounts may be blocked out. • Canadian employees who do not claim dependents on their U.S. federal income tax must submit their Canadian income tax form listing eligible dependents. If an identification number is used in place of a dependent name, documentation such as the social insurance number card must be submitted that links the dependent's name to the identification number. • Copy of qualified medical child support order (QMCSO). • Documentation from Social Security or physician certifying that total and permanent disability incurred before age 19. • For medical, vision and dental, your dependents can be married.	**Proof of dependent relationship from any one of the following documents:** • Copy of the first page of the most recently filed federal income tax return showing the individual listed as a dependent and indicating that they lived with you. Financial amounts may be blocked out. • If your sponsored dependent is Medicare eligible, provide a copy of their Medicare card parts A and B *and* a copy of the first page of the most recently filed federal income tax return as noted above.

HEALTH PLANS FOR DEPENDENTS TURNING 26

Health Alliance Plan provides coverage for individuals turning 26 and aging off their parents' health plan. This is a life event that qualifies the individual to sign up by the end of the month that the individual turns 26. During this special enrollment period, you or your dependent can obtain coverage under a separate contract/policy. Visit **hap.org** for more information on the policies designed for young adults.

Your Medical & Vision Benefits



Medical Plan Options Overview

HFHS understands that satisfying your family's health care needs is a significant priority for you, and that's why HFHS continues to offer medical/vision options to meet these needs. Carefully review your coverage options and consider how each will work with the other plans in the My Choice Rewards program or other coverage you may have. For example, if you choose a medical/vision plan option with **copays**, you may want to put pre-tax dollars in a health care FSA to cover the total copays you expect to incur during the year. If you choose a CDHP, you can take advantage of the HSA.

HFHS ADVANTAGE TIERED ACCESS PLAN

This plan has two "**in-network**" tiers that provide flexibility when you need care. It encourages employees to use Henry Ford-affiliated physicians who participate in the Henry Ford Physician Network (HFPN), the Jackson Health Network and Genesys.

As a reminder, the HFPN includes the Henry Ford Medical Group, hospital-employed physicians and some private practice physicians on staff at Henry Ford facilities. One advantage of this plan is it provides flexibility for those who may want or need to go outside Henry Ford for care without changing plans.

Instead of choosing one plan over another at open enrollment, the two-tier system allows employees to determine the network they want to use at the time service is required. For example, if your **primary care physician (PCP)** is in Tier 1, but you want to see a specialist in Tier 2, you can do that within this single-plan option. However, employees who use both tiers are required to meet the **deductible** maximums of both. Some services, such as pediatric specialty care, may not be available in Tier 1. These services are available in Tier 2 at higher copays, deductibles and coinsurance.

CDHP BASIC FULL HAP

This plan provides catastrophic coverage for worst-case scenarios like serious accidents/illness, with a high deductible and access to the broader network of HAP-affiliated providers.

CDHP COMPREHENSIVE HFHS PREFERRED NETWORK

This plan provides coverage for everyday needs, with the same deductible and copays as the CDHP Comprehensive Full HAP plan, but you must use HFHS Preferred Network providers. You will pay less in payroll contributions for this plan option. Employees may use the broader HAP-affiliated providers for pediatric services and routine OB/GYN services.

CDHP COMPREHENSIVE FULL HAP

Choose this plan to cover everyday needs, with a lower deductible than the CDHP Basic plan and access to the broader network of HAP-affiliated providers. You will pay more in payroll contributions compared to the other two CDHPs.

Medical Plan Options Snapshot

The chart below provides a snapshot of how coverage compares under each medical plan. See the detailed coverage charts starting on page 17.

	HFHS ADVANTAGE TIERED ACCESS PLAN		CDHP BASIC FULL HAP	CDHP COMPREHENSIVE HFHS PREFERRED NETWORK	CDHP COMPREHENSIVE FULL HAP
	TIER 1	TIER 2			
Deductible (Employee Only/ Family)	$250/$500	$1,250/$2,500	$4,500/$9,000	$1,400/$2,800*	
Coinsurance	None	30%	20%	None	
Out-of-pocket maximum (Employee Only/Family)	$6,850/$13,700		$6,000/$12,000 Not to exceed $6,000 for any one person	$6,550/$13,100 Not to exceed $6,550 for any one person	
HSA money from HFHS (Employee Only/Family)	N/A		$250/$500 base HFHS funding, plus $250/$500 for completing wellness requirements		
Primary care/ specialist	$20/$40 copay	$40/$80 copay	$20 copay**/$40 copay**		
Urgent care	$50 copay		$50 copay**		
Emergency room* **	$200 copay		$150 copay**		

** These deductible amounts reflect the IRS requirements for 2021*
*** After deductible*
**** Waived if admitted*

Family amounts in the table above apply for all coverage levels except Employee Only.





The HFHS Advantage Tiered Access Plan Provides You Access To Two Network Tiers

TIER 1*

Tier 1 has a network of HFHS and other providers and offers lower deductibles and copays. Choose from Henry Ford-affiliated physicians that participate in:

- The Henry Ford Physician Network (HFPN), including Henry Ford Medical Group, hospital-employed physicians and some private practice physicians on staff at Henry Ford facilities
- The Jackson Health Network
- Genesys

These are known as Henry Ford-affiliated providers and facilities.

Lower deductibles and copays

Henry Ford-affiliated providers and facilities

TIER 2

Tier 2 has a broader network of HAP providers and facilities, but also comes with significantly higher deductibles and copays.

Higher deductibles and copays

Broader network of HAP providers and facilities

** Not all services are available in Tier 1 (e.g., pediatric specialty care). These services would need to be provided under Tier 2 at the Tier 2 cost share.*

HAP Provider Information

All medical plans offered through My Choice Rewards are self-funded plans.
To find out if your physician accepts any of the HAP medical options, review the information below.

1. Log onto **www.hap.org**
2. Click on *Find a Doctor* and then *Search*
3. Use the drop-down box to select your plan using the appropriate Plan Look Up Name below
4. Enter the information you want to search on to determine if your provider is in the network that accepts your plan
5. Click on *Search Providers*

IF YOU ENROLL IN THIS PLAN	USE THIS PLAN LOOK UP NAME
HFHS Advantage Tiered Access Plan	HFHS Employee Advantage Tiered Access EPA
CDHP Comprehensive HFHS Preferred Network	HFHS Employee CDHP Comprehensive Preferred **HMO**
CDHP Comprehensive Full HAP	HFHS Employee CDHP EPA
CDHP Basic Full HAP	HFHS Employee CDHP EPA

HENRY FORD MYCHART

This online tool offers patients a convenient way to manage their health care. MyChart is secure, free and available 24 hours per day. You can view MyChart on your desktop computer or mobile device. For more information **click here**.

CHECK OUT ALEX

An interactive decision-making tool called "Alex" allows you to compare benefit options and helps you decide on the best choices for you and your family. Although Alex will provide recommendations, you will make the decision about what's best for you and your family. Alex is available on Employee Self Service.

Your Health Care Costs

Health care costs rise each year. While HFHS works diligently to minimize employee payroll contribution increases, some level of increase is necessary to ensure the long-term stability and competitiveness of the program. As a result, we are increasing employee payroll contributions across most plans and most coverage levels for 2021.

2021 EMPLOYEE CONTRIBUTIONS PER PAY – IF YOU COMPLETED WELLNESS REQUIREMENTS IN 2020

STATUS	Medical Plan Coverage Levels	HFHS Advantage Tiered Access Plan	CDHP Basic Full HAP*	CDHP Comprehensive HFHS Preferred Network**	CDHP Comprehensive Full HAP**
Full Time	Employee	$61.10	$29.38	$39.59	$87.66
	Employee + Spouse	$159.19	$83.73	$89.07	$216.31
	Employee + Child(ren)	$136.85	$68.84	$78.47	$183.09
	Family	$194.57	$102.33	$108.86	$264.38
Sponsored Dependent Cost	With Medicare	$295.65	N/A	N/A	N/A
	Without Medicare	$369.56	$114.90	$220.51	$415.48

Note: Vision is included in the contributions above.
** Plan has deductibles of $4,500/$9,000 that must be paid by you before benefits are paid by the plan (including prescription drugs).*
*** Plans have deductibles of $1,400/$2,800 that must be paid by you before benefits are paid by the plan (including prescription drugs).*

Medical Plan Scenarios

When choosing your health plan, there's a lot to consider, including your age, health and family history. As you think about the best choice for you and your family, review these scenarios. These highlight three different levels of health care needs: low, average and high health care usage. Each shows the total cost to an employee when you take payroll contributions and costs for services into account. This gives you a sense of how the cost of each plan compares. The examples are for illustrative purposes, and your actual costs may be different based on the specific medical services you use in a given year.

MEET AMY: She's single and in good health

Amy is in good health. She requires coverage only for herself. Based on her healthy status, Amy needs limited medical services. Let's look at Amy's total annual cost with one preventive office visit (covered at 100%), one primary care physician (PCP) office visit, two generic prescriptions and $500 in non-preventive medical claims costs, subject to **coinsurance**.

You might relate to Amy if:

- You are in good health.
- You need coverage only for yourself.
- You use minimal health care services during the year.
- You need only a couple of prescriptions.

	Amy's **Payroll contributions** for the year		Amy's **Additional medical costs** *(Toward deductible, copays and coinsurance)*		Amy's **Prescription costs** *(Toward copays and coinsurance)*		**HSA dollars** from HFHS that **reduce** Amy's costs		Amy's **Total costs**
HFHS ADVANTAGE TIERED ACCESS PLAN TIER 1	$1,589	+	$270	+	$8	-	N/A	=	**$1,867**
HFHS ADVANTAGE TIERED ACCESS PLAN TIER 2	$1,589	+	$600	+	$40	-	N/A	=	**$2,229**
CDHP BASIC FULL HAP	$764	+	$600	+	$70	-	$500	=	**$934**
CDHP HFHS PREFERRED NETWORK	$1,029	+	$600	+	$70	-	$500	=	**$1,199**
CDHP FULL HAP	$2,279	+	$600	+	$70	-	$500	=	**$2,449**

Amy gets the best cost in the **CDHP Basic Full HAP,** based on her situation. However, she could have significant out-of-pocket expenses if she has an unexpected high-cost medical service.

MEET THE SMITHS: A family with average health care needs

John is an employee who is looking to cover himself, his wife, Anne, and their two young kids, Jane and Lee. The Smiths live an active lifestyle and have moderate health care needs. Let's take a look at what plan is best for the Smiths if, over the course of the year, their family receives four preventive office visits covered at 100%, six PCP office visits, 24 generic prescriptions, eight brand prescriptions and $10,000 in non-preventive medical claim costs, subject to coinsurance.

You might relate to the Smiths if:

- You need coverage for your entire family.
- Your family members are in relatively good health, with average health care needs.
- You need several maintenance prescriptions (some generic and some brand name) throughout the year.

	The Smiths' **Payroll contributions** for the year		The Smiths' **Additional medical costs** *(Toward deductible, copays and coinsurance)*		The Smiths' **Prescription costs** *(Toward copays and coinsurance)*		**HSA Dollars** from HFHS that **reduce** the Smiths' costs		The Smiths' **Total costs**
HFHS ADVANTAGE TIERED ACCESS PLAN TIER 1	$5,059	+	$620	+	$312	-	N/A	=	**$5,991**
HFHS ADVANTAGE TIERED ACCESS PLAN TIER 2	$5,059	+	$4,990	+	$800	-	N/A	=	**$10,849**
CDHP BASIC FULL HAP	$2,661	+	$9,320	+	$408	-	$1,000	=	**$11,389**
CDHP HFHS PREFERRED NETWORK	$2,830	+	$2,920	+	$312	-	$1,000	=	**$5,062**
CDHP FULL HAP	$6,874	+	$2,920	+	$680	-	$1,000	=	**$9,474**

With lower payroll contributions and moderate health care needs, the **CDHP Comprehensive HFHS Preferred Network** is the most cost-effective option for the Smiths.

MEET THE GARCIAS: A family managing a chronic condition

The Garcias are a family of four with a child who needs help managing a chronic condition. Let's consider the Garcias' total cost if they receive four preventive office visits covered at 100%, 12 PCP office visits, 48 generic prescriptions, 24 brand prescriptions and $30,000 in non-preventive medical claims costs, subject to coinsurance.

You might relate to the Garcias if:

- You or a member of your family has a chronic condition.
- You or a member of your family require a high level of medical services, including prescriptions.

	The Garcias' **Payroll contributions** for the year		The Garcias' **Additional medical costs** *(Toward deductible, copays and coinsurance)*		The Garcias' **Prescription costs** *(Toward copays and coinsurance)*		**HSA Dollars from HFHS that reduce the Garcias' costs**		The Garcias' **Total costs**
HFHS ADVANTAGE TIERED ACCESS PLAN TIER 1	$5,059	+	$740	+	$840	-	N/A	=	**$6,639**
HFHS ADVANTAGE TIERED ACCESS PLAN TIER 2	$5,059	+	$11,230	+	$1,920	-	N/A	=	**$18,209**
CDHP BASIC FULL HAP	$2,661	+	$12,000	+	$0	-	$1,000	=	**$13,661**
CDHP HFHS PREFERRED NETWORK	$2,830	+	$3,040	+	$840	-	$1,000	=	**$5,710**
CDHP FULL HAP	$6,874	+	$3,040	+	$1,680	-	$1,000	=	**$10,594**

With the Garcias' higher use of medical services and management of a chronic condition, **the CDHP Comprehensive HFHS Preferred Network** is the best option for them.

Note: The scenarios in this section are based on the following details and assumptions:

- Annual 2021 employee payroll contributions shown are based on full-time employees who complied with the wellness requirements.
- For the CDHP Comprehensive HFHS Preferred Network and Advantage Tiered Access plan (Tier I), costs are based on use of a System pharmacy.
- Brand drugs are assumed to all be Formulary drugs, so Formulary copays apply. All drugs in all illustrations are assumed to be 30-day supply.

HFHS Advantage Tiered Access Plan

This plan gives you access to two network tiers.

The plan encourages employees to use Henry Ford providers and facilities, while still providing flexibility for those who may want, or need, to go outside Henry Ford for care — without changing plans. Instead of choosing one plan over another at open enrollment, the two-tier system allows employees to determine the network they want or need to use at the time service is required.

INTEGRATIVE MEDICINE FOR CANCER CARE

Research shows integrative medicine can help cancer patients with potential treatment side effects, reduce fatigue and stress, and improve physical function and sleep. With this in mind, massage therapy, acupuncture and yoga will be covered benefits for employees and their family members with a cancer diagnosis within the past three years. Eligibility for the program is limited and requires employees and their family members be enrolled in the CDHP Comprehensive HFHS Preferred Network or the HFHS Advantage Tiered Access options (Tier 1 only). A $20 copay per visit will be applied to massage therapy and acupuncture benefits. There is no copay for yoga. **For more information, contact HAP at 866-766-4709.**

THINGS TO CONSIDER

- With Tier 1 providers and facilities, you'll enjoy lower costs when you go to the doctor.
- In Tier 1, you will get high-quality, coordinated care through Henry Ford providers and facilities.
- Tier 2 still provides market-competitive coverage, and allows you the flexibility to go to some providers outside of Henry Ford.
- If you use both tiers, you are required to meet the deductible maximums of both.
- If you plan to use only Henry Ford providers and facilities, this plan has the lowest deductibles.
- Some services, such as pediatric specialty care services, may not be available through Tier 1, so if you need those services, you will need to use Tier 2 providers and pay higher deductibles and copays.
- If you think you'll use several non-Henry Ford providers, you may want to consider the CDHP plan options.
- You can pay for eligible health care expenses using the FSA, but the "use it or lose it" rule applies.
- You cannot enroll in the HSA.
- Employees and their family members enrolled in the HFHS Advantage Tiered Access option who have a cancer diagnosis within the past three years are eligible for integrative medicine benefits (Tier 1 only).
- For family coverage, all family members work together to meet the family deductible amount. However, the most any one person in the family will pay before the benefits are triggered for that individual is $250 (the individual deductible limit). Once the remaining family members collectively meet the additional $250 deductible, benefits are triggered for all covered family members for Tier 1.

HFHS ADVANTAGE TIERED ACCESS PLAN

Health Care Services	Tier 1	Tier 2
Benefit Period and Annual Deductible Maximums		
Benefit Period	***Calendar Year***	
Annual Deductible	$250 Employee Only; $500 Family (2 or more)	$1,250 Employee Only; $2,500 Family (2 or more)
	Deductible does not include copays or coinsurance Deductible applies to the annual out-of-pocket maximum	
Coinsurance (what you pay)	None	30%
Annual Out-of-Pocket Maximums	$6,850 Employee Only; $13,700 Family The most you have to pay for covered services in a **plan year.** After you spend this amount on deductibles, **copayments** and coinsurance, the plan pays 100% of the costs of covered services. These values do not accumulate: Premiums, balance-billed charges and health care this plan doesn't cover; all other cost-sharing accumulates	
Preventive Services		
Preventive Office Visit	Covered Deductible does not apply	
Related Laboratory and Radiology Services		
Pap Smears, Mammograms and Tubal Ligation		
Immunizations		
Outpatient and Physician Services		
Primary Care Office Visit	$20 copay / Deductible does not apply	$40 copay / Deductible does not apply
Telehealth Visit	$20 copay / Deductible does not apply	Not covered
	Must be performed by plan's contracted telehealth services provider	
Specialty Physician Office Visit	$40 copay / Deductible does not apply	$80 copay / Deductible does not apply
Gynecology Office Visit	$20 copay / Deductible does not apply	$40 copay / Deductible does not apply
Audiology Office Visit	$40 copay / Deductible does not apply	$80 copay / Deductible does not apply
Eye Exam Office Visit	$40 copay / Deductible does not apply	$80 copay / Deductible does not apply
	One routine eye exam per benefit period at no cost	
Allergy Treatment and Injections	Covered after deductible	30% coinsurance after deductible
Laboratory and Pathology		
Imaging MRI's, CT & PET Scans		
Radiology (Xray)		
Radiation Therapy & Chemotherapy		
Dialysis		
Outpatient Surgery	$100 copay after deductible	30% coinsurance after deductible
Chiropractic	Not covered	Not covered

HFHS ADVANTAGE TIERED ACCESS PLAN (CONTINUED)

Health Care Services	Tier 1	Tier 2
Emergency/Urgent Care		
Emergency Room Services	$200 copay / Deductible does not apply Copay waived if admitted	
Urgent Care	$50 copay / Deductible does not apply	
Emergency Medical Transportation	Covered after Tier 1 deductible Emergency transport only	
Inpatient Hospital Services		
Facility Fee	$100 copay per admission after deductible	30% coinsurance after deductible
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after deductible	30% coinsurance after deductible
Bariatric Surgery & Related Services	$500 copay after deductible Limited to one procedure per lifetime; must be performed at a Henry Ford facility	Not covered
Maternity Services		
Prenatal Office Visits	Covered Deductible does not apply	
Postnatal Office Visits		
Labor, Delivery and Newborn Care	See Inpatient Services	30% coinsurance after deductible
Behavioral Health and Substance Use Disorder		
Inpatient Services	See Inpatient Services	30% coinsurance after deductible
Outpatient Services	$20 copay / Deductible does not apply	$20 copay / Deductible does not apply
Other Services		
Home Health Care	Covered after deductible	30% coinsurance after deductible
	Unlimited	
Hospice Care	Covered after deductible	30% coinsurance after deductible
	210 days per lifetime (combined in Tiers 1 & 2)	
Skilled Nursing Care	Covered after deductible	30% coinsurance after deductible
	Covered for authorized services; up to 730 days renewable after 60 days of nonconfinement (combined Tiers 1 & 2)	
Durable Medical Equipment, Prosthetics & Orthotics	Covered after deductible	30% coinsurance after deductible
	Coverage provided for approved equipment based on AHLIC's* guidelines	
Hearing Aid Hardware	Covered after deductible	Not covered
	Covered for conventional hearing aid	

HFHS ADVANTAGE TIERED ACCESS PLAN (CONTINUED)

Health Care Services	Tier 1	Tier 2
Other Services (Continued)		
Rehabilitation Services, Physical, Speech and Occupational Therapy	Covered after deductible	30% coinsurance after deductible
	May be rendered at home. 60 combined visits per benefit period (combined in Tiers 1 & 2)	
Rehabilitation Services	Covered after deductible	30% coinsurance after deductible
	Limited to Applied Behavioral 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 Behavioral Health for ABA cost-share amount	
Voluntary Sterilizations	$100 copay after deductible	30% coinsurance after deductible
	Limited to vasectomy	
Infertility Services	Covered after deductible	30% coinsurance after deductible
	Services for diagnosis, counseling and treatment of anatomical disorders causing infertility in accordance with AHLIC's* benefit referral and practice policies	
Assisted Reproductive Technologies	Covered after deductible	30% coinsurance after deductible
	One attempt of artificial insemination per lifetime	
Temporomandibular Joint (TMJ) Disorder	Covered after deductible	30% coinsurance after deductible
	Limited to non-invasive reversible procedures only	
Pharmacy	**HFHS Preferred Pharmacy**	**Any Other Contracted Pharmacy**
Generic / Preferred Brand / Non-Preferred Brand / Specialty Drug Copay	30-day supply: $4 / $27 / $45 / $100 copay 90-day supply: $12 / $67 / $105 / $100 copay	30-day supply: $20 / $40 / $80 / $100 copay 90-day supply: $40 / $80 / $160 / $100 copay
	A 90-day supply of non-maintenance drugs must be filled at AHLIC's* designated mail order pharmacy; other exclusions and limitations** may apply	

** Alliance Health and Life Insurance Company*

*** Limitations:*

- *Hospital admissions require that Alliance Health and Life Insurance Company (AHLIC) be notified within 48 hours of admission. Failure to notify AHLIC within 48 hours could result in a reduction of benefits or non-payment. AHLIC administers Henry Ford Health System HAP self-funded medical plans.*
- *Students away at school are covered for acute illness and injury-related services according to AHLIC criteria.*
- *In cases of conflict between this summary and your Self-Funded Benefit Guide, the terms and conditions of the Self-Funded Benefit Guide govern.*
- *Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a denial of benefits.*

FREE PRESCRIPTION HOME DELIVERY

Have your medications shipped right to your door. **Pharmacy Advantage** offers free home delivery of your medications, whether you need a simple refill or a new prescription. To find out how, call **800-456-2112** or ask a Henry Ford pharmacist.

SPECIAL MEDICAL CREDIT

The special medical credit is available for Employee, Employee + Spouse, Employee + Child(ren) and Family households. The credit is available for full-time employees who enroll in either the CDHP Comprehensive HFHS Preferred Network Plan or the HFHS Advantage Tiered Access Plan. The **credits** per pay period are as follows:

CDHP Comprehensive HFHS Preferred Network Plan	
Employee	$18.46
Employee + Spouse	$41.54
Employee + Child(ren)	$34.15
Family	$50.77
HFHS Advantage Tiered Access Plan	
Employee	$32.31
Employee + Spouse	$72.69
Employee + Child(ren)	$59.77
Family	$88.85

Eligibility for the credit is based on the total family income as indicated on the most recently filed Form 1040 tax return and the number of dependents indicated on that tax return(s). A new online application must be completed each year. Please refer to the chart on the right.

Special Medical Credit Income Guidelines	
Family Size*	**1040 Earnings****
1	$25,520
2	$34,480
3	$43,440
4	$52,400
5	$60,760
6	$70,320
7	$79,280
8+	$88,240

** Based on the number of exemptions (you, spouse, dependents) reported on your most recent federal tax return under "family size."*

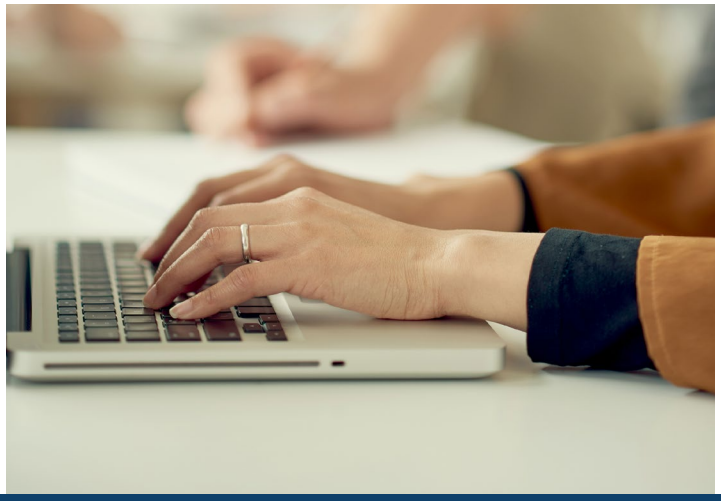
*** Based on the total family income amount indicated on your federal income tax Form 1040 or Form 1040EZ.*

HOW TO APPLY AND HOW IT WORKS

- Apply for the special medical credit during open enrollment or throughout the year due to life events, status changes and new hire eligibility.
- Locate the online application on Employee Self Service under Hot Spots. You have until Dec. 7, 2020 to complete the application in time for the first pay of January.
- Employee Services will notify you if you will receive the credit after reviewing your application and tax return information.
- Your credit ends if you are no longer a full-time employee enrolled in the HFHS Advantage Tiered Access or CDHP Comprehensive HFHS Preferred Network plans, or you are no longer eligible for benefits.

SUPPLEMENTAL COVERAGE OPTIONS THAT HELP WITH YOUR MEDICAL COSTS WHEN CERTAIN HEALTH CARE NEEDS ARISE

- Hospital indemnity insurance
- Critical illness insurance
- Accident insurance



Consumer Driven Health Plans

HFHS offers three consumer driven health plans (CDHPs). CDHPs typically feature lower paycheck contributions and higher deductibles, plus you have an opportunity to save for health care expenses with an HSA. Take a look at how they work:

CDHP Comprehensive HFHS Preferred Network – Employees choosing this option are required to use HFHS Preferred Network providers. The plan design is the same as the CDHP Comprehensive Full HAP plan option, but the per-pay contributions are lower. Employees must pay the full cost of their medical services, including prescription drugs, until the deductible has been reached. The deductible is $1,400 for Employee Only and $2,800 for Family (two or more individuals). Preventive care is covered at 100% and the deductible does not apply.

CDHP Comprehensive Full HAP – Employees choosing this option may select any provider within the broader HAP network. Employees must pay the full cost of their medical services, including prescription drugs, until the deductible has been reached. The deductible is $1,400 for Employee Only and $2,800 for Family (two or more individuals). Preventive care is covered at 100% and the deductible does not apply.

CDHP Basic Full HAP – This plan provides catastrophic coverage that protects you from worst-case scenarios like serious accidents or illnesses. While the employee contribution is low, the deductible is $4,500 for Employee Only and $9,000 for Family (two or more individuals). Employees pay the full cost of their medical services, including prescription drugs, until the deductible has been reached. Preventive care is covered at 100% and the deductible does not apply. This option allows members to choose from a broader network of HAP-affiliated providers.

THINGS TO CONSIDER

- Pay as you go. Generally, you'll have lower paycheck contributions and pay only for the health care services you use.
- Preventive care is covered at 100% and the deductible does not apply.
- You'll have a higher deductible and higher cost when you receive care, including prescription drugs, until your deductible is met. Prescription drugs count toward the deductible. Once you reach the **out-of-pocket maximum**, other services during the year are covered in full.
- You can save tax free with an HSA. Pay for eligible health care expenses and watch your account grow – through contributions from you and/or HFHS, interest and investment returns – tax free. Plus, the HSA is yours to keep and your funds roll over each year, even into retirement.
- If you and your spouse complete the **Thrive Rewards** requirements, HFHS will deposit up to $500 (Employee Only) and up to $1,000 (all other coverage levels) in your HSA. See pages 28-29 to learn more.
- You will need to select a HFHS primary care physician under the CDHP Comprehensive HFHS Preferred Network.
- Under the CDHP Comprehensive HFHS Preferred Network plan, you can have the flexibility to use the broader network of HAP-affiliated providers if you require pediatric care or routine OB/GYN services.
- Employees and their family members enrolled in the CDHP Comprehensive HFHS Preferred Network option, who have a cancer diagnosis within the past three years are eligible for integrative medicine benefits.

HOW THE FAMILY DEDUCTIBLE WORKS

For family coverage in the CDHP Plans, all family members work together to meet the family deductible amount. Here's how it works for the specific plans:

- **CDHP Comprehensive HFHS Preferred Network and Full HAP Plans:** When one individual or all family members collectively meet the $2,800 deductible, benefits are triggered for all covered family members.
- **CDHP Basic Full HAP Plan:** The most any one person in the family will pay toward the deductible is $6,000 (due to the individual out-of-pocket limit). Once a family member meets this amount, benefits are triggered for that family member. Once the family collectively meets the $9,000 deductible, benefits are triggered for all covered family members.

Health Savings Account (HSA)

All CDHP plans offer a Henry Ford-funded HSA. An HSA offers flexibility when it comes to planning for medical costs now and in the future.

- For employees who enroll in any of the CDHP options, Henry Ford will contribute up to $500 (Employee Only), or up to $1,000 (all other coverage levels) to the HSA by Jan. 4, 2021. This money can be used toward the deductible. You automatically receive half of the amount provided by HFHS, and the other half can be earned by completing the Thrive Rewards requirements.
- Employees also may contribute to their HSA using pre-tax dollars. The annual limit combining the Henry Ford and employee contributions is $3,600 for an Employee or $7,200 for a Family (two or more individuals). Employees age 55+ may contribute an additional $1,000 over the maximum amounts listed above.
- HSA funds roll over from year to year, even into retirement, and the benefit is portable between employers. This makes it a good way to save for future medical costs in retirement. In addition to saving for retirement, there are opportunities to invest your HSA contributions.
- Monthly administrative fees for the account are paid by HFHS. If you change health plans or employers, your account may be charged $3.95 per month.
- If you participate in one of the CDHPs with an HSA you cannot enroll in the health care Flexible Spending Account (HCFSA). You are still eligible for the dependent care FSA (DCFSA).
- HealthEquity is the vendor used for the HSA and FSA programs.
- There are eligibility requirements to participate in the HSA. For example, if you have Medicare or are eligible for Canadian Health Care, you are not eligible. For these and other HSA details, click here.
- The employer contribution is pro-rated for new hires, benefit status changes and mid-year events that occur after Jan. 1.

If you plan to retire in 2021, you must stop contributing to your HSA at least six months before you start the application process with Social Security and/or Medicare to avoid IRS penalty. Click here for more information.

ANY UNUSED DOLLARS IN YOUR HSA AT THE END OF THE YEAR WILL ROLL OVER TO THE NEXT YEAR.

YOUR HSA: TAKE ADVANTAGE OF THE TRIPLE-TAX ADVANTAGE

Your contributions go in tax free

Your contributions are made pre-tax

Your contributions grow tax free

Your account balance accumulates tax-free interest and earnings

Your contributions come out tax free

Your funds are not taxed when you use them to pay for eligible health care expenses

TAKE NOTE

If you plan to contribute to an HSA in 2021 and you currently are enrolled in the health care FSA for 2020, be sure that the balance of your health care FSA is $0.00 on Dec. 15, 2020 in order to contribute and receive the employer funding to your HSA on Jan. 4, 2021.

- If your health care FSA balance is $0.00 on Dec. 31, 2020, you can expect to receive your contributions and the employer funding on Jan. 22, 2021.
- If your health care FSA balance is not $0.00 on Dec. 31, 2020, your contributions and the employer-funded portion will be deposited on April 2, 2021.

FSA claims must be paid and reimbursed by Dec. 31 (not incurred or in a review status).

HOW YOUR HSA WORKS

(AVAILABLE WHEN YOU SELECT A CDHP)

YOUR ANNUAL HSA CONTRIBUTIONS *(Single/Family)*

Your contributions

+

HFHS Wellness Incentive $250/$500

+

HFHS Contribution $250/$500

Your ANNUAL CONTRIBUTIONS are **TAX FREE:**

Sample Employee Contribution = $2,000 annually

Tax Rate of 20% (20% x $2,000 = $400)

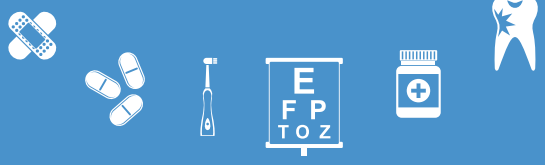
Tax Savings = $400 annually

MINUS

YOUR QUALIFIED MEDICAL EXPENSES

HEALTH CARE EXPENSES

(Medical, Pharmacy, Dental, Vision, etc.)



Any WITHDRAWALS you make to pay for medical expenses are **TAX FREE.**

EQUALS

YOUR BALANCE ROLLS OVER YEAR AFTER YEAR

Your HSA account balance at year end

You can invest part of your balance, and the interest/earnings grow **TAX FREE**

CONSUMER DRIVEN HEALTH PLANS

Health Care Services	CDHP Comprehensive HFHS Preferred Network	CDHP Comprehensive Full HAP	CDHP Basic Full HAP
Benefit Period and Annual Deductible Maximums			
Benefit Period	***Calendar Year***		
Annual Deductible	$1,400 Employee Only, $2,800 Family If more than one person is covered under this plan, all family members must collectively or individually meet the family coverage amounts		$4,500 Employee Only; $9,000 Family Not to exceed $6,000 for any one person
	Deductible does not include copays or coinsurance Deductible applies to the annual out-of-pocket maximum		
Coinsurance (what you pay)	None		20%
Annual Out-of-Pocket Maximums	$6,550 Employee Only; $13,100 Family Not to exceed $6,550 for any one person		$6,000 Employee Only; $12,000 Family Not to exceed $6,000 for any one person
	The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, the plan pays 100% of the costs of covered services. The following values do not accumulate: Premiums, balance-billed charges and health care not covered by the Plan; all other cost-sharing accumulates.		
Preventive Services			
Preventive Office Visit	Covered Deductible does not apply		
Related Laboratory and Radiology Services			
Pap Smears, Mammograms and Tubal Ligation			
Immunizations			
Outpatient and Physician Services			
Primary Care Office Visit	$20 copay after the deductible		
Telehealth Visit	$20 copay after the deductible Must be performed by Plan's contracted telehealth services provider		
Specialty Physician Office Visit	$40 copay after the deductible		
Gynecology Office Visit	$20 copay after the deductible		
Audiology Office Visit	$40 copay after the deductible		
Eye Exam Office Visit	$40 copay after the deductible One routine eye exam per benefit period at no cost share		
Allergy Treatment and Injections	Covered after deductible		
Laboratory and Pathology			
Imaging MRI's, CT & PET Scans			
Radiology (Xray)			
Radiation Therapy & Chemotherapy			
Dialysis			
Outpatient Surgery	$100 copay after deductible		
Chiropractic	Not covered		

CONSUMER DRIVEN HEALTH PLANS (CONTINUED)

Health Care Services	CDHP Comprehensive HFHS Preferred Network	CDHP Comprehensive Full HAP	CDHP Basic Full HAP
Emergency/Urgent Care			
Emergency Room Services	$150 copay after the deductible Copay waived if admitted		
Urgent Care	$50 copay after the deductible		
Emergency Medical Transportation	Covered after the deductible Emergency transport only		
Inpatient Hospital Services			
Facility Fee	$100 copay per admission		
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after deductible		
Bariatric Surgery & Related Services	$500 copay after deductible Limited to one procedure per lifetime		
Maternity Services			
Prenatal Office Visit	Covered		
Postnatal Office Visits	Covered after the deductible		
Labor, Delivery and Newborn Care	See Inpatient Hospital Services		
Behavioral Health and Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services		
Outpatient Services	$20 copay after the deductible		
Other Services			
Home Health Care	Covered after deductible Unlimited		
Hospice Care	Covered after deductible 210 days per lifetime		
Skilled Nursing Care	Covered after deductible Covered for authorized services; up to 730 days renewable after 60 days of nonconfinement		
Durable Medical Equipment, Prosthetics & Orthotics	Covered after deductible Coverage provided for approved equipment based on AHLIC's* guidelines		
Hearing Aid Hardware	Covered after deductible Covered for conventional hearing aid		

CONSUMER DRIVEN HEALTH PLANS (CONTINUED)

Health Care Services	CDHP Comprehensive HFHS Preferred Network	CDHP Comprehensive Full HAP	CDHP Basic Full HAP
Other Services (Continued)			
Rehabilitation Services, Physical, Speech and Occupational Therapy	Covered after deductible		
Rehabilitation Services	Covered after deductible Limited to Applied Behavioral 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 Behavioral Health for ABA cost-share amount		
Voluntary Sterilizations	$100 copay after deductible Limited to vasectomy		
Infertility Services	Covered after deductible Services for diagnosis, counseling and treatment of anatomical disorders causing infertility in accordance with AHLIC's* benefit referral and practice policies		
Assisted Reproductive Technologies	Covered after deductible One attempt of artificial insemination per lifetime		
Pharmacy	**HFHS Preferred Pharmacy**	**Any Other Contracted Pharmacy**	
Generic / Preferred Brand / Non-Preferred Brand / Specialty Drug Copay	30-day supply: $4 / $27 / $45 / $100 copay after deductible 90-day supply: $12 / $67 / $105 / $100 copay after deductible	30-day supply: $15 / $40 / $60 copay after deductible 90-day supply: $30 / $90 / $120 copay after deductible	30-day supply: 20% coinsurance after deductible 90-day supply: 20% coinsurance after deductible
	A 90-day supply of non-maintenance drugs must be filled at AHLIC's* designated mail order pharmacy; other exclusions and limitations** may apply		

** Alliance Health and Life Insurance Company*

*** Limitations:*

- *Hospital admissions require that Alliance Health and Life Insurance Company (AHLIC) be notified within 48 hours of admission. Failure to notify AHLIC within 48 hours could result in a reduction of benefits, or non-payment. AHLIC administers Henry Ford Health System HAP self-funded medical plans.*
- *Students away at school are covered for acute illness and injury related services according to AHLIC criteria.*
- *In cases of conflict between this summary and your Self-Funded Benefit Guide, the terms and conditions of the Self-Funded Benefit Guide govern. Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a denial of benefits.*

PRIMARY CARE PHYSICIAN AND NETWORK CHANGES

You and your dependents can change your primary care physician (PCP) and remain part of the CDHP Comprehensive HFHS Preferred Network option, as long as the new PCP is part of the CDHP Comprehensive HFHS Preferred Network. Changing your PCP will not affect your contribution for medical coverage. If you need to change your network assignment and move from the CDHP Comprehensive HFHS Preferred Network option to the CDHP Basic or CDHP Comprehensive Full HAP option, your medical contribution will change. You will continue to have a pre-tax deduction up to the cost of the CDHP Comprehensive HFHS Preferred Network option. The additional contribution will be an after-tax deduction. For example, if you have employee coverage under the CDHP Comprehensive HFHS Preferred Network option at $39.59 per pay pre-tax, and you change your network selection to the CDHP Comprehensive Full HAP option, which is $87.66 per pay pre-tax, your pre-tax contribution will be $39.59 and your after-tax contribution will be $48.07 per pay for the remainder of the year.

THRIVE REWARDS: QUICK FACTS FOR 2021

Who is eligible?

- All employees and spouses enrolled in a HAP health plan as of March 31, 2021.
- All new hires and employees new to a HAP health plan from Jan. 1 to March 31, 2021.

When do I participate?

- Jan. 1 through July 31, 2021 – you must complete and submit all requirements by July 31, 2021.

What do I earn?

- Reduced payroll contribution for medical coverage for 2022, and/or
- An additional HSA employer-provided contribution for 2022.

What are the requirements?

You and your covered spouse (if applicable) must meet the following requirements by July 31, 2021:

- Know your numbers (BMI, blood pressure, cholesterol, fasting blood glucose)
- Take your online **health assessment**
- Be tobacco free
- Complete a wellness activity
- Complete all recommended preventive screenings.

Where do I learn more or get started?

Starting January 2021, OneHENRY and emails from WebMD will provide information you need to complete the requirements. Be sure you register your email with HAP and WebMD. Go to **hap.org**, click on *Thrive Rewards*.

THRIVE REWARDS AFFECTS YOUR COSTS

If you completed **Thrive Rewards** requirements by July 31, 2020, you will pay a lower contribution for your medical coverage each pay and/or receive funding to an HSA if enrolled in one of the three CDHP options. Newly eligible employees and their spouses with HAP coverage after March 31, 2020 will also receive the lower employee contributions, but will need to qualify in 2021 to continue receiving lower contributions in 2022. See page 29 for per pay contributions if you did **not** complete the Thrive Rewards requirements.

THRIVE REWARDS OVERVIEW

Thrive Rewards is the wellness program for HFHS employees and their spouses enrolled in HAP health plans. This includes each medical plan option provided by HFHS. By meeting the Thrive Rewards wellness requirements, you pay a lower employee contribution for your medical coverage, and/or receive money to your HSA from HFHS for those enrolled in a CDHP medical plan.

HSA contribution if enrolled in a CDHP medical plan option

If you enroll in one of the three CDHP options, you receive a base HSA contribution from HFHS. If you and your spouse met the wellness requirements in 2020 and enroll in one of the three CDHP options, you will also receive an additional Thrive Rewards HSA contribution in 2021. These amounts are shown to the right.

	BASE HFHS PROVIDED HSA CONTRIBUTION	ADDITIONAL THRIVE REWARDS CONTRIBUTION IN 2021
	For all employees enrolled in CDHP options	*For employees enrolled in CDHP option for 2021 who completed wellness requirements in 2020*
Employee	$250	$250
Employee + Spouse	$500	$500
Employee + Child(ren)	$500	$500
Family	$500	$500

Impact on employee per-pay contribution

If you met the Thrive Rewards wellness requirements in 2020, you will pay a lower employee contribution for medical coverage in 2021, as listed on page 12. If you did not meet the wellness requirements in 2020, you will pay a higher employee contribution for medical coverage in 2021, as listed below:

STATUS	Medical Plan Coverage Levels	HFHS Advantage Tiered Access Plan	CDHP Basic Full HAP	CDHP Comprehensive HFHS Preferred Network	CDHP Comprehensive Full HAP
Full Time	Employee	$76.10	$34.38	$44.58	$92.65
	Employee + Spouse	$189.19	$93.73	$99.07	$226.32
	Employee + Child(ren)	$166.84	$78.84	$88.47	$193.09
	Family	$224.57	$112.33	$118.86	$274.38
Sponsored Dependent Cost	With Medicare	$295.65	N/A	N/A	N/A
	Without Medicare	$369.56	$114.90	$220.51	$415.48

To receive a reduced contribution and/or money to an HSA in 2022, you must be enrolled in a HAP plan as of March 31, 2021 and meet the Thrive Rewards wellness program requirements between Jan. 1 and July 31, 2021. Rewards are adjusted annually and communicated during open enrollment. Newly eligible employees in a HAP plan after March 31, 2021, will receive the reduced contribution and/or money to an HSA for the remainder of 2021 and in 2022.

Sponsored Dependents and Spouses

SPONSORED DEPENDENTS

You also may cover certain sponsored dependents. For related information, see pages 5-6. Sponsored dependents are not eligible for dental coverage or standalone vision. The rates per pay period for sponsored dependent medical coverage are:

Medical Option	Sponsored Dependent with Medicare	Sponsored Dependent without Medicare
CDHP Basic Full HAP	Not Eligible	$114.90
CDHP Comprehensive HFHS Preferred Network	Not Eligible	$220.51
CDHP Comprehensive Full HAP	Not Eligible	$415.48
HFHS Advantage Tiered Access Plan	$295.65	$369.56

SPOUSAL SURCHARGE

If you elect to cover a spouse who is eligible for health insurance with their own non-HFHS employer, you will pay a surcharge of $46.15 pre-tax, per pay. This surcharge is in addition to your per-pay contribution for medical coverage and is designed to shift the responsibility of coverage to a broader spectrum of employers.

Note: During open enrollment, you will be asked to complete an online verification form indicating whether or not your spouse has access to coverage through a non-HFHS employer. If you elect coverage for your spouse and do not complete the form, you will pay the ***spousal surcharge****. If you later complete the form and your spouse does not have access to coverage, the surcharge deduction will stop but no refunds will be provided. Keep in mind, random audits will be conducted and ineligible spouses will be removed. Falsification may result in disciplinary action, which could include termination.*

Vision

THE VISION COVERAGE BELOW IS BASED ON THE MEDICAL OPTION YOU SELECTED.

	HFHS ADVANTAGE TIERED ACCESS		CDHP BASIC FULL HAP	CDHP COMPREHENSIVE HFHS PREFERRED NETWORK AND CDHP COMPREHENSIVE FULL HAP
SERVICES	**TIER 1**	**TIER 2**	**COVERAGE**	
Eye Exam	$40 copay; unlimited exams (waived for preventive care)	$60 copay; unlimited exams (waived for preventive care)	Covered in full	$40 copay; after deductible, unlimited exams (waived for preventive care)
Frames	Covered up to $40; one pair every 12 months	Covered up to $40; one pair every 12 months	Covered up to $40; one pair every 12 months	Covered up to $40 after deductible; one pair every 12 months
Lenses	Covered in full up to the approved charges; one pair every 12 months	Covered in full up to the approved charges; one pair every 12 months	Covered in full up to $40; one pair every 12 months with prescription change; otherwise one pair every 24 months	Covered in full up to the approved charges; one pair every 12 months
Contact Lenses	Covered in full up to $80 in lieu of eye glasses; contact lens fitting exams are not covered	Covered in full up to $80 in lieu of eye glasses; contact lens fitting exams are not covered	Covered in full up to $80 in lieu of eye glasses; contact lens fitting exams are not covered	Covered in full up to $80 in lieu of eye glasses; contact lens fitting exams are not covered

In case of discrepancies between this summary and the vision plan contract, the terms and conditions of the contract govern.

In addition to the vision plan you choose, eligible full-time employees (after 90 days) receive:

- One free eye exam every calendar year.
- One free pair of frames (from the approved vendor list) and lenses, or up to an $80 retail value in prescription contact lenses every calendar year.
- 50% off up to two pairs of ready-to-wear sunglasses.
- 25% off accessories.
- 25% off additional boxes of contact lenses.
- 50% off Lipi-Flow treatment.
- Additional frames and prescription lenses may be purchased at 70% off full retail (except for Maui Jim or Oakley, which are 50% off full retail). Benefit is not to go below HFO cost. No special orders.
- If insurance is used for an additional pair, the remaining balance is discounted by 70%.
- Employee's immediate family (spouse, children, step children, parents or step parents) receive an annual exam at no charge, as well as one pair of frames and lenses at 70% off retail, one pair of sunglasses at 50% off and contact lenses at 25% off.
- Employee's extended family (siblings, step siblings, half siblings, grandparents, step grandparents, grandchildren, parents in-law, siblings in-law and grandparents in-law) receive an annual exam at no charge, as well as one pair of frames and lenses at 50% off retail, one pair of sunglasses at 50% off and contact lenses at 25% off.
- Other family members not listed above will be eligible for discounts on eyeglasses. There is no discount on exams, contact lenses or accessories.
- Please see your Staff Member Handbook for additional information and restrictions.

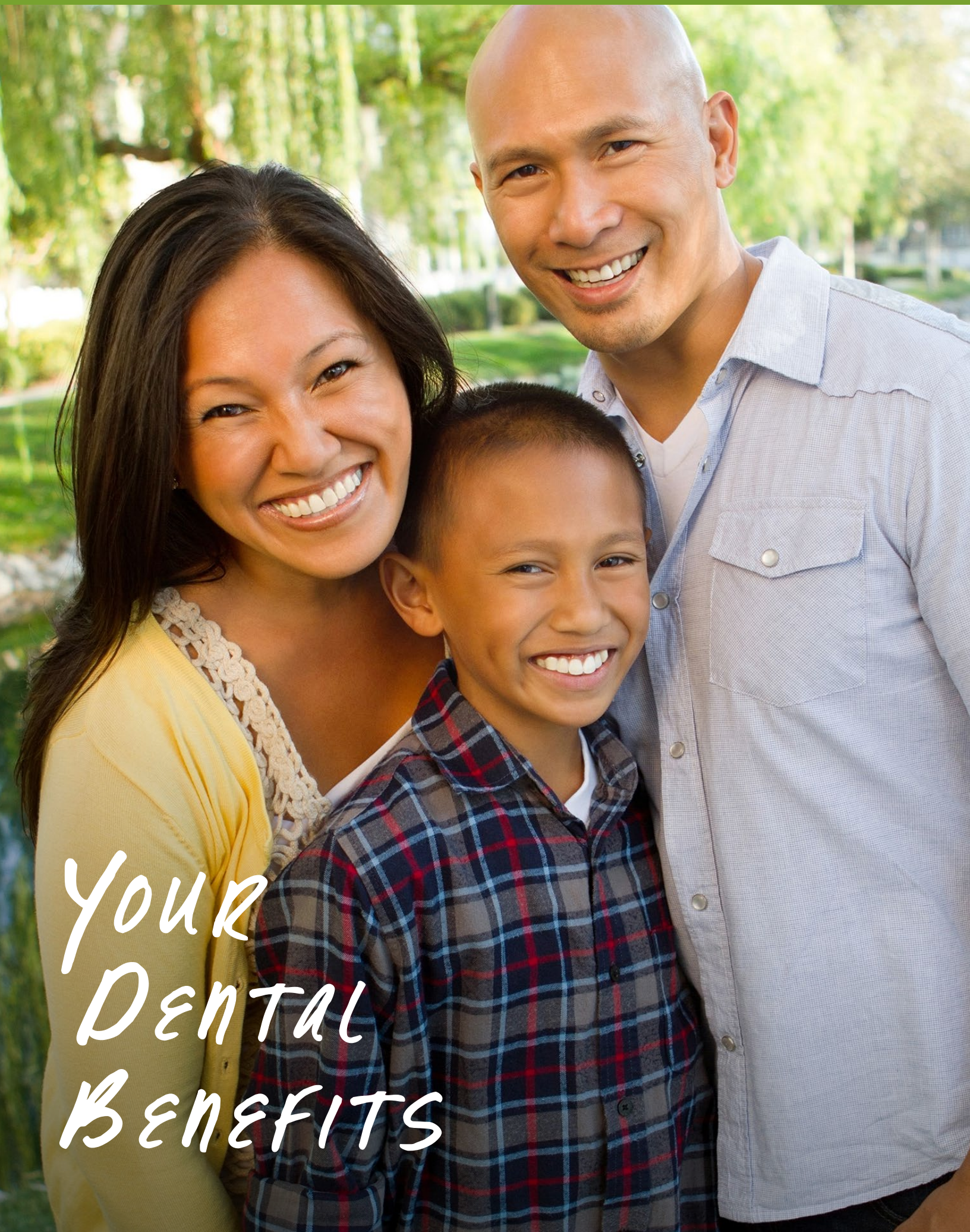
Discounts may not be combined with other discounts, coupons or promotions. Sale price merchandise is not included in the discount program. These benefits are available to you and your immediate family members (spouse and dependents). To take advantage of these discounts, simply present your Henry Ford identification badge and indicate that you are a System employee at the time the eligible service is provided. **For a Henry Ford OptimEyes location near you, go online to henryfordoptimeyes.com or call 800-EYE-CARE.**

HAP STANDALONE VISION PLAN

Vision coverage is included in the medical coverage options you have through HFHS. If you opt out of these medical coverage options, you may purchase vision coverage only. Services and benefits are available through Henry Ford OptimEyes and HAP.

Vision Plan	
Services	**Coverage**
Eye Exam	Covered one per benefit period when performed by a Henry Ford OptimEyes Optometrist
Frames	Covered up to $40; one pair every 12 months
Lenses	Covered in full, up to the approved charges; one pair every 12 months
Contact Lenses	Covered up to $80 in lieu of eyeglasses; contact lens fitting exams are not included

2021 Employee Vision Contributions (Per Pay)	
Stand-alone vision plan coverage levels	**HAP Vision**
Employee	$4.10
Employee + Spouse	$9.42
Employee + Child(ren)	$9.42
Family	$10.65


Your
Dental
Benefits

Dental

You have two dental plan options through Delta Dental – Delta Basic or Delta Comprehensive. These options each have two networks from which to choose a Delta Dental participating provider:

- You receive the highest level of coverage if you go to a Delta Dental PPO dentist.
- Although your coverage levels will be lower for some services when you go to a non-PPO dentist, you may still save money if that dentist participates in the Delta Dental Premier Network.

Service	Delta Basic		Delta Comprehensive	
Diagnostic & Preventive - Class I	**PPO**	**Premier**	**PPO**	**Premier**
Deductible	**$25 Employee Only; $50 Family**			
Diagnostic and Preventive Services – Used to diagnose and/or prevent dental abnormalities or disease (includes exams, cleanings and fluoride treatment)	Plan pays 100%			
Emergency Palliative Treatment – Used to temporarily relieve pain				
Sealants – to prevent decay of permanent teeth				
Brush Biopsy – to detect oral cancer				
Radiographs – X-rays				
Basic Services - Class II				
Oral Surgery Services – Extractions and dental surgery, including preoperative and postoperative care	Plan pays 60%	Plan pays 40%	Plan pays 85%	Plan pays 65%
Relines and Repairs – Relines and repairs to bridges and dentures				
Minor Restorative Services – Used to repair teeth damaged by disease or injury (for example, amalgam [silver] and resin [white] fillings				
Major Restorative Services – Used when teeth can't be restored with another filling material (for example, crowns)				
Periodontic Services – Used to treat diseases of the gums and supporting structures of the teeth				
Endodontic Services – Used to treat teeth with diseased or damaged nerves (for example, root canals)				
Major Services – Class III				
Posthodontic Services – Used to replace missing natural teeth (for example, bridges and dentures)	Plan pays 60%	Plan pays 40%	Plan pays 60%	Plan pays 40%
Orthodontic Services – Class IV				
Orthodontic Services – Used to correct malposed teeth and/or facial bones (for example, braces)	No coverage	No coverage	Plan pays 60%	Plan pays 50%
Ortho Lifetime Maximum	No coverage		$1,500 per person	
Maximum Payment				
Maximum Payment – Per-person, per-contract year	$750		$1,500 Does not include lifetime ortho maximum	

In cases of discrepancies between this summary and the dental plan contract, the terms and conditions of the contract govern.

2021 EMPLOYEE DENTAL CONTRIBUTIONS (PER PAY)

STATUS	Dental Plan Coverage Levels	Delta Premier Basic	Delta Premier Comprehensive (PPO)
Full Time	Employee	$2.11	$14.21
	Employee + Spouse	$5.29	$30.44
	Employee + Child(ren)	$5.95	$34.25
	Family	$9.26	$53.27

DENTAL PLAN PPO (POINT-OF-SERVICE) QUESTIONS AND ANSWERS

What are Delta Dental PPO℠ and Delta Dental Premier®?
Delta Dental PPO (Point-of-Service) is Delta Dental's national preferred provider organization program that gives you access to two of the nation's largest networks of participating dentists: Delta Dental PPO and Delta Dental Premier. Although you can go to any licensed dentist anywhere, your out-of-pocket costs are likely to be lower if you go to a dentist who participates in one of these networks.

How do I find a participating dentist?
To find out whether your dentist participates in Delta Dental PPO or Delta Dental Premier, you can call his or her office, check the website at **www.deltadentalmi.com**, or call the Customer Service department at **800-524-0149.**

Do I have to go to a participating dentist?
No. You can go to any licensed dentist anywhere, regardless of whether he or she participates in Delta Dental PPO or Delta Dental Premier. However, your out-of-pocket costs may be higher if you go to a nonparticipating dentist.

Can I change dentists whenever I'd like?
Yes. You can change dentists at any time.

Can each member of my family choose a different dentist?
Yes. Each member of your family may see a different dentist.

Am I covered if I go to a nonparticipating dentist?
Yes. However, when you seek care from a nonparticipating dentist, you are responsible for all fees charged. Delta Dental will reimburse you up to our nonparticipating dentist fee, which is generally lower than the fee for participating dentists.

Am I covered for emergency services?
Yes.

Will I receive dental cards?
No. Your dentist can verify your eligibility through the Customer Service department or the online Dental Office Toolkit.

Who do I call if I have questions?
If you have questions, please call the Customer Service Department at **800-524-0149.**


Flexible
Spending
Accounts

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) allow you to pay for out-of-pocket health care and dependent care expenses with pre-tax dollars. Your contributions are subtracted from your paycheck before federal, state and FICA taxes are calculated on your pay, so you save money on taxes.

How the health care FSA account works

- You decide how much you want to deposit during the calendar year. The maximum you can contribute to a health care FSA is $2,750 in 2021.
- The annual amount you elect for a health care FSA is available as of Jan. 1, 2021, or the date you become benefit eligible and enroll in the plan.
- Your 2021 contributions for a health care FSA must be used for eligible expenses you incur between Jan. 1, 2021 and March 15, 2022.
- You can pay the expense with your HealthEquity health care FSA card at the point of purchase. For a list of eligible expenses, **click here**.
- When you have an eligible health care FSA expense, such as a prescription drug copay, save the itemized receipt. HealthEquity may request a copy of your itemized receipts. To reduce the amount of substantiation that may be required, both HAP and Delta Dental provide medical and dental claims data to HealthEquity. HealthEquity is rigorous in reviewing and processing claims. This is good for HFHS and you from an IRS compliance perspective and any audits that could occur.
- You incur an expense on the date the service is provided — not when you are billed or when you pay it.
- You cannot submit a claim for services incurred prior to becoming eligible for the FSA.
- By law, any money remaining in your health care FSA after April 30, 2022 is forfeited and will not be returned to you. This is known as the "use it or lose it" rule.
- If you terminate employment or have a status change mid-year and you are no longer eligible to participate in a health care FSA, you have 90 days from the date of your event to submit eligible expenses incurred on or before your mid-year event.
- For more information on the health care FSA, contact HealthEquity at **866-346-5800** or **click here**.

THINGS TO CONSIDER

THERE ARE TWO TYPES OF FSAs. YOU MAY PARTICIPATE IN EITHER OR BOTH:

Health Care FSA — covers eligible health care expenses for you and your eligible dependents.

Dependent Care FSA — covers eligible dependent day care or elder-care expenses so you and your spouse can work or attend school full time.

Here are some key things to know:

- HealthEquity is the third-party administrator for the FSA program.
- There are some IRS rules you need to know before you decide to participate in a health care and/or dependent care FSA. You must enroll each year if you want to participate. FSAs do not carry over from year to year.
- The annual limit you elect is calculated over 26 pay periods (or for a new hire, over the remaining pay periods in the year) to determine the per-pay deduction.
- The health care and dependent care FSAs must remain separate accounts. Money cannot be transferred between the accounts. Health care services cannot be reimbursed from a dependent care account or vice versa.
- See pages 51-54 for qualified mid-year events that may allow you to change your election to a health care and/or dependent care FSA.

How the dependent care FSA account works

- You decide how much you want to deposit during the calendar year. The maximum you can contribute to a dependent care FSA is $5,000 in 2021.
- Your 2021 contributions for a dependent care FSA must be used for eligible expenses you incur between Jan. 1 and Dec. 31, 2021, or the date you become eligible and enroll in the plan.
- You can only receive reimbursement up to the amount available in your dependent care FSA (DCFSA).
- Eligible expenses for a DCFSA include, but are not limited to, care for dependents age 12 or younger, or dependents regardless of age who are physically or mentally incapable of caring for themselves and whom you claim as a dependent on your federal income tax return. You (and your spouse if you are married) must maintain a home that you live in for more than half of the year with your qualifying child or dependent.
  For more information on eligible expenses, click here.
- For dependent care claims, save the itemized receipts from your day care provider and submit a claim form with your receipt to HealthEquity.
- You cannot submit a claim for services provided prior to becoming eligible and enrolled in the plan.
- If you are married, your spouse must also be at work, school (as a full-time student), searching for a job, or mentally or physically disabled and unable to provide care for a dependent.
- By law, any money remaining in your DCFSA after Dec. 31, 2021 is forfeited and will not be returned to you. This is known as the "use it or lose it" rule.
- If you terminate employment or have a status change mid-year and you are no longer eligible to participate in a DCFSA, you have 30 days from the date of your event in which to submit eligible expenses incurred on or before your mid-year event.
- For more information on the DCFSA, contact HealthEquity at **866-346-5800** or **click here**.

Health Care FSA (Flexible Savings Account) and HSA (Health Savings Account): A side-by-side comparison

Description	FSA	HSA
Use it to pay for medical expenses before you meet the deductible for your CDHP.		X
Use it to pay for a variety of eligible health and medical expenses including dental expenses.	X	X
You must use it by the end of the year or first quarter of the new year or forfeit the remaining funds.	X	
Rolls over from year to year.		X
You can take it with you when you change employers or retire.		X
You can invest the funds in your account.		X
Make contributions with pre-tax dollars.	X	X
Employees can contribute a maximum of $2,750 annually.	X	
Employee and employer together may contribute a maximum of $3,600 to $7,200 depending on family status (Employee Only/Family).		X
Catch-up contributions up to an additional $1,000 for employees age 55+.		X
All funds available by Jan. 4, 2021.	X	X
Only funds that have already been deposited into the account are available.		X

Life & Disability Insurance

Life Insurance: Income Replacement and Survivor Benefits

HFHS offers voluntary life insurance options to provide important income protection for your family.

EMPLOYEE TERM LIFE INSURANCE

My Choice Rewards provides you with a variety of life insurance options. You may choose either more or less coverage, in the increments shown below, based on your projected needs. Coverage is purchased with pre-tax dollars. The maximum protection you can receive from this benefit is $1 million.

Coverage Level	Maximum Benefit
1 x Your Base Pay	$250,000
2 x Your Base Pay	$500,000
3 x Your Base Pay	$750,000
4 x Your Base Pay	$1 million
Fixed Amount	$10,000 $25,000 $50,000

Life insurance deductions are based on an employee's age and salary. Deductions change based on the following age groups:

Age	Rate per $1,000 of Coverage
29 and younger	$0.022
30 to 34	$0.033
35 to 39	$0.049
40 to 44	$0.071
45 to 49	$0.108
50 to 54	$0.180
55 to 59	$0.321
60 to 64	$0.440
65 to 69	$0.892
70 and older	$2.046

If you move up more than one coverage level, or you are electing coverage when you previously waived coverage, you must furnish **evidence of insurability** (EOI).

Coverage after age 65

If you continue to work after age 65, the amount of your life insurance will decrease on Jan. 1 following your 65th birthday as follows:

- **Age 65-69** 65% of elected option
- **Age 70-74** 50% of elected option
- **Age 75+** 20% of elected option

Dependent term life insurance coverage does not decrease if you continue working past age 65.

Imputed income

When you purchase insurance in excess of $50,000, you are subject to the IRS imputed income rules. Imputed Income is the value of your life insurance in excess of $50,000. You are required to pay federal and state income taxes, as well as Social Security tax on this "excess" amount. The amount of tax you pay is based on your age. The value of the life insurance in excess of $50,000 will be reported on your W-2.

Terminal illness benefit

Enrollees who are diagnosed with a terminal illness (life expectancy of 12 months or less) may apply to have up to 50% of their employee life insurance paid out to them in advance. Information is available from Employee Services.

DEPENDENT TERM LIFE INSURANCE

My Choice Rewards also provides dependent term life insurance options on an after-tax basis. Because of IRS regulations, no pre-tax dollars or credits may be used for this coverage. Your dependent term life insurance options are:

Spouse Coverage Level	Child(ren) Coverage
$100,000	$15,000 each child
$50,000	$10,000 each child
$25,000	$5,000 each child
$10,000	

If you choose to enroll, you must designate who will be covered by the dependent term life insurance. You may choose spouse-only coverage or, child(ren)-only coverage. For dependent eligibility requirements, see pages 5-6 of this guide. You are the beneficiary for your spouse or dependent's life insurance. If you move up more than one coverage level, or you are electing dependent life coverage when you previously waived coverage, you must furnish evidence of insurability for your spouse; children do not require EOI. Any dependents you cover must live with you. Coverage stops at the end of the month your dependent turns 26.

SHORT- AND LONG-TERM DISABILITY

Short-term disability (STD) and long-term disability (LTD) insurance provide a source of income for you if you are unable to work due to a serious illness or injury. STD and LTD premiums are paid by you.

STD provides a weekly benefit of 60% of your base pay, with a maximum benefit of $1,500 per week for up to 26 weeks. You must first reduce your combined time off bank to 80 hours or less before you are eligible to receive benefits. The cost you pay for this coverage is after tax.

LTD provides 60% of your base monthly pay, up to a maximum benefit of $12,850. There is a six month waiting period before LTD benefits begin. Any LTD benefits you receive will be subject to taxes. If you have previously waived LTD and would now like to elect coverage, you will have to furnish evidence of insurability (EOI). The insurance company, not HFHS, makes the determination for coverage, and you could be denied.

If you are initially enrolling in STD or LTD coverage during open enrollment, you will not be eligible for the higher coverage amount for any disability resulting from a pre-existing condition that begins three months before the coverage effective date and in the first 12 months after the effective date of coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

AD&D insurance provides protection against financial hardship when you or a covered dependent suffer an accidental death, loss of limb, paralysis or loss of sight. Full-time employees receive credits to offset the cost of this coverage. Your AD&D coverage options are indicated in the chart below.

Coverage level and maximum benefits		
5 x base annual salary for employee ($1.25 million) 2.5 x employee's base annual salary for spouse ($500,000) 0.1 x employee's base annual salary for each child ($50,000)		
4 x base annual salary for employee ($1 million) 2 x employee's base annual salary for spouse ($500,000) 0.1 x employee's base annual salary for each child ($50,000)		
3 x base annual salary for employee ($750,000) 1.5 x employee's base annual salary for spouse ($375,000) 0.1 x employee's base annual salary for each child ($50,000)		
$100,000 employee	$50,000 spouse	$10,000 each child
$50,000 employee	$25,000 spouse	$5,000 each child
$20,000 employee	$10,000 spouse	$5,000 each child

If you choose to enroll in AD&D coverage, you must designate who will be covered. You may choose either employee coverage or employee and dependents coverage. For dependent eligibility requirements, see pages 5-6 of this guide. Any dependents you cover must live with you.

Coverage at age 75 and older

When you or your spouse reach age 75, the coverage amount is reduced on Jan. 1 following the 75th birthday as follows:

- **Age 75-79** 57.5% of the elected coverage amounts
- **Age 80-84** 37.5% of the elected coverage amounts
- **Age 85+** 20% of the elected coverage amounts

Voluntary Benefits

Voluntary Benefits: Supplemental Coverage for Medical and Personal Needs

HFHS offers a variety of voluntary benefits to meet your medical and personal needs.

During open enrollment, you can elect:

- **Hospital indemnity insurance**, pays benefits when you or a covered family member have an inpatient hospital stay due to an accident or illness.
- **Critical illness insurance**, pays a lump sum benefit if you or a covered family member are diagnosed with a covered illness or condition on or after the coverage effective date.
- **Accident insurance**, pays fixed amounts for medical treatment needed when you or a covered family member have an accidental injury.
- **Identity theft protection**, provides identity, financial and privacy protection.
- **Group legal plan**, offers financial protection for an employee or covered family member from potential costs associated with legal services required.

HFHS CONTINUES TO OFFER THE FOLLOWING VOLUNTARY BENEFITS THAT EMPLOYEES CAN ENROLL IN AT ANY TIME:

- **Group auto and home insurance**, which offers auto and home coverage at a discounted rate with the convenience of payroll deduction.
- **Purchasing power,** a premium-purchasing program that allows you to purchase products through the convenience of payroll deduction over the next 12 months after the purchase.
- **Pet insurance**, to cover your pets for injuries, illness and wellness care.

When you enroll in voluntary benefits, you'll pay for your coverage through payroll deductions.

For more information, go to the Voluntary Benefits Portal or call 313-879-0755.

OTHER BENEFITS

Your benefits extend beyond your paycheck and health insurance coverage. Rewards are benefits employees receive at no cost as valued members of the health system. To find out more, click on the **HR Connect** button at the top of the OneHENRY homepage from any work computer. Look for categories listed in the left navigation for more information. Remember, from non-HFHS devices, employees can get to HR Connect by going to **henryford.com/connect.**

BALANCE LIFE AND STRESS: ENHANCE CAN HELP

Take advantage of free and confidential resources available through Henry Ford ENHANCE that can help you balance the demands of work, family and daily life, including:

- Stress management
- Finding a healthy work/life balance
- Conflict resolution
- Relationship building skills

Learn more.

How to Enroll

My Choice Rewards Enrollment Instructions

START WITH THESE LOG-IN INSTRUCTIONS TO COMPLETE YOUR 2021 ENROLLMENT NOV. 2-16, 2020

- From a Henry Ford device inside the "firewall" — from your desktop computer, for example — go to OneHENRY and click on HR Self Service at the top of the page.
- From any device not on the Henry Ford network, including your mobile phone or home computer, go to **HenryFord.com/connect** and click on "Log in to Employee Self Service."
- To log on, enter your corporate ID and password. This is the same as your Employee Self Service login information. If you don't remember your password, click "Forgot Your Password."

REVIEW YOUR ELECTIONS

- Review your 2021 benefit elections, even if you don't plan to make changes.
- Re-enroll in the HSA and/or FSAs to participate in these savings accounts in 2021. Note: you cannot participate in both the HSA and health care FSA.
- If you cover a spouse on your medical plan, you must complete the online **spouse surcharge** form.

MAKE YOUR BENEFIT ELECTIONS FOR 2021

- Click on "Benefit Enrollment" on the right side of the page under "Hot Spots" and make your elections for each benefit.
- Update your dependent information. If you add new dependents, upload birth certificates and/or marriage certificates while online.
- After completing your benefit elections, if you are satisfied with your choices, click "Submit."

CONFIRM YOUR ELECTION WAS RECEIVED

- Record your confirmation number, which verifies you have completed your enrollment and that your benefit elections have been recorded and submitted.
- Review the **confirmation statement** you receive by email for accuracy and keep it as proof of your enrollment for 2021. Confirmation statements will not be mailed home.
- Update your elections as many times as you want through Nov. 16, 2020. Your last confirmation number and statement during the open enrollment period will apply.
- Go to Employee Self Service/Benefits Home to view and/or print a final confirmation statement beginning the week of Dec. 14, 2020.

A REMINDER ABOUT TWO-STEP VERIFICATION WITH DUO

If you didn't set up two-step verification through Duo Security, you'll have to download the app from the app store to use any HFHS application, including Employee Self Service. Search for Duo Security and install it like any other app. Two-step verification allows HFHS to enhance the security of individuals' accounts by using a secondary device to verify your identity. For questions, call the IT Help desk at 248-853-4900.

*For help enrolling or any questions about your benefits choices after reviewing this document and the 2021 My Choice Rewards Highlights, send an email to **openenrollment@hfhs.org** or contact Employee Services at **855-874-7100**.*

SPECIAL CIRCUMSTANCES

Coverage for HFHS couples

Certain rules apply for married employees who both work for HFHS:

- You cannot be "double covered" by HFHS. However, one spouse can opt out of health care coverage and be covered as a dependent by the other.
- Eligible dependents of a couple employed by HFHS can be double covered. Coordination of benefits rules apply for health care coverage, so up to 100% of eligible expenses can be paid.
- An employee cannot be covered as a dependent on a spouse's life insurance contract. However, an eligible dependent may be covered under both spouse's dependent life insurance contracts. If that dependent dies, both spouses can collect on the dependent life coverage.
- An eligible expense may only be reimbursed once, even if both spouses participate in Flexible Spending Accounts or Health Savings Account.

Leave of absence

If you are on a leave of absence or furloughed during open enrollment, changes made to your medical/vision or dental plans will be effective Jan. 1. All other benefit changes made during open enrollment will not be in effect until you have returned to work in the new plan year.

Termination of benefits

Benefit coverage for you and your family will terminate on the last day of the month in which you terminate your employment or are in an ineligible benefit status. Long-term disability coverage ends on the date of termination. If you become ineligible for coverage, you and your eligible dependents may have continuation rights for medical/vision, dental and Health Care Flexible Spending Account benefits under the federal law known as COBRA. If you terminate your employment or are in an ineligible benefit status, you will be notified about your continuation rights.

Health Alliance coverage for gaps

Employees who are leaving the System or are no longer eligible for coverage because of a life event will experience a discontinuation of coverage. For these gaps in coverage, HAP offers health plans for individuals and families that may be a lower-cost alternative to COBRA. If your loss of coverage is due to a qualifying life event, you can sign up during a special enrollment period (SEP). The loss of previous coverage is considered a qualifying event. Call HAP at 855 WITH-HAP, or visit **hap.org** for information about special enrollment period qualifying events.

Health plans for those turning 26

HAP provides coverage for individuals turning 26 and aging off their parents' health plan. This is a life event that qualifies the individual to sign up by the end of the month the individual turns 26. During the SEP, you or your dependent can obtain coverage under a separate contract/policy. Visit **hap.org** for more information about the policies designed for young adults.

You must notify Employee Services when a covered dependent no longer remains eligible for benefit coverage by going online to Employee Self Service within 30 days of the event to remove your dependent.

DON'T FORGET

Alex is an interactive decision-making tool to help you compare benefit options and decide what's best for you and your family. Although Alex will provide recommendations, you will make the decisions about what's best for your situation. Access Alex through Employee Self Service.

REVIEW YOUR ELECTIONS

Receiving a confirmation number does not mean benefit elections are correct. It only means the information entered was recorded. Thoroughly review the confirmation statement provided at the end of the enrollment process to ensure your elections are correct. Your covered dependents must have a "Y" in the medical and or dental columns if they are to have coverage in 2021.

Important Federal Notices

WOMEN'S HEALTH & CANCER RIGHTS ACT

The Women's Health & Cancer Rights Act requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. This law also requires that written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This language serves to fulfill that requirement for 2021. 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,
- Prostheses, and
- Treatment for physical complications during all stages of mastectomy, including lymphedema.

In addition, the plan may not:

- Interfere with a woman's rights under the plan to avoid these requirements, or
- 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 copays consistent with other coverage provided by the plan.

HIPAA RIGHTS

HFHS sponsors a group health plan. As such, the System has access to the individually identifiable health information of plan participants (1) on behalf of the plan itself; or (2) on behalf of the System, for administrative functions of the plan. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations restrict the System's ability to use and disclose Protected Health Information (PHI). PHI means any information relating to the past, present or future physical or mental condition of an individual (or payment thereof) that identifies the individual, or can be used to identify the individual.

It is Henry Ford Health System's policy to comply fully with HIPAA requirements. Consequently, if you become a covered participant under the group health plan, you have a right under HIPAA to receive a Notice of Privacy Practices for Protected Health Information. To request a copy, call **855-874-7100** or email **ask_Ben1@hfhs.org.**

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health plan 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 caesarean 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 law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

SUMMARY OF BENEFITS AND COVERAGE (SBC) AND UNIFORM GLOSSARY

In addition to the detailed Medical Plan **Comparison Chart** in this benefit guide, a document called a Summary of Benefits and Coverage (SBC) is also **here**. An SBC is a federally mandated document intended to help individuals across the nation compare health plans. Each health plan is required to issue an SBC for every group health plan it offers. An SBC details deductibles, coinsurance and out-of-pocket limits for various services in a prescribed format. A Uniform Glossary of Health Coverage and Medical Terms to accompany the SBC is also available.
To view a health plan SBC and/or the Uniform Glossary, log on to HR Connect/Benefits.

SPECIAL ENROLLMENT RIGHTS

Under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for health plan coverage may be available if you lose health care coverage under certain conditions, or when you acquire new dependents by marriage, birth or adoption.

If, during open enrollment you decline enrollment for yourself or your dependents (including your spouse) because you have other health care coverage, and later you involuntarily lose that coverage, you may be able to enroll yourself or your dependents in health care coverage outside the annual open enrollment period, provided you previously declined enrollment due to coverage elsewhere and you request enrollment within 30 days after your other coverage ends.

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 for health coverage outside the annual open enrollment period, provided you previously declined enrollment due to coverage elsewhere and you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Special Rules for Gain or Loss of Eligibility for Medicaid/CHIPRA

When you experience a change that results in a gain or loss of eligibility for Medicaid/CHIP,* you may be able to make certain adjustments to your benefits correlating to your status change within 60 days.

Effective April 1, 2009, the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") adds two new special enrollment events. You or your dependent(s) will be permitted to enroll or cancel your medical coverage in either of the following circumstances:

1. You or your dependent's Medicaid or state Children's Health Insurance Program ("CHIP") coverage is cancelled due to a loss of eligibility. You must go online to Employee Self Service within 60 days from the date you or your dependent loses coverage and make this change.
2. You or your dependent(s) enrolls in Medicaid or the state CHIP. You may cancel your HFHS provided medical coverage within 60 days of your or your dependent's coverage effective date by going online to Employee Self Service to make this change.

For further details on Medicaid or Michigan's CHIP program, call the Michigan Department of Community Health at **888-988-6300** toll-free.

**The state Children's Health Insurance Program in Michigan is called MIChild.*

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

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. (For a list of participating states, visit **dol.gov/ebsa/chipmodelnotice.doc**). If you or your dependents are not currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office, or you may contact 1-877-KIDS NOW or visit **insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled. As of the date of this publication the State of Michigan does not participate in this program.

Events Permitting Mid-Year Election Changes Consistent with Event					
IRS Qualifying Event*	**Explanation of Event**	**Medical/Vision, Dental and Voluntary Benefits****	**Health Care/ Dependent Care Flexible Spending Accounts**	**Life, Accidental Death & Dismemberment, Long-Term Disability**	**Dependent Life**
Marriage	Allows you to add your new spouse within 30 days of your marriage. Stepchildren may be added. Proof is required.	**You may:** Enroll Add spouse Change option Opt out	**You may:** Increase coverage Decrease coverage Opt out **You may not:** Enroll	**You may:** Increase coverage Decrease coverage Opt out **You may not:** Enroll	**You may:** Enroll Increase coverage Decrease coverage Opt out
Divorce, legal separation/ annulment or death of spouse	Allows you to remove your spouse within 30 days of the event. Proof is required.	**You may:** Remove spouse and dependents Enroll Change option **You may not:** Opt out	**You may:** Enroll Increase coverage Decrease coverage Opt out	**You may:** Increase coverage Decrease coverage Opt out **You may not:** Enroll	**You may:** Enroll Increase coverage Decrease coverage Opt out
Birth, adoption, placement for adoption of a child or gain step-child(ren)	Allows you to add your newborn child or newly adopted child within 30 days of the event. Proof is required.	**You may:** Enroll Add dependent Change option **You may not:** Remove dependents Opt out	**You may:** Enroll Increase coverage **You may not:** Decrease coverage Opt out	**You may:** Increase coverage Decrease coverage Opt out **You may not:** Enroll	**You may:** Enroll **You may not:** Increase coverage Decrease coverage Opt out
Death of dependent	Allows you to remove your dependent within 30 days of the event. Proof is required.	**You may:** Remove dependent Change option **You may not:** Enroll Add dependents Opt out	**You may:** Decrease coverage Opt out **You may not:** Enroll Increase coverage	**You may:** Increase coverage Decrease coverage Opt out **You may not:** Enroll	**You may:** Decrease coverage Opt out **You may not:** Enroll Increase coverage
Other eligible dependents (aged parents)	Allows you to add a sponsored dependent to your existing medical coverage only within 30 days of the event. Proof is required. A sponsored dependent must be an IRS dependent such as a parent or adult child who lives with you and is claimed on your Federal Income Tax.	**You may:** Add your sponsored dependent **You may not:** Enroll Add other dependents Remove other dependents Opt out Make any changes to dental coverage or voluntary benefits	**You may:** Enroll Increase limit **You may not:** Decrease limit Opt out	No changes are allowed	No changes are allowed
Employee changes status **Part time to full time**	Allows you to enroll in medical/vision or dental if your status changes from part time to full time. You have 30 days to make your elections.	**You may:** Enroll **You may not:** Opt out	No changes are allowed	**You may:** Increase coverage Decrease coverage **You may not:** Enroll Opt out	**You may:** Increase coverage Decrease coverage **You may not:** Enroll Opt out

Events Permitting Mid-Year Election Changes Consistent with Event					
IRS Qualifying Event*	**Explanation of Event**	**Medical/Vision, Dental and Voluntary Benefits****	**Health Care/ Dependent Care Flexible Spending Accounts**	**Life, Accidental Death & Dismemberment, Long-Term Disability**	**Dependent Life**
Employee changes status **Full time to part time**	For status changes from full time to part time, please see event for significant cost changes	Please see event for significant cost changes	Please see event for significant cost changes	Please see event for significant cost changes	Please see event for significant cost changes
Employee now ineligible for benefits	You are no longer eligible for active benefits. All benefits will be cancelled and COBRA or conversion rights will be provided.	**You may:** Elect COBRA continuation Active coverage will be cancelled **You may not:** Enroll in active benefits	**You may:** Elect COBRA continuation Active coverage will be cancelled **You may not:** Enroll in active benefits Continue COBRA coverage for dependent care FSA	**You may:** Conversion rights are available Active coverage will be cancelled **You may not:** Enroll in active benefits	**You may:** Conversion rights are available Active coverage will be cancelled **You may not:** Enroll in active benefits
Employee rehires within 30 days	Allows you to be reinstated in your prior elections within 30 days of your rehire.	**You may:** Have your prior elections reinstated **You may not:** Make changes to prior elections	**You may:** Have your prior elections reinstated **You may not:** Make changes to prior elections	**You may:** Have your prior elections reinstated **You may not:** Make changes to prior elections	**You may:** Have your prior elections reinstated **You may not:** Make changes to prior elections
Employee rehires after 30 days	Allows you to enroll in all of your benefits as a new hire within 30 days of your rehire.	**You may:** Enroll	**You may:** Enroll	**You may:** Enroll	**You may:** Enroll
Change in residence or worksite of employee, spouse or dependent that causes eligibility or loss of eligibility	Allows you to change your medical/vision or dental coverage, within 30 days, because you or a dependent moved out of the service area (as defined by the insurance contract).	**You may:** Change option **You may not:** Enroll Add dependents Remove dependents Opt out	No changes are allowed	No changes are allowed	No changes are allowed
Employee begins FMLA leave	Allows you to change certain benefits within 30 days as a result of your FMLA leave.	**You may:** Change option Opt out **You may not:** Enroll Add dependents Remove dependents	**You may:** Enroll Increase limit Decrease limit Opt out	**You may:** Enroll Increase coverage Decrease coverage Opt out	**You may:** Enroll Increase coverage Decrease coverage Opt out
Employee returns from FMLA leave	Allows you to change certain benefits within 30 days that were terminated as a result of your FMLA leave.	**You may:** Enroll if coverage was terminated while on FMLA Change option **You may not:** Enroll if coverage was not terminated while on FMLA Add dependents Remove dependents Opt out	**You may:** Enroll if coverage was terminated while on FMLA **You may not:** Enroll if coverage was not terminated while on FMLA	**You may:** Enroll if coverage was terminated while on FMLA **You may not:** Enroll if coverage was not terminated while on FMLA	**You may:** Enroll if coverage was terminated while on FMLA **You may not:** Enroll if coverage was not terminated while on FMLA

Events Permitting Mid-Year Election Changes Consistent with Event					
IRS Qualifying Event*	**Explanation of Event**	**Medical/Vision, Dental and Voluntary Benefits****	**Health Care/ Dependent Care Flexible Spending Accounts**	**Life, Accidental Death & Dismemberment, Long-Term Disability**	**Dependent Life**
Spouse/ dependent or HFHS employee lose eligibility for their employer's plan	Allows you to change some of your options within 30 days, due to your spouse/dependent losing coverage through their employer's plan. Losing coverage does not mean voluntarily opting out of coverage. Proof is required. In rare situations, an HFHS employee may waive coverage because they are employed and have full time benefits elsewhere. If the employee loses their eligibility through that employer, they would be entitled to enroll in all of the HFHS benefits listed in this chart. Proof is required.	**You may:** Enroll Add dependents who lost coverage **You may not:** Remove dependents Opt out	**You may:** Enroll Increase limit **You may not:** Decrease limit Opt out	**You may:** Increase coverage Decrease coverage **You may not:** Enroll Opt out	**You may:** Increase coverage Decrease coverage **You may not:** Enroll Opt out
Spouse/ dependent now eligible for their employer's plan	Allows you to change some of your options within 30 days of being covered under your spouse/dependent employer's plan. Proof is required.	**You may:** Remove dependents who now have other coverage Opt out if covered by spouse/ dependent's plan **You may not:** Enroll Add dependents	**You may:** Decrease coverage Opt out **You may not:** Enroll Increase limit	**You may:** Increase coverage Decrease coverage **You may not:** Enroll Opt out	No changes are allowed
Significant cost changes for HFHS employee	Allows you to change certain benefits within 30 days, due to your status change from full-time to part-time.	**You may:** Switch to less costly option Remove dependents **You may not:** Enroll Add dependents Opt out	No changes are allowed	**You may:** Decrease coverage Opt out **You may not:** Enroll Increase coverage	**You may:** Decrease coverage Opt out **You may not:** Enroll Increase coverage

Events Permitting Mid-Year Election Changes Consistent with Event					
IRS Qualifying Event*	**Explanation of Event**	**Medical/Vision, Dental and Voluntary Benefits****	**Health Care/ Dependent Care Flexible Spending Accounts**	**Life, Accidental Death & Dismemberment, Long-Term Disability**	**Dependent Life**
Special enrollment rights under HIPAA Loss of other coverage or acquisition of new dependent	Allows you to enroll in medical coverage within 30 days, even though you previously opted out. Eligibility to enroll is contingent on adding a newborn or adding a dependent that recently lost coverage. Losing coverage does not mean voluntarily opting out of coverage. Proof is required.	**You may:** Enroll in medical/ vision only Add dependent(s) **You may not:** Enroll in dental Opt out of dental	No changes are allowed	No changes are allowed	No changes are allowed
Judgment, divorce or medical child support order require coverage for child(ren) under employee's plan	Allows you to enroll your dependent within 30 days, as a result of a Judgment, Divorce or Medical Child Support Order. Proof is required.	**You may:** Add dependent as a result of the Order **You may not:** Add dependents not part of the Order Remove dependents Change option Opt out	**You may:** Elect if Order requires Increase limit if Order requires **You may not:** Decrease limit Opt out	No changes are allowed	No changes are allowed
Coverage required under spouse's plan	Allows you to remove your dependent within 30 days because your dependent is now enrolled under your spouse's plan. Proof is required.	**You may:** Remove dependent **You may not:** Enroll Add dependent Change option Opt out	**You may:** Decrease limit Opt out **You may not:** Enroll Increase limit	No changes are allowed	No changes are allowed
Entitlement to Medicare/ Medicaid	Allows you to remove you or your dependent that is now eligible for Medicare or Medicaid within 30 days of becoming eligible. Proof is required.	**You may:** Remove dependents Opt out **You may not:** Enroll Add dependent Change option	**You may:** Decrease limit Opt out **You may not:** Enroll Increase limit	No changes are allowed	No changes are allowed
Loss of Medicare/ Medicaid eligibility	Allows you to enroll your dependent that is no longer eligible for Medicare or Medicaid within 30 days of losing eligibility. Proof is required.	**You may:** Enroll in medical/vision only Add dependent to medical/vision only **You may not:** Change options Remove dependents Opt out	**You may:** Enroll Increase limit **You may not:** Decrease limit Opt out	No changes are allowed	No changes are allowed

** Changes must be made within 30 days of the life event.*

*** Voluntary benefits include Accident, Critical Illness, Hospital Indemnity, Identity Protection and Legal.*

Key Terms & Contacts

KEY TERMS

Comparison chart – A chart that allows you to compare the medical, vision or dental plans available to you.

Confirmation statement – A statement available online to confirm the selections you made.

Consumer Driven Health Plan (CDHP) – A health plan that has higher deductibles and lower employee contributions. The plan requires a member to meet their deductible before any benefits are paid by the plan. Only preventive care is covered before meeting the deductible. A CDHP is sometimes referred to as a consumer-directed health plan or a qualified high deductible health plan. The terms are interchangeable and refer to the same type of plan.

Coinsurance – The percentage you pay (20%, for example) toward the cost of a health care service.

Copayment – The percentage or flat dollar amount of covered expenses you must pay.

Deductible – The expense you incur before the plan or insurance carrier begins paying your covered expenses.

Effective date – All benefits are effective as of Jan. 1 for employees making their elections during open enrollment. For employees enrolling outside of open enrollment, benefits are effective first of the month following their start date or qualifying life event.

Evidence of insurability (EOI) – This is an application process where you provide information on the condition of your health or your spouse's health in order to be considered for certain types of employee or dependent life or disability insurance coverage if you did not enroll in coverage when first eligible or you want to increase your coverage by more than one level. The insurance company (not HFHS) determines your eligibility for this coverage.

Exclusive provider arrangement (EPA) – An EPA is similar to a health maintenance organization (HMO). However, the network is much broader. Members must choose a primary care physician (PCP) from the network of providers who they will see for routine medical care. This physician will ensure that members receive the most appropriate and efficient care available. There are no out-of-network benefits available to members, except for treatment of emergency medical conditions.

Flexible Spending Accounts (FSAs) – There are two types of FSA accounts. The health care FSA allows an employee to contribute pre-tax dollars to pay for medical expenses not covered under the plan. The dependent care FSA allows an employee to use pre-tax dollars to pay for eligible dependent day care or elder care expenses so you and your spouse can work or attend school full time. Money not used by a certain date is forfeited.

Full-time employee eligibility – Employees regularly scheduled to work 64 to 80 hours every two weeks may participate in the My Choice Rewards program.

Health assessment – The health assessment is one of the requirements to qualify for a reduced employee contribution as part of Thrive Rewards. All employees and their spouses enrolled in a HAP medical plan through HFHS as of March 31 are required to complete the online health assessment between Jan. 1 and July 31.

Health maintenance organization (HMO) – A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. You are required to select a primary care physician (PCP) who coordinates the member's care and refers the member to a specialist when medically necessary. A HMO generally won't cover out-of-network care except in an emergency. A HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Heath Savings Account (HSA) – An account created for employees who are covered on a CDHP to save for medical or dental expenses that CDHPs or dental plans do not cover. Contributions (pre-tax) are made by the employee and/or employer and are limited to a maximum amount each year. Contributions carry over each year and can be invested over time. The HSA is portable between employers and even into retirement.

In-network – A doctor or facility that participates in the EPA, HMO or PPO plan and has agreed to a reduced fee schedule which lowers your out-of-pocket cost.

Options – The choices you have in each benefit area.

Out-of-network – A doctor or facility not part of the EPA, HMO or PPO plan network. Generally services are either not covered or covered at a lower percentage than if your doctor were in network. Using out-of-network physicians or facilities increases your out-of-pocket costs.

Out-of-pocket maximums – The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, the plan pays 100% of the costs of covered services. These values do not accumulate: Premiums, balance-billed charges and health care this plan doesn't cover; all other cost-sharing accumulates.

PCP – Primary care physician you designate from the EPA or HMO participating network to coordinate all of your medical needs, including referrals to a specialist.

Plan year – The My Choice Rewards plan year is Jan. 1 through Dec. 31. Each fall, you will make your selections for the following plan year.

Preferred provider organization (PPO) – A type of managed care plan that gives you the choice to obtain medical services from a network or non-network provider. You make the decision at the time you need medical care. In a PPO, the doctors and hospitals have agreed to provide medical services at a reduced cost. Generally, you will receive a higher level of coverage if you receive care in-network.

Spouse surcharge – An additional pre-tax charge assessed to an HFHS employee who covers their spouse who is also eligible for medical coverage through their non-HFHS employer.

Thrive Rewards – A wellness program for HFHS employees and their spouses enrolled in a HAP health plan. Currently your reward is a lower contribution toward the cost of your medical premiums and/or funding to an HSA. Your qualification period is Jan. 1 through July 31. When you and/or your covered spouse enroll in one of the HAP medical options provided by HFHS, you will need to know your numbers (BMI, blood pressure, cholesterol, fasting blood glucose), take your online health assessment, be tobacco free, complete a wellness activity and complete all recommended preventive screenings. Completing these requirements will provide you with lower employee contributions toward the cost of your HAP medical coverage and/or funding to an HSA in the following year.

Contact Information

Benefit	Resource	Contact Information
All Benefits	Employee Services	855-874-7100 **employeeservices@hfhs.org** 1 Ford Place - 4E, Detroit, MI 48202
Medical and Vision	Health Alliance Plan / Alliance Health and Life	866-766-4709 **hap.org** 2850 W. Grand Blvd., Detroit, MI 48202
Dental	Delta Dental Plan of Michigan (Point-of-Service)	800-524-0149 **deltadentalmi.com** 27500 Stansbury St., Farmington Hills, MI 48334-3811
Flexible Spending Accounts/ Health Savings Accounts	HealthEquity	866-346-5800 **healthequity.com** 10 W. Scenic Pointe DR., Suite 100, Draper, UT 84020
Life Insurance	CIGNA Group Insurance	800-238-2125 **cigna.com** 1600 W. Carson St., Suite 300, Pittsburgh, PA 15219
AD&D Insurance	CIGNA Group Insurance	800-238-2125 **cigna.com** P.O. Box 22328, Pittsburgh, PA 15222-0328
Long-Term Disability Insurance	CIGNA Disability Management Solutions	800-362-4462 **cigna.com** P.O. Box 22325, Pittsburgh, PA 15222-0325

Voluntary Benefits

Accident Insurance	VOYA	313-879-0755 **https://www.hfhsvb.com**
Auto/Home Insurance	Liberty Mutual	
Critical Illness Insurance	VOYA	
Group Legal Insurance	ARAG	
Hospital Indemnity	VOYA	
Identity Theft Insurance	Allstate	
Pet Insurance	Nationwide	
Purchasing Power	Premier Purchasing	