LIGHT OF THE WORLD ACADEMY
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BALLARD BENEFIT WORKS

Hourly Employee Benefits Guide

Plan Year: 01/1/2018 – 12/31/2018

Who is Eligible?

If you are a Light of the World Academy employee, you are eligible for either all or some of the benefits found in this guide. Eligibility is available to those employees who work a minimum of 30 hours per week.

How to Enroll?

To enroll, you must complete the Contribution Election Form and each of the respective company elections forms. Once you have made your elections, you will not be able to make changes again until the next open enrollment period. The only exception is if you have a "qualified event" that changes your status. Qualified events are:

- marriage,
- divorce, legal separation,
- birth or adoption of a child, change in child's dependent status,
- death of a spouse, child or other qualified dependent,
- change in residence due to an employment transfer for you,
- your spouse commence or termination of adoption proceedings, or change in spouse benefits or employment status.

A new Contribution Election Form must be completed along with the proper Change in Status insurance forms indicating the changes within 30 days of the occurrence of the qualifying event.

When to Enroll?

The open enrollment period for current employees runs from November 8 through November 20, 2017 with an effective date of January 1, 2018. For new employees, open enrollment runs during the first 30 days of your employment unless otherwise stated by each policy.

What's New for 2018?

Your Benefit Coverage

Dear GPS Employee,

BCBSM/BCN medical benefits for 2018 will remain the same. However, Dental and Vison will be offered on a voluntary basis under a Blue Cross Blue Shield plan. As of December 1st, Life Insurance/Accidental Death & Dismemberment, Voluntary Life/Accidental Death & Dismemberment and Long-Term Disability are with MetLife. A MetLife Voluntary Short-Term Disability plan is being offered effective 1/1/2018.

- Medical and Prescription Drugs – Blue Cross Blue Shield of Michigan/Blue Care Network
- **Voluntary** Dental & Vision – Blue Cross Blue Shield of Michigan – **Plan change from current**
- Long-Term Disability – MetLife – **Carrier change from current**
- Life Insurance/Accidental Death & Dismemberment – Met Life – **Carrier change from current**
- Voluntary Life Insurance/Accidental Death &Dismemberment – MetLife – **Carrier change from current**
- Voluntary Short Term Disability – MetLife – **New offering**

We encourage you to take the time to educate yourself about our benefit programs to fully understand the coverage available to you and your family.

Welcome to Open Enrollment

The LOTWA Open Enrollment Period is November 8, 2017 – November 20, 2017. During Open Enrollment you should review the plan offerings outlined in this guide and presented at the Open Enrollment Meeting to determine whether you wish to elect or decline benefits for the 2018 calendar year, beginning January 1, 2018. **These elections/declinations are due to Human Resources by Monday, November 20th**. It is our goal to offer you benefit programs and resources that provide you with options for an enriched quality of life to support overall health and wellness for you and your family.

Medical Plan Options

During this Open Enrollment Period you will have the opportunity to choose one of two offerings for medical coverage. One is a Health Maintenance Organization (HMO) administered by Blue Care Network (BCN) and one is a Preferred Provider Organization (PPO) administered by Blue Cross Blue Shield (BCBS). This is the time when you can switch from a PPO plan to HMO plan and vice versa. You can also add or remove dependents without a qualifying life event.

An HMO is a network of Participating Providers who have discounted their fees, and benefits are only available if you seek services from their participating providers. Also, when participating in an HMO, you must identify a Primary Care Physician who will assist you in managing your healthcare and in navigating the healthcare system. Keep in mind, any services outside of your primary care physician require referrals from your primary physician.

With a PPO you can choose to use in-network providers or out-of-network providers. Out-of-network providers will be at a higher cost to you. In Southeast Michigan, the majority of providers are in-network. The BCBSM.com website can assist you in determining your in and out of network resources.

The charts enclosed will provide a high level overview of the benefits offered under each Plan. You should consult the Summary of Benefit and Coverage provided by BCBSM in your Open Enrollment Packet for a more detailed description.

Items worthy of highlight:

- Due to Healthcare Reform, carriers must now provide True Out Of Pocket (TROOP) accrual. TROOP definition now includes deductible amounts, co-insurance amounts and copayment amounts. Once the TROOP maximum is met for the year, expenses, if eligible, will become payable at 100%.

- Single, double (2-person) and family premiums are set to offer equally distributed cost sharing per plan option for all employees.

- A payroll deduction statement is required for all benefit employees, whether electing or declining coverage. These should be e-mailed to l.welch@globalpsychology.net, faxed to (248) 254-3445 or dropped off/mailed to GPS, 34505 W. 12 Mile, Suite 210, Farmington Hills, MI 48331. **Must be received by 11/20/2017.**
    - **All employees are asked to complete a form if they currently have or want to enroll in medical coverage:**
        - Complete Payroll Deduction Statement
        - BCN HMO Plan
            - Complete New Subscriber Enrollment Form. Please refer to the "Confirmation of Enrollment or First Time Enrollment in Blue Care Network" instruction sheet..
        - BCBS PPO Plan
            - Complete New Subscriber Enrollment Form. Please refer to the "Confirmation of Enrollment or First Time Enrollment in Blue Cross Blue Shield" instruction sheet..
    - **If declining medical coverage:**
        - Complete Payroll Deduction Statement
        - Complete "Waiver of Coverage Form. Please refer to the "Waiving all Medical Coverage" instruction sheet.
        - Provide copy of benefit card to confirm active medical coverage.

BCN HMO Plan

This plan is a Health Maintenance Organization (HMO) which means that **you must seek services from a provider participating with Blue Care Network in order to receive benefits**. **Referrals from your Primary Care Physician required before seeking other services.** The following chart is a brief summary of the plan. For further plan details please refer to the Summary of Benefits and Coverage. To find a participating Primary Care Provider, go to www.bcbsm.com.

Blue Care Network HMO $1000/20%

Services	In-Network
Deductible • Individual • Family	• $1,000 for one member • $2,000 for two or more members
Coinsurance	• 80/20% after deductible
Coinsurance Out-Of- Pocket Annual Maximum - Deductible and copayments not included • Individual • Family	• $2,500 for one member • $5,000 for two or more members
Co-payments • Primary Care Physician • Specialist • Urgent Care • Online Visits	• $20 copay per office visit • $40 copay per office visit • $50 copay per office visit • $20 copay
Emergency Room	• $150 copay per visit - copay waived if admitted
True Out-of-Pocket Annual Max includes Deductible, Coinsurance and Copayments • Individual • Family	• $6,600 for one member • $13,200 for two or more members
Preventive Care	• 100/0% (Deductible waived)
Prescription Drugs for retail 30 day supply • Generic • Preferred Brand • Non-Preferred • Specialty Tier 4 • Specialty Tier 5 **Prescription Drugs for 90 day supply (retail and mail order)**	• $10 copayment Tier 1A, $30 Tier 1B • $60 copayment • $80 copayment • 20% of approved amount, but no more than $200 • 20% of approved amount, but no more than $300 • Consult the BCN Benefits-at-a-Glance

To find a Primary Care Physician, go to www.BCBSM.com.

- Select "**Find A Doctor**".
- Select "**Get Started**". Under "**Choose a health plan**", select "**All Plans**".
- Next, select "**Employer Group Plans"** Then, under "HMO Plans", select "**Blue Care Network (HMO)**".
- Input your city, state or a doctor, specialty or hospital. If necessary, scroll down and check "**Eligible PCP Providers**" or "**Accepting PCP Patients**".

Simply Blue PPO Plan

The following chart is a brief summary of the plan. For further plan details please refer to the Summary of Benefits and Coverage. To find an in-network provider, go to www.bcbsm.com.

Blue Cross Blue Shield Simply Blue PPO LG $1000

Services	In-Network	Notes
Deductible • Individual • Family	• $1,000 for one member • $2,000 for two or more members	• $2,000 for one member • $4,000 for two or more members
Coinsurance	• 80/20% after deductible	• 60%/40%, after deductible
Coinsurance Out-Of-Pocket Annual Maximum – Deductible and copayments not included	• $2,500 for one member • $5,000 for two or more members	• $5,000 for one member • $10,000 for two or more members
Co-payments • Primary Care Physician • Specialist • Urgent Care • Online Visits	• $30 copayment per office visit • $50 copayment per office visit • $60 copayment per office visit • $30 copayment per office visit	• 40% after out-of-network deductible
Emergency Room	• $150 copay per visit - copay waived if admitted	• $150 copay per visit - copay waived if admitted
True Out-of-Pocket Annual Max includes Deductible, Coinsurance and Copayments • Individual • Family	• $6,350 for one member • $12,700 for two or more members	• $12,700 for one member • $25,400 for two or more members
Preventive Care	• 100/0% (Deductible waived)	• Consult the BCBSM Benefits-at-a-Glance
Prescription Drugs for retail 30 day supply • Generic • Preferred Brand • Non-Preferred • Specialty Tier 4 • Specialty Tier 5 **Prescription Drugs for 90 day supply (retail and mail order)**	• $15 copayment • $50 copayment • Greater of $70 or 50% max $100 copayment • 20% of approved amount, but no more than $200 • 25% of approved amount, but no more than $300 • Consult the BCN Benefits At A Glance	• All Tiers are the same as the copayments on the left + 25% of the approved amount

Employee and Employer Contribution Rates
LOTWA - Hourly

2018 BCBSM PPO Plan			
Coverage Type	Employer Premium	Employee Premium	For 20 Payroll Deductions
Single	$325.00	$110.74	$66.44
Double	$650.00	$395.80	$237.48
Family	$725.00	$582.25	$349.35

2018 BCN HMO Plan			
Coverage Type	Employer Premium	Employee Premium	For 20 Payroll Deductions
Single	$325.00	$14.16	$8.50
Double	$650.00	$163.98	$98.39
Family	$725.00	$292.48	$175.49

HMO Premium Savings over PPO Annually	
Single	$1,158.96
Double	$2,781.84
Family	$3,477.24

MEDICATIONS MADE EASY: HOW TO ORDER A 90-DAY SUPPLY USING MAIL ORDER OR A RETAIL PHARMACY

Use mail order for the drugs you use all the time

You can order up to a 90-day supply of a covered drug for a reduced copay by mail.

To order most drugs by mail:

- Order convenient pre-addressed order envelopes by calling Express Scripts at 1-800-903-8346.
- Ask your doctor to write you a new prescription for a 90-day supply.
- Send your original prescription and copay in a pre-addressed order envelope to Express Scripts.
- Have your doctor fax the prescription to Express Scripts or write you a 90-day prescription.
- Each prescription will have a suggested refill date to remind you to order your refills on time. You can order refills by phone, by mail or online at **express-scripts.com**.

BCBSM's mail order prescription drug program is convenient.

- You don't have to wait in line at a retail pharmacy to have your prescription filled.
- There are no shipping or handling fees for standard prescriptions.
- You can order refills by phone, by mail or online.
- Prescriptions are filled quickly and shipped directly to your home.

Get a 90-day supply of your medication at a local retail pharmacy

You can receive a 90-day supply of medication from participating walk-in retail pharmacies for the same copay you would pay for mail order.

To use this benefit, ask your doctor to write a new prescription for a 90-day supply, and take the prescription to a local pharmacy. Most chain and independent pharmacies in Michigan participate in the 90-day commercial retail program, as do many network pharmacies outside Michigan. Ask your pharmacist if the pharmacy participates in the 90-day program before you have your prescription filled.

In order to receive a 90-day supply of medication at a participating 90-day retail pharmacy, the following must be met:

- Your 90-day supply of medication must comply with state laws.
- Your doctor must write the prescription for a 90-day supply.

Voluntary Dental Coverage

Dental coverage is moving to a voluntary plan. You can elect Voluntary Dental with or without a medical plan sponsored by GPS. You can elect Voluntary Dental with or without Voluntary Vision and vice versa. If you have single coverage under your medical plan sponsored by GPS, the Voluntary Dental must be single person enrollment. The same is true for Double (two person) and Family enrollment.

The payroll deduction form shows the employee cost. A 30% participation is required for BCBSM to approve the policy.

If you waive medical coverage with GPS and are not enrolled in a medical plan elsewhere, you **cannot** elect Voluntary Dental.

The Blue Dental PPO Plus SG 100/80/50/50 Plan

Services	Coverage
Deductible (ONLY Class II & III Services) –	• $50 per member limited to a maximum of $150 per family per calendar year
Coinsurance (Percentage of BCBSM's approval amount for covered services • Class I services • Class II Services • Class III Services • Class IV Services	• None (covered at 100%) • 20% • 50% • 50%
Annual Maximum for Class I, II and III Services	• $1,000 per member per calendar year
Lifetime Maximum for Class IV Services	• $1,000 per member
Out-of-pocket maximum	• No longer applicable

Note:

Members who go to nonparticipating dentists may be billed for any difference between the BCBSM approved amount and the dentist's charge. Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 260,000 dentist locations nationwide. PPO dentists agree to accept approved amounts as full payment for covered services – members pay only their applicable coinsurance and deductible amounts. Members also receive discounts on non-covered services when they use PPO dentists (in states where permitted by law). To find a PPO dentist near you, please visit **www.mibluedentist.com** or call 1-888-826-8152.

Blue Dental uses the Dental Network of America (DNoA) Preferred Network for its dental plans.

Consult the Blue Dental PPO Plus SG 100/80/50/50 Benefits-at-a-Glance for more details.

Voluntary Vision Coverage

Vision coverage is moving to a voluntary plan. You can elect Voluntary Vision with or without a medical plan sponsored by GPS. You can elect Voluntary Vision with or without Voluntary Dental and vice versa. If you have single coverage under your medical plan sponsored by GPS, the Voluntary Vision must be single person enrollment. The same is true for Double (two person) and Family enrollment.

The payroll deduction form shows the employee cost. A 30% participation is required for BCBSM to approve the policy.

If you waive medical coverage with GPS and are not enrolled in a medical plan elsewhere, you **cannot** elect Voluntary Vision.

Blue Vision 12/12/12 Plan

Services	VSP Provider	Non-VSP Provider under BCN Plan	Non-VSP Provider under BCBSM Plan
Eye Exam	$10 copay	Reimbursement up to $50 less $10 copay	Reimbursement up to $35 less $10 copay
	One eye exam every 12 months.		
Standard Lenses	$10 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount less copay which varies based on lens type.	
	One pair of lenses, with or without frames, every 12 months.		
Standard Frames	$130 allowance that is applied toward frames less $10 copay (one copay applies to both lenses and frames)	Reimbursement up to $70 less $10 copay	Reimbursement up to $70 less $10 copay
	One frame every 12 months.		
Medically necessary contact lenses	$10 copay	Reimbursement up to $210 less $10 copay	
	Contact lenses are covered up to allowance once every 12 months.		
Elective Contact Lenses	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses	$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses	
	Contact lenses are covered up to allowance once every 12 months.		

Note:

Members who go to a non-VSP provider may be billed for any difference between the BCBSM approved amount and the provider's charge. Member is responsible for any costs that exceed the approved amount or the BCBSM allowance. To find a VSP doctor, visit **www.vsp.com** or call 1-800-877-7195.

Consult the Blue Vision 12/12/12 Benefits-at-a-Glance for more details.

Basic Life Insurance

GPS provides full-time employees with $25,000 group life and accidental death and dismemberment (AD&D) insurance, and pays the full cost of this benefit. Contact Human Resources anytime to update beneficiary information.

Long-Term Disability Income Benefits

GPS provides full-time employees with long-term disability income benefits and pays the full cost of this coverage.

	Long-term Disability
Waiting Period	None
Benefits Begin	90 days
Benefits Payable	Social Security Normal Retirement Age
Percentage of Income Replaced	60% of monthly earnings
Maximum Benefit	Up to $6,000 monthly benefit

Voluntary Life/Accidental Death & Dismemberment

Employees may elect additional Life / Accident Disability & Dismemberment (AD&D) Coverage through MetLife

Enrollment in the Voluntary Life/AD&D plan is **available to all employees working 30 or more hours a week**. Otherwise, any future elections can or will be subject to Evidence of Insurability. If you are a new employee, you are eligible for guaranteed issue coverage at your initial date of hire for employment only.

The voluntary life has a guaranteed issue limit, which means medical underwriting is not required. The guaranteed issue limit is $150,000.

The voluntary life plan maximum is 5 times annual earnings to a maximum of $500,000. Amounts over $150,000 and equal to or less than $500,000 would require medical underwriting approval.

You would need to complete an Evidence of Insurability form for medical underwriting if you chose a limit over the guaranteed issue. This would be submitted to Met Life to underwrite and request further medical requirements such as a medical exam, blood test, etc. if necessary.

To make your selection, please refer to the Voluntary Life / AD&D section on the payroll deduction sheet for minimum, maximum and guaranteed issue values. Please refer to the plan for coverage eligibility and to the certificate and election forms for terms and conditions.

For assistance, contact MetLife at 800-638-5433.

Voluntary Short-Term Disability Income Benefits

Employees working 30 or more hours per week can elect voluntary short-term disability income benefits and pay the full cost of this coverage.

	Voluntary Short-term Disability
Waiting Period	None
Benefits Begin	For Accident or injury - day 15
Benefits Payable	11 weeks
Percentage of Income Replaced	60%
Maximum Benefit	Up to $1,500 weekly benefit

For assistance, contact MetLife at 800-638-5433.

Voluntary Benefits with Colonial Life

Employees working 30 or more hours per week can elect voluntary benefits with Colonial Life, They offer::

- Accident Insurance
- Cancer Insurance
- Critical Illness Insurance

A Colonial Life representative will be in attendance at the Open Enrollment Meeting. For new hire employees, please contact Evette Kendzierski 586-243-6100 for more details.

Federally Required Notices

Women's Health and Cancer Rights Act of 1998

Under federal law, the WHCRA notice provided upon enrollment in the plan must state that for the covered worker or family member who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits may be subject only to deductibles and coinsurance limitations consistent with those established for other benefits under the plan coverage.

FOR ADDITIONAL INFORMATION: Contact the nearest office of the Employee Benefits Security Administration by visiting www.dol.gov/ebsa or call 1-866-444-EBSA (3272). For TTY, call 1-877-889-5627.

Newborns' and Mothers' Health Protection Act

This notification is a requirement of the act. If you have any questions you may contact your Plan Administrator or your health insurance carrier directly. Group health plans and health insurance issuers offering group health insurance coverage may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

FOR ADDITIONAL INFORMATION: Contact the nearest office of the Employee Benefits Security Administration by visiting www.dol.gov/ebsa or call 1-866-444-EBSA (3272). For TTY, call 1-877-889-5627.

Premium Assistance Under Medicaid and the Children's Health Assistance Program

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

State Premium Assistance Subsidy

If the family income for a family which includes uninsured children falls below certain levels, many states provide health coverage, known as Children's Health Insurance Program to these families. Each state may elect to offer premium assistance which subsidizes the cost of premiums for defined qualified employer-sponsored coverage. (Health Flexible Spending Accounts and high deductible health plans are specifically excluded under the definition.) Go to www.dol.gov/ebsa for listing of participating states and contact information

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

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

Additional Information

NOTE: The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, please contact Human Resources.

Qualifying Life Events

- Benefit elections may only change during the year if you experience a qualified life event
- Qualified life events include: marriage, divorce, birth, adoption, etc.
- Qualified life events need to be reported to HR within 30 days
- If you miss the 30 day deadline, you must wait until the next enrollment period

Where do I go if I have questions?

Coverage/Vendor	Website	Customer Service
Medical - BCBSM	www.bcbsm.com	800-637-2227
Medical – BCN	www.bcbsm.com	800-637-2227
Voluntary Dental – Dental Network of America	www.mibluedentist.com	888-826-8152
Voluntary Vision – VSP	www.vsp.com	800-877-7195
Life, AD&D, LTD – MetLife	www.MetLife.com	800-638-5433
Voluntary Life, AD&D - MetLife	www.MetLife.com	800-638-5433
Voluntary STD - MetLife	www.MetLife.com	800-638-5433
Voluntary Benefits with Colonial Life	www.ColonialLife.com	586-243-6100

You may also contact Human Resources directly at (248) 254-3445.