

Research Scholar Assistants

2010 Insurance Guide



Medicare Part D- Prescription Drug Information

If you have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see pages 15 and 16 for more details.

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Please note: This is not a contract. You and your provider should contact the insurance carrier for full benefits description and applicable restrictions (if any) before services are provided. See your plan certificates for clarification.

Health Care Highlights

LTU offers you a variety of health care options to protect you and your eligible family members. This booklet highlights the main features of the plans offered. The insurance (medical, vision and dental) plan year is January 1, 2010—December 31, 2010.

The information provided in this Guide is meant to help you and your family choose the health care options best suited to your needs. Be sure to study each option carefully. If you have any questions, contact the Office of Human Resources at 248.204.2150.

Although the Summary of Benefits and Benefits-at-a-Glance material provides a summary of coverage available under these options, it does not address important limitations and restrictions that may apply to the health care plans. It is your responsibility to understand how the options work – including the limitations and restrictions – and to make the appropriate health care choices.

More detailed information on all these plan options can be obtained from the Office of Human Resources. In the event of a discrepancy between the Summary of Benefits or Benefits-at-a-Glance material and the plan's membership booklet, certificates and riders, the latter will govern.

Making Changes to Your Elections

The elections you make are for the entire plan year January 1, 2010 – December 31, 2010. Your benefit elections cannot be changed unless you experience a status change. **Status changes** include:

- Change in marital status
- Birth or adoption of a child
- Death of a spouse or dependent
- Termination of your spouse's employment
- Change in dependent eligibility

You must report any status change to the Office of Human Resources within **30 days** of occurrence in order to be allowed to select different insurance options.

Note: All RSA appointments are subject to 100% approved grant funding. Insurance coverage for the RSA and the RSA's spouse and dependents are subject to the grant-funding agency provisions.

Based on your elections, you authorize the appropriate payroll adjustments accordingly.

Notice of Non-discrimination Policy

Lawrence Technological University adheres and conforms to all Federal, state and local civil rights regulations, statutes and ordinances. No person, student, faculty or staff member will knowingly be discriminated against relative to the above statutes. Lawrence Technological University is an Equal Opportunity Employer.

For information on Medicare Part D Disclosure of Creditable Coverage please refer to the appendix.

For information regarding iStrive for better health Program refer to page 4.

Access to Your Insurance Information

You can access your insurance customer service to request a physician provider directory, medical membership ID cards, or to locate a network provider via phone or internet as follows:

Benefit	Customer Service Number	Hours Available	Internet
Lawrence Technological University Office of Human Resources	248.204.2150 or 248.204.2151 Fax: 248.204.2118	Monday - Friday: 8:00 am to 4:30 pm	www.ltu.edu/human_resources Email: benefits@ltu.edu
ADN Dental	888.236.1100 or 248.901.3705	Monday - Friday: 8:00 am to 5:00 pm EST	www.adndental.com
Alliance Health and Life (AHL)	888.999.4347	Monday - Friday: 7:00 am to 7:00 pm Saturday: 8:00 am to noon	www.hap.org
EyeMed Vision Care/ECPA	866.939.3633	Monday - Saturday: 8:00 am to 11:00 pm Sunday: 11:00 am to 8:00 pm	www.eyemedvisioncare.com
Med Impact	Rx Inquires/Verification: 800.788.2949 or 800.748.6277	24 hours	www.medimpact.com

Medical Insurance Options

LTU provides a comprehensive medical plan. The cost of the monthly premium may be shared by Lawrence Tech and the employee. The employee's cost depends on the number of people covered and the plan that is chosen. Additional cost to the employee may also include co-payments, deductible and co-insurance.

The basic medical insurance plans coverage includes preventive care, hospitalization, emergency services, urgent care, mental health and chemical dependency treatment, outpatient services, and prescription drug coverage. Additional details regarding the plans are available in the Office of Human Resources.



Medical Insurance-at-a-Glance

Exclusive Provider Organization (EPO) Plan Alliance Health and Life

The EPO is a managed care program through HAP in which members receive care within a specific provider network. Members must use the EPO provider network exclusively, however, they are not required to select a primary care physician. Referrals are not required for in-network specialty care. Medical services received outside the EPO network are not covered. The plan includes deductibles, copays and coinsurance costs.

AHL EPO Members SAVE MONEY by Completing the Health Assessment Questionnaire

You may qualify for no employee contribution or a discounted employee contribution rate under the AHL plan. In order to qualify for the free or discounted rate, you (employee only) are required to complete the health assessment questionnaire (HAQ) through HAP's iStrive for Better Health Program via on-line at www.hap.org. Download *Accessing iStrive on the HAP Web Site* from the HR web site at http://www.ltu.edu/human_resources/benefit_forms.asp. For additional assistance with completing the HAQ, please call customer service at 888.999.4347. (Note: Your private health information will not be shared with LTU.) If you do not complete the HAQ within 30 days of the coverage effective date (or before February 1, 2010 for 2010 insurance open enrollment), a monthly employee contribution will be applied or increased through payroll deduction.

2010 Contribution Rates

The following chart summarizes your monthly contribution for the various plan options, based on the coverage level and in some cases your completion of the Health Assessment Questionnaire (HAQ) through HAP's web site at www.hap.org. Once you are on the site, login with *Online Services*. New users must first click on "Registration Information" to register and create a password. Once you are logged in, follow the *iStrive* links to access the questionnaire. The questionnaire must be completed within **31 days** of your coverage effective date. For insurance open enrollment, the questionnaire must be completed by **January 31, 2010**.

Medical Plan	Monthly Premium	LTU Contribution	Employee Contribution
AHL EPO¹ – Rate if HAQ Completed			
Single	\$453.65	\$453.65	\$0.00
2 Person	\$965.55	\$965.55	\$0.00
Family	\$1,080.44	\$1,080.44	\$0.00
Sponsored Dependent	\$567.06	\$0.00	\$567.06
AHL EPO² – Rate if HAQ Not Completed			
Single	\$453.65	\$408.29	\$45.36
2 Person	\$965.55	\$869.00	\$96.55
Family	\$1,080.44	\$972.40	\$108.04
Sponsored Dependent	\$567.06	\$0.00	\$567.06

- 1 AHL EPO members must complete the on-line HAQ at www.hap.org within 31 days of the coverage effective date. For insurance open enrollment, the HAQ must be completed before February 1, 2010.
- 2 If AHL EPO members do not complete the HAQ, this rate will be applied beginning the 1st pay following 30 days of the coverage effective date. Note: For insurance open enrollment, if the HAQ is not completed before February 1, 2010, this rate will be applied on the February 15, 2010 payroll.

Medical Plan Highlights

Your Medical Option:

- Alliance Health and Life – Exclusive Provider Organization AHL – EPO)

Plan Highlights	AHL – EPO ¹
	In-network Only
Annual Deductible ¹ (does not include copays)	Yes
Individual	\$250
Family	\$500
Coinsurance ² (does not include deductibles or copays)	Plan pays 90% You pay 10%
Annual Out-of-Pocket Maximum ¹	Yes
Individual	\$600
Family	\$1,200
Office Visit Copay	\$35
Preventative Care	Yes
Urgent Care Copay	\$75
Emergency Room Copay ³	\$150
Outpatient & Physician Services	Plan pays 90% after deductible
Inpatient Hospital Services	Plan pays 90% after deductible
Mental Health Care	Yes
Prescription Drugs ⁴	Yes
Generic Copay	\$20
Brand Name Copay	\$40
Non-Formulary (non-preferred)	\$60
Mail Order – 90 Day Supply	2x copay

¹ Deductibles and copays do not apply toward annual out-of-pocket maximum.

² Your 10% coinsurance goes towards your out-of-pocket maximum.

³ Emergency room copay waived if admitted.

⁴ Prescription Drugs include contraceptives as a covered benefit.

Vision Insurance—EyeMed Vision Care

LTU offers vision care coverage through EyeMed Vision Care. The University pays the full cost of this coverage for both the employee and the employee's spouse and dependents (age 19, 25 years if full time student). You are responsible for applicable copayments.

EyeMed Vision Care offers a network of over 35,000 optical providers including optical retailers LensCrafters®, Target Optical® and most Sears Optical® and Pearle Vision® locations who have agreed to provide their services at reduced fees. This means lower out-of-pocket costs for you. You do not have to use a network provider, however you pay less out-of-pocket costs if you use a network provider. The process for members to access their EyeMed vision care benefit is simple. You can access providers by calling the toll-free locator service, visiting the web site, or referring to the provider listings that are part of the member brochure/ID Cards you will receive.



Every 12 months, the new vision plan covers the following benefits less the exam and material copays:

<u>Procedure</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Eye Exam	Covered – \$10 copay	Reimbursement up to \$35
Contact Exam Option		
– Standard	Covered up to \$55	N/A
– Premium	10% off retail price	N/A
Frames	\$0 copay, \$100 allowance for a frame plus 20% off balance over \$100	Reimbursement up to \$45
Lenses	Covered \$25 copay, up to allowable amount (one copay/lenses and frames)	Reimbursement to predetermined amount after copay
Contacts		
– Conventional	Covered \$115 allowance toward materials, 15% discount off balance over \$115	Reimbursement to \$92
– Disposables	Covered \$115 allowance, plus balance over \$115	Reimbursement to \$92

Other Benefits

Secondary Discount

EyeMed Vision Care offers members discounts on purchases through their secondary purchase plan. These discounts are available on services and products that are purchased after the covered benefits have been used. This plan provides reduced fees for exams, frames, lenses, contact lenses, and accessories, saving members money on these additional purchases.

Laser Vision Correction Benefits

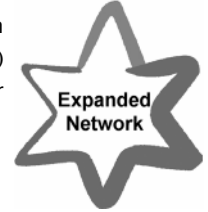
Members utilizing their EyeMed Vision Care benefit receive a 15% discount off the retail price or 5% off the promotion price for LASIK (Laser In-Situ Keratomileusis) and PRK (Photorefractive Keratectomy) treatments through the U.S. Laser Network, which is administered by LCA-Vision. This includes all pre- and post-operative care at no additional charge if the treatment is performed at a Lasik Plus Center, which is part of the U.S. Laser Network.

Dental Insurance—ADN Dental

LTU offers dental coverage through ADN Dental. The University pays the full cost of the monthly premium for both the employee and the employee's spouse and eligible dependents (age 19, or 25 years if full time student). You are responsible for applicable copayments.

Who is ADN Dental?

Formed in 1993, ADN is the largest independent dental PPO in Michigan, offering more than 3,100 dentists in Michigan and many more in other states. Though the ADN network, its affiliation with Michigan Dental Plans (MDP) and Dentemax, you have access to a broad range of dentists. Dentemax adds over 600 providers to the network. Your dental card will reflect the new Dentemax logo.



How does this benefit me?

When you seek dental services with a participating ADN Dental Network, MDP or Dentemax dentist, you receive no billing except for deductibles and copays. This means you will not be responsible for a dentist exceeding the "reasonable and customary" charges; by contract, network providers agree that this won't happen. We encourage you to contact ADN if your provider does not currently participate with ADN or Dentemax. Seeking care from a participating dentist results in a greater benefit and less out-of-pocket costs for you.

Do I have to use a participating ADN Network Dentist?

No. You are not required to use an ADN, MDP or Dentemax dentist. However, if you do not use an ADN Network Dentist, your out-of-pocket costs are greater.

Will I have to submit any claim forms?

No. Your dentist should mail all claims directly to ADN. When you pay your copay depends on your dentist. Some dentists may ask for your copay at the time service is rendered. Other dentists may bill first, then send you a bill for your copay amount.

Lawrence Tech Dental Insurance at a Glance

<u>Annual Deductible:</u>	<u>In-Network</u>	<u>Out-Network</u>
Applies to Type 2 and Type 3 Benefits Only	\$50 per individual \$150 per family	\$50 per individual \$150 per family
<u>Annual Benefit Maximum:</u>	\$1,000	\$1,000
<u>Type 1 – Preventive Services:</u> Exams, X-Rays, Cleaning, Fluoride for Children (to age 14)	100%	100%
<u>Type 2 – Basic Services:</u> Fillings, Extractions, Root Canals, Treatment of Gum Disease, Repairs to Dentures and Bridges	100%	85%
<u>Type 3 – Major Services:</u> Crowns (caps) fixed, Bridges, Removable Partial or Complete Dentures	60%	50%
<u>Type 4 – Orthodontia (to age 18):</u> Lifetime Maximum	50% \$1,500	50% \$1,500

Health Care Terms

Annual Copay Maximum: The maximum amount you will pay out of your own pocket for covered medical expenses during the year. Once your payments total the out-of-pocket maximum, the plan pays 100% of covered expenses for the rest of the plan year.

Beneficiary: A person who is eligible to receive benefits under a health benefits plan. Sometimes “beneficiary” is used for eligible dependents enrolled under a benefits plan; “beneficiary” can also be used to mean any person eligible for benefits, including both employees and eligible dependents.

Benefit Year: The coverage period, usually 12 months long, which is used for administration of a health benefits plan.

Brand-Name Drug: A drug manufactured by a pharmaceutical company which has chosen to patent the drug’s formula and register its brand name.

Carrier: A term historically used for licensed insurance companies, although now sometimes used to include both licensed insurers and HMOs.

Case Management: Coordination of services to help meet a patient’s health care needs, usually when the patient has a condition that requires multiple services from multiple providers. This term is also used to refer to coordination of care during and after a hospital stay.

Coinsurance: The percentage of the cost you pay after the deductible has been met.

Coordination of Benefits: A provision in a contract that applies when a person is covered under more than one group health benefits program. It requires that payment of benefits be coordinated by all programs to eliminate over-insurance or duplication of benefits.

Copayment (copay): What the participant pays at the time of service. Copayments are predetermined fees for physician office visits, prescriptions or hospital services. Usually, the plan pays 100% of eligible expenses after you pay the copay.

Deductible: The money an individual or family must pay from their own funds toward covered medical expenses, usually based on a calendar year. For example, if a plan has a \$100 deductible, the deductible is met once the first \$100 of the covered medical expenses for that year have been paid. After that, the plan begins to pay toward the cost of covered health care services.

Dependent: A person eligible for coverage under an employee benefits plan because of that person’s relationship to an employee. Spouses, children and adopted children are often eligible for dependent coverage.

Exclusive Provider Organization (EPO): Plan members can visit specialists without a referral. Members don't need to choose a primary care physician for coverage. An annual deductible is required, and an out-of-pocket maximum applies. Coverage is not available for out-of-network service.

Explanation of Benefits (EOB): A statement provided by the health benefits administrator that explains the benefits provided, the allowable reimbursement amounts, any deductibles, coinsurance or other adjustments taken and the net amount paid. A participant typically receives an explanation of benefits with a claim reimbursement check or as confirmation that a claim has been paid directly to the provider.

Extension of Benefits: When a person’s coverage is extended under certain conditions, such as disability, after their group health coverage would otherwise have ended.

Formulary: A list of preferred drugs. Medications on this formulary list have been shown to be safe, effective and affordable. Formulary includes brand-name and generic drugs that have been approved by the Food and Drug Administration.

Generic Drug: A prescription drug that has the same active-ingredient formula as a brand-name drug. A generic drug is known only by its formula name and its formula is available to any pharmaceutical company. Generic drugs are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs and are typically less costly.

Health Maintenance Organization (HMO): An HMO requires a Primary Care Physician must be selected and members must work with the PCP for specialty care referrals. HMOs are prepaid capitated health care plans structured to emphasize care and cost containment. HMO is the most restrictive plan in health care, giving the greatest level of benefit.

Maintenance Medication: Medication that is prescribed for long-term treatment of chronic conditions, such as diabetes, high blood pressure or asthma. Maintenance medications are often available through the carrier's mail order service for up to a 90-day supply and at participating network retail pharmacies for up to a 30-day supply.

Non-formulary (Non-preferred): A drug which is not on an approved list for use and/or coverage by the plan.

Network: A group of providers (doctors, hospitals and others) who have contracted with a plan to provide health care services. *Under some options, receiving care from out-of-network providers can severely limit, or eliminate, plan benefits.*

Preferred Provider Organization (PPO): The PPO offers coverage in or out of network, without a referral. No PCP is required. In-network coverage is at a higher level than out-of-network.

Reasonable and Customary Charges: The commonly charged or prevailing fees for health services within a geographic area. A fee is considered reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community.



Federal Laws

Your Continuation Coverage Rights Under COBRA

As a participant in the Lawrence Tech Medical, Dental, Vision, and FSA (referred to here as "the plan(s)"), you are receiving this notice that describes your right to COBRA continuation coverage.

COBRA, or the Consolidated Omnibus Budget Reconciliation Act of 1985, is a federal law affecting most employers who offer group health benefits to their employees. Under this law, you and other members of your family may have the right to temporarily continue your group health benefits when you would ordinarily lose coverage. This document describes your right to this COBRA continuation coverage, when it may become available to you and your family and what you must do to protect your right to receive it.

What is COBRA continuation coverage?

COBRA continuation coverage extends your health plan coverage when it would otherwise end because of a life change (known here as a qualifying event). After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the full cost of the benefit.

As an employee covered by the plan, you will become a qualified beneficiary if you lose your plan coverage because:

- Your hours of employment are reduced, or
- Your employment ends for any reason except for gross misconduct on your part.

As the spouse of a covered employee, you will become a qualified beneficiary if you lose your plan coverage for any of the following reasons:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than gross misconduct.
- Your spouse becomes entitled to Medicare benefits.
- You become divorced or legally separated from your spouse.

As a dependent child of a covered employee, you will become a qualified beneficiary if you lose your plan coverage for any of the following reasons:

- Your employee-parent dies.
- Your employee-parent's hours of employment are reduced.
- Your employee-parent's employment ends for any reason other than gross misconduct.
- Your employee-parent becomes entitled to Medicare benefits.
- You cease to be a "dependent child" under the terms of the plan.

When is COBRA coverage available?

You are eligible for COBRA continuation coverage only after the plan administrator has been notified that a qualifying event has occurred.

Who is responsible for notifying the plan administrator of a qualifying event?

Your employer is responsible for notifying the plan administrator if the qualifying event is one of these:

- Your termination or a reduction in your hours of employment.
- Your death.
- Your becoming entitled to Medicare.

You are responsible for notifying the plan administrator that a qualifying event has occurred when the event is one of these:

- You become divorced or legally separated from your spouse.
- Your dependent child ceases to be eligible under the plan.

You must notify the plan administrator within 60 days after the qualifying event has occurred. Provide this notice in writing to:

Lawrence Technological University
Office of Human Resources
21000 West Ten Mile Rd.
Southfield, MI 48075

What happens next?

Once the plan administrator has received notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each person will have an independent right to elect or decline the coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouse, and parents may elect the coverage on behalf of their children.

How long does COBRA continuation coverage last?

COBRA continuation coverage is temporary coverage. Generally, it lasts only up to 18 months, when the qualifying event is a reduction in your hours of employment or your employment ends.

COBRA continuation coverage can last up to 36 months when the qualifying event is one of the following:

- You die.
- You become entitled to Medicare benefits.
- You and your spouse become divorced or legally separated.
- Your dependent child ceases to be eligible under the plan.

An 18-month coverage period can be extended in two ways: through (i) disability or (ii) a second qualifying event.

Disability extension

If the Social Security Administration determines you or another covered individual in your family to be disabled and you notify the plan administrator in a timely manner (within 60 days of the Social Security determination), you and your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started sometime before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. If you qualify for the disability extension, you may be required to pay up to 150% of the full cost of the benefit for the additional 11 months of COBRA continuation coverage.

A second qualifying event

If your family experiences a second qualifying event during its 18-month period of COBRA continuation coverage, other qualified beneficiaries in your family can obtain an additional 18 months of coverage, for a maximum of 36 months, if the plan administrator is notified in a timely manner of one of these second events:

- You die.
- You become entitled to Medicare benefits.
- You become divorced or legally separated from your spouse.
- Your dependent child ceases to be an eligible dependent under the plan.

A "second qualifying event" extension may be available to your spouse and dependent children only if the event would have caused them to lose coverage under the plan had the first qualifying event not occurred.

Protect your rights

- Always keep the plan administrator informed of any address change for any family member.
- Whenever you correspond with the plan administrator, keep a copy for your records.
- Keep in mind that this notice is only a summary of the most important provisions of COBRA. If you have questions or need additional information about COBRA continuation coverage or your group health plan, review your Summary Plan Description or contact the plan administrator:

Lawrence Technological University
Office of Human Resources
21 000 West Ten Mile Rd.
Southfield, MI 48075

For answers to your questions concerning your rights under COBRA, ERISA, HIPAA and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration or visit the EBSA web site at www.dol.gov/ebsa.

Women's Health and Cancer Rights Act of 1998

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

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

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

Newborn and Mother's Health Protection Act

This 1998 Federal law states: "Group plans and health insurers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth."

The law provides that neither you nor your newborn baby may be sent home less than 48 hours following a natural childbirth. If you have a Caesarean section, you may remain at the hospital for 96 hours. A longer stay is based on medical necessity, which is determined by your physician. However, the law does not prohibit either of you from going home in less than 48 hours, or 96 hours following a Caesarean section, provided that you or your physician agrees that it is safe to do so.



Federal Laws ...continued

Michelle's Law

Michelle's law requires group health plans to continue coverage for up to one year for seriously ill or injured college students who leave school due to a medically necessary leave of absence. To qualify for continued coverage, the student's attending physician must certify in writing to the health plan that the student's leave is medically necessary. The student must continue to meet all other health plan eligibility requirements.

Children's Health Insurance Program

If you or a dependent is covered under a Medicaid or Children's Health Insurance Program Reauthorization Act (the "Act") of 2009 plan and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage, you may be able to enroll yourself and/or your dependent(s). However, you must request enrollment within 60 days after the date eligibility is lost.

Finally, if you or a dependent becomes eligible for premium assistance under an applicable State Medicaid or CHIP plan to purchase coverage under the group health plan, you may be able to enroll yourself and/or your dependent(s). However, you must request enrollment within 60 days after you or your dependent is determined to be eligible for State premium assistance. Please note that premium assistance is not available in all states.

HIPAA Notice of Privacy Practices

We understand that medical information about you and your health is personal. We are committed to protecting your medical information. For plan administration purposes, the health plan creates a record of reimbursed health care claims.

Because we create this record we are required to follow federal health information privacy laws. This notice is to remind you that as a participant in the Lawrence Technological University Benefit Plan you are protected by these laws and you have a right to a copy of our plan's Privacy Notice upon request. In addition, you will automatically be provided an updated notice if the current privacy policy is changed. This updated notice will be made available within 60 days of the date a material change is made to the privacy policy.

As required by HIPAA, the Plan will: make sure that medical information which identifies you is kept private; give you notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the policy and notice that is currently in effect.

The program benefits that are subject to the privacy laws include: dental and/or health care reimbursement accounts.

While we treat all information confidentially, other benefit programs are not subject to the same requirements and there is no specific privacy notice for those plans. If you have questions, please call 248-204-2151.

To request a copy of the privacy notice please forward a written request for a copy of the Plan's privacy notice to (please allow two weeks for the delivery of the notice):

Lawrence Technological University
c/o Office of Human Resources
21000 West Ten Mile Road
Southfield, MI 48075-1058
(248) 204-2150 or 2151

Or you may download a copy of the privacy notice at www.ltu.edu/human_resources/privacy.asp.

Medicare Part D—Notice of Creditable Coverage

Important Notice from Lawrence Technological University (LTU) About Your Prescription Drug Coverage and Medicare

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

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

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Lawrence Technological University has determined that the prescription drug coverage offered by the Lawrence Technological University Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Lawrence Technological University coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Lawrence Technological University coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period.

Note that your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan and keep your coverage under the Lawrence Technological University Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

Medicare Part D—Notice of Creditable Coverage ...continued

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

Medical and prescription drug coverage are offered as a package under the Lawrence Technological University Plan (you cannot elect medical coverage without prescription drug coverage).

Continue medical and prescription drug coverage under the Lawrence Technological University Plan and do not elect Medicare D coverage. **Impact** – your claims continue to be paid by the Lawrence Technological University Plan.

Continue medical and prescription drug coverage under the Lawrence Technological University Plan and elect Medicare D coverage. **Impact** – As an active employee (or dependent of an active employee) the Lawrence Technological University Plan continues to pay primary on your claims (pays before Medicare D).

Drop the Lawrence Technological University Plan coverage and elect Medicare Part D coverage. **Impact** – Medicare is your primary coverage. You will not be able to rejoin the Lawrence Technological University Plan unless you experience a family circumstance change or until the next open enrollment period.

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

Contact the Office of Human Resources at (248) 204-2150 or 2151 for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Lawrence Technological University changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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Lawrence Technological University

Office: Office of Human Resources

21000 West Ten Mile Road, Southfield, MI 48075

(248) 204-2150 or 2151

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

AHL EPO Schedule of Benefits



ALLIANCE HEALTH AND LIFE INSURANCE COMPANY EXCLUSIVE PROVIDER ORGANIZATION (EPO) PLAN SCHEDULE OF BENEFITS

This Summary of Benefits is designed to provide an overview of the Alliance EPO Plan and is subject to the terms and conditions of the actual policy. In cases of conflict between this summary and the policy, the terms and conditions of the policy govern. This program features a network of health care providers through which the Subscriber and Dependents can receive services at the In-Network level of benefits through their network providers. There are no referral and PCP requirements in network. There are no Out-of-Network benefits. Alliance EPO Subscribers and Dependents who do not seek services through a network provider will have no covered medical services.

HEALTH CARE SERVICES	IN-NETWORK	LIMITATIONS
Benefit Period	Plan year (Fiscal)	
Annual Deductibles	\$250 Individual	Deductibles do not include co-pays.
	\$500 Family	
Coinsurance Maximums	\$600 Individual	Coinsurance Out-of-Pocket maximums do not include deductibles
	\$1,200 Family	
Lifetime Maximum per Covered Individual		\$5,000,000
Preventive Services	(No annual dollar limit)	
Preventive Office Visits	\$35 co-pay per office visit then 100%	
Periodic Physical Exams	\$35 co-pay per office visit then 100%	
Well Baby/Child Exams	\$35 co-pay per office visit then 100%	
Immunizations	Covered - Deductible does not apply	
Routine Eye and Hearing Exams	\$35 co-pay per office visit then 100%	
Related Lab Tests and X-Rays	Covered - Deductible does not apply	
Pap Smears and Mammograms	Covered - Deductible does not apply	
Outpatient & Physician Services		
Office Visits	\$35 co-pay per office visit then 100%	
Allergy Testing and Injections	Plan pays 90% after deductible	
Other Injections	Plan pays 90% after deductible	
Labs Tests & X-Rays	Plan pays 90% after deductible	
Chiropractic Services	\$35 co-pay per visit then 100%	Manipulation of the spine for subluxation only- 20 visits per benefit year
Outpatient/Office Surgery & Related Svc	Plan pays 90% after deductible	
Radiation/Chemotherapy	Plan pays 90% after deductible	
Eye Examinations	\$35 co-pay per office visit then 100%	Does not include lenses/frames/contacts
Audiology Examinations	\$35 co-pay per office visit then 100%	
Emergency Services		
Emergency Room Services	\$150 co-pay then 100%	Co-pay waived if admitted.
Urgent Care Facility Services	\$75 co-pay then 100%	
Emergency Ambulance Services	Covered - Deductible does not apply	Emergency transport only
Inpatient Hospital Services		Unlimited days of care
Semi-Private Room	Plan pays 90% after deductible	
Intensive, Cardiac and Other Specialty Units as necessary	Plan pays 90% after deductible	Admissions require Alliance be notified within 48 hours of admission. Failure to notify Alliance within 48 hours could result in benefit reduction.
Related Therapy Services	Plan pays 90% after deductible	
Surgery and Related Services	Plan pays 90% after deductible	
Related Lab Tests and X-Rays	Plan pays 90% after deductible	
Physician/Professional Services	Plan pays 90% after deductible	

AHL EPO Schedule of Benefits ...continued

HEALTH CARE SERVICES	IN-NETWORK	LIMITATIONS
Maternity Services		
Outpatient Pre- and Post-natal Visits	\$35 co-pay per office visit then 100%	
Labor and Delivery	Plan pays 90% after deductible	
Newborn Care in Hospital	Plan pays 90% after deductible	
Ancillary Services		
Home Health Care	Plan pays 90% after deductible	The number of visits for Medically Necessary home health care shall not exceed 100 visits per Benefit Period. Coinsurance does not apply to out-of-pocket max.
Hospice Care	Plan pays 90% after deductible	
Physical Therapy	\$35 co-pay per visit then 100%	Up to 60 combined visits per benefit year
Speech Therapy	\$35 co-pay per visit then 100%	
Occupational Therapy	\$35 co-pay per visit then 100%	
Durable Medical Equipment (DME)	Plan pays 90% after deductible	Must be an authorized piece of equipment based on Alliance guidelines
Prosthetics and Orthotics	Plan pays 90% after deductible	Must be an authorized piece of equipment based on Alliance guidelines
Skilled Nursing Facility	Plan pays 90% after deductible	100 days per benefit year
Mental Health Services		
Inpatient Services	Plan pays 90% after deductible	Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at 1-800-444-5755.
Outpatient Services	\$35 co-pay per office visit then 100%	
Chemical Dependency Services		
Inpatient Services	Plan pays 90% after deductible	Services must be precertified and can be directly accessed by calling Coordinated Behavioral Health Management at 1-800-444-5755.
Outpatient Services	\$35 co-pay per office visit then 100%	
Transplant Services		
Organ Transplant and Related Services	Plan pays 90% after deductible	Lifetime maximum of \$1,000,000 per person
Precertification Penalty		
		If precertification procedures are not followed, inpatient benefits will be subject to a \$250 penalty and outpatient benefits will be subject to a 50% penalty up to a maximum of \$250. The penalty does not apply toward satisfying the Out-of-Pocket Maximum. This penalty is imposed for each incidence of non-compliance.
Prescription Drugs		
	100% after \$20 co-pay per Generic; \$40 co-pay per Preferred Brand-Name; \$60 co-pay per Non Preferred Brand-Name prescription will apply.	Does not include infertility agents. Does not include Obesity or Smoking Cessation drugs. Contraceptives are included. All prescriptions must meet Alliance guidelines. Mail Order: 90 day supply for both eligible maintenance and non-maintenance drugs at 2 co-pays
Voluntary Sterilization	Plan pays 90% after deductible	Any procedure, including vasectomy and tubal ligation, whose sole intent is to induce sterility.
Hearing Aid	Plan pays 90% after deductible	Covered for authorized conventional hearing aids
Infertility Services	Plan pays 90% after deductible	Any services rendered with the sole intent to induce conception to an individual with the inability to produce offspring. Limited to aggregate amount of \$3,000 per member per lifetime.
Sponsored Dependent	Covered	Relative by blood or marriage or non-relative for which principal support is provided.
Dependent Child Continuation	Covered	Dependent unmarried children to age 25
Medicare Complementary	Covered	For retirees only who are enrolled in Medicare Parts A and B. Coverage is for deductibles and coinsurance under Parts A and B of Medicare for benefits covered by Medicare. Benefits described in this policy are reduced to the extent they are covered by Medicare parts A and B.



Lawrence Technological University
Office of Human Resources
21000 West Ten Mile Road
Southfield, MI 48075-1058
248.204.2150
benefits@ltu.edu
Ltu.edu/human_resources