Education Management & Networks Employee Benefit Guide

Effective November 1, 2023

Education Management & Networks

44NORTH

ACRISURE® PARTNER

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Introduction

THE FOLLOWING PLAN OPTIONS ARE EFFECTIVE:

November 1, 2023 through October 31, 2024

Medical

The medical coverage will remain the same this year

- Health Alliance Plan (HAP)

Prescription

The prescription drug coverage will remain the same this year

- Health Alliance Plan (HAP)

Dental

The dental coverage will remain the same this year

- Delta Dental

Vision

The vision coverage will remain the same this year

- VSP

Short-Term Disability & Employee Assistance Program

The short-term disability coverage and the employee assistance program will be through the same carrier

- Lincoln Financial Group

Your Dedicated Service Team

JOHN O'CONNOR

VICE PRESIDENT
GROUP BENEFIT CONSULANT
P: 855.306.1099 ext. 1020
E: joconnor@44n.com

John oversees operations and provides consulting and advisory services to accounts. Through strategic planning and solid carrier partnerships, John lends his expertise to help set goals and introduce tools in order to determine the best solution for each client.

DEENA LOHR

ACCOUNT EXECUTIVE
P: 855.306.1099 ext. 1024
E: dlohr@44n.com

In addition to working closely with John during the planning and implementation process, Deena brings her experience to light each year during the group renewal process, always looking for innovative ways to improve group benefits while decreasing cost.

NIKI NICHOLS

ACCOUNT MANAGER
P: 855.306.1099 ext. 1066
E: nnichols@44n.com

Niki works very closely with Deena to provide onsite employee education. Niki also serves as a point of contact for Human Resource/Benefit departments and attentively addresses both employer and employee benefit questions.

DAWN TAYLOR

PATIENT ADVOCATE
P: 855.306.1099 ext. 1012
E: dtaylor@44n.com

As your dedicated Patient Advocate, Dawn works directly with carriers and providers as a liaison for your employees' claim issues and inquiries to make sure everything is processed correctly.

As always, our emergency 24/7 service line is available at (855) 306-1099

44NORTH
ACRISURE® PARTNER

Contact Information

PROVIDER	BENEFIT	CONTACT INFORMATION
44North	24/7 Patient Advocacy	855-306-1099 www.44N.com
Health Alliance Plan	Medical & Prescription Drug	800-422-4641 www.hap.org
Delta Dental of Michigan	Dental	800-524-0149 www.DeltaDentalMI.com
Vision Service Plan	Vision	800-877-7195 www.vsp.com
Lincoln Financial Group	EAP Short Term Disability	877-275-5462 www.lfg.com

EMAN CONTACT INFORMATION

Iman Alkhalaf	HR Coordinator	248-327-7673 Iman.alkhalaf@emanschools.net

Insurance Eligibility

Insurance Plan Year:

November 1, 2023 ⟶ October 31, 2024

Employee Eligibility

Full-time employees who work 30 hours or more per week are eligible to participate in the insurance plans.

- Benefits begin on the first of the month following 60 days after date of hire

Dependent Eligibility

A dependent is defined as the legal spouse and/or dependent child(ren) of the participant. The term "child" includes any of the following:

- Natural child or Stepchild
- Legally adopted child
- Other child for whom the team member has permanent legal custody

Dependent Child Age Requirements

- Medical, Dental and Vision: Dependent children up to the end of the calendar year in which they turn 26

What if I Separate From Employment?

- Medical, Dental and Vision will end the last day of the month in which the separation of employment occurred. COBRA Continuation of coverage may be available as applicable by law.

Qualifying Events & IRS Code Sec. 125

IRS Code Section 125

Premiums for medical, dental, vision insurance and contributions to Flexible Spending Accounts (Heath Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to your pre-tax benefits can be made ONLY during the Open Enrollment period unless you or your qualified dependents experience a qualifying event (Marriage, Death, Birth, Adoption or loss of coverage) and the request to make a change is made within 30 days of the qualifying event. If the Qualifying Event is a divorce or the dependent ages out of the eligibility, you are allowed 60 days to notify Human Resources.

Under certain circumstances, you may be allowed to make changes to your benefit elections during the plan year, if the event affects your own, your spouse's or your dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125.

Examples of Qualifying Events:

- Legal marital status
  - Marriage
  - Divorce
  - Legal Separation
- Number of eligible dependents
  - Birth
  - Death
  - Adoption
- Employment status
- Change in employment status
- A covered dependents status
- Loss of other coverage
- Enrollment in another health plan

Special Enrollment Events & Changes in Family Status

IMPORTANT

If you are declining enrollment in the group health plan for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you experience a Qualified Event.

If you experience a qualifying event you must contact Human Resources within 30 days of the qualifying event to make the appropriate changes to your coverage. If the Qualifying Event is a divorce or dependent ages out of eligibility, you are allowed 60 days to notify Human Resources. Beyond 30 days, requests will be denied and you may be responsible both legally and financially for any claims and/or expense incurred as a result of the employee or a dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes will take place on the date of the qualifying event. You will be required to furnish valid documentation supporting a change in status or "Qualifying Event."

If you or your eligible dependents are eligible for, but not enrolled in, the group health plan and your coverage or the coverage of your spouse or other eligible dependent under a Medicaid plan or state Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, you must notify Human Resources no later than 60 days after the date the Medicaid or CHIP coverage terminates. If you, your spouse or other eligible dependent become eligible for a premium subsidy in this Plan under a Medicaid plan or state CHIP (including any waiver or demonstration project) you must contact Human Resources to request coverage under this Plan no later than 60 days after the date you are determined to be eligible for such assistance. Your enrollment will take effect no later than the first of the month following your loss of coverage and the date the company receives your request for enrollment, as long as your request to enroll on or before the date that is 60 days after the lost of coverage.

To request special enrollment or obtain additional information, please contact Human Resources.

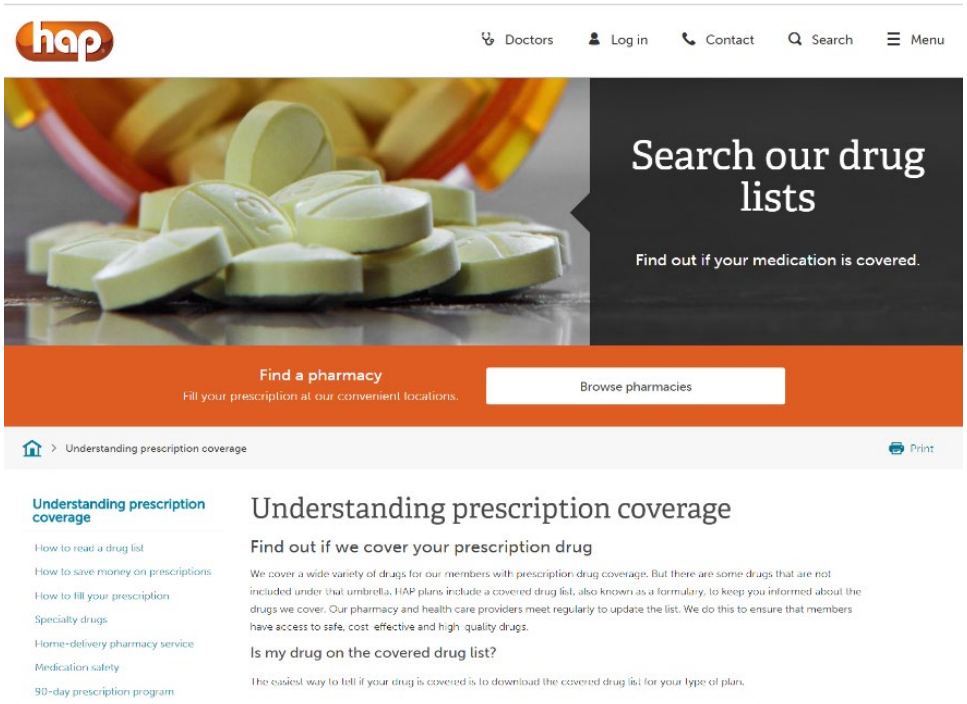
Medical Insurance

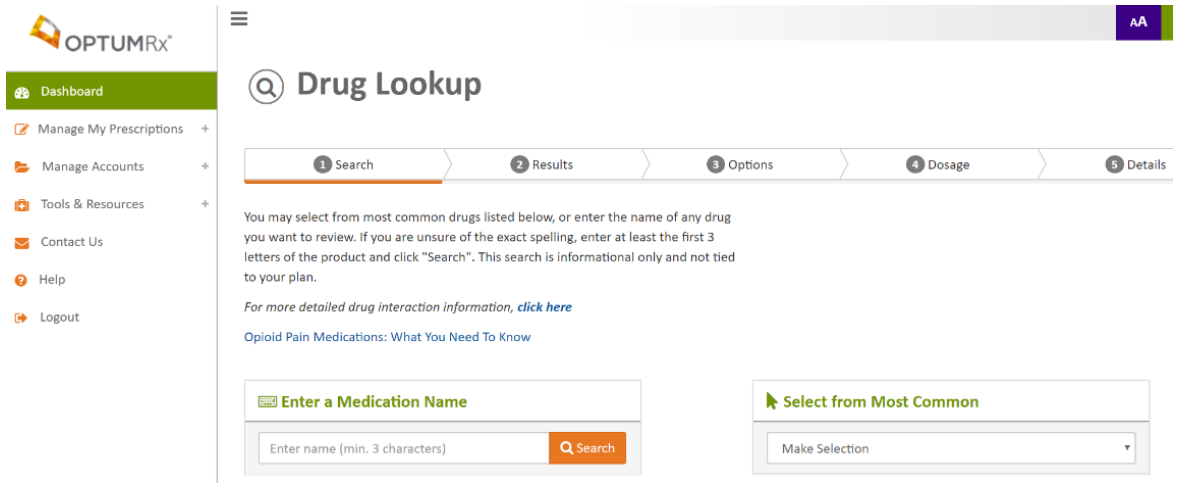
Deductible – Calendar Year	**In-Network**
Individual	$500
Family	$1,000
Coinsurance	
Member Responsibility	10%
Annual Out-of-Pocket Maximum – Deductible, Coinsurance & Copays	
Individual	$5,000
Family	$10,000
Provider Costs	
Primary Care Visit Copay	$20
Specialist Visit Copay	$40
Urgent Care Copay	$75
Emergency Room Copay	$250
Chiropractic Copay – 20 visit maximum, per benefit period	$40
Prescription	
30 – Day Supply	$5 / $15 / $20 / $40
90 – Day Supply	$10 / $30 / $40 / $80
Specialty*	20% ($200 max)
Non-Preferred Specialty*	50% ($200 max)

*Please note that Specialty medications can only be filled at a Specialty pharmacy for a 30-day supply

Prescription Drug Assistance

- Tools to help you find prescription drug information
- Drug lists and formulary search
  - Access by logging in to your hap.org account, then click My Prescription Coverage
- Home delivery prescriptions – through Pharmacy Advantage





Telehealth Services

See a Doctor Now with HAP Telehealth

Getting health care online has never been easier.

HAP Telehealth, powered by Amwell® provides round-the-clock telehealth services. Doctors are now available 24/7 for live, online visits.

Doctors are always available

Not feeling well? Is your doctor's office closed? Too sick to leave home?

Now you can see a doctor using your mobile phone, tablet or computer. Here are the benefits of using telehealth services:

- Affordable, easy and convenient
- Doctors are licensed and board certified
- No appointment, short wait
- 24/7 access
- Online visits are secure

How do I sign up?

It's free to enroll. Follow these easy steps:

Desktop users:

1. Visit **haptelehealth.org**
2. Enter your information and click *Sign Up.*
3. For Service Key, leave blank.

Mobile users:

1. Search Apple's iTunes or Google's Play App Store for **HAP Telehealth** and download the app.
2. Enter your information and click *Sign Up.*
3. For Service Key, leave blank.

Frequently asked questions

What can doctors treat?

You can get treatment for nonemergency illnesses. See doctors for conditions such as:

- Colds
- Flu
- Headache
- Sprains and strains
- Rashes and sinus infections
- Pink eye
- Other minor conditions

Using telehealth services for treatment of non-emergency illnesses can save you money compared to visiting the emergency room or urgent care.

Can medicines be prescribed?

If it's medically necessary, doctors can even prescribe certain medications.[1]

What will I pay?

See your benefit summary for cost share information on HAP Telehealth services.

Can I use telehealth services when I'm traveling?

Telehealth services are great when you're on the road for vacation or work. Telehealth services are available in all 50 states. Exclusions include U.S. Territories like Puerto Rico and international locations. For a full list of where you can reach a doctor online, visit haptelehealth.org.

[1]Based on current regulations.

hap telehealth

HAP Network

Leading doctors and hospitals

Our network has thousands of participating doctors in Michigan and northwest Ohio. Chances are pretty good your doctor is a HAP doctor.

Go with experience

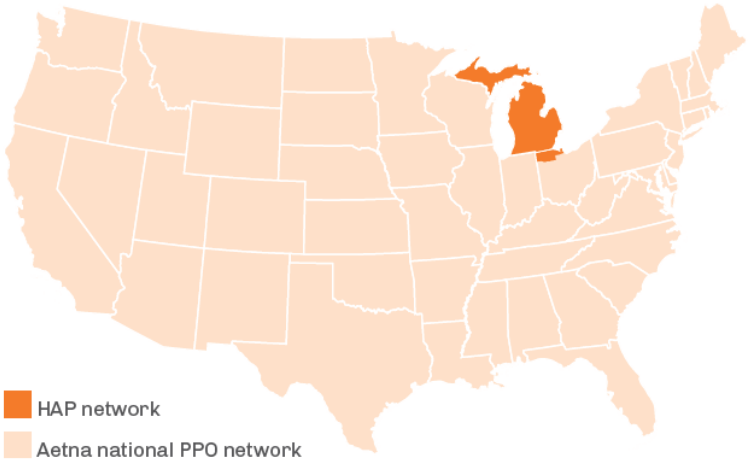
As one of Michigan's largest and most experienced health plans, HAP offers you and your family a large network of doctors and hospitals in Michigan and northwest Ohio. You also don't need referrals.

Out-of-State coverage

Outside of Michigan, you'll find a large network of doctors and hospitals across the country through our partnership with Aetna Signature Administrators®- one of the nation's largest health service networks. HAP has partnered with Aetna Signature Administrators® to offer you the Aetna national PPO network outside of Michigan and Northwest Ohio*.

Aetna's network gives you access to more than 1.4 million providers including over 6,100 hospitals and thousands of MinuteClinic® locations around the country.

HAP's PPO network**



* HAP's PPO provider network includes these seven counties of northwest Ohio: Defiance, Fulton, Henry, Lucas, Ottawa, Williams and Wood.
** Does not apply to Medicare.

Finding a doctor is easy

To find doctors who accept your plan in Michigan and northwest Ohio, visit **hap.org/ppodoctors**.

To find doctors in the Aetna national PPO network, visit **hap.org/find-a-doctor** and select the "Care Outside of Michigan" button.

For more information about HAP, visit **hap.org**.

Mobile Apps

Discover the apps worth downloading.		
	myHAP card digital ID card	View the ID cards of everyone on your plan from the convenience of your smartphone. You can also use it to share your ID card via email or fax.
	Wellness at Your Side® app	A fast, easy way to access your HAP iStrive® for Better Health account.
	HAP telehealth: Doctor Visits 24/7 app	Talk to licensed, board-certified doctors who are available 24/7 for live, secure online visits.
	HAP Member Discount App	Get savings on health and wellness-related activities and services
	Assist America app	Global emergency medical services if you're ill or injured while traveling more than 100 miles from home, or while in a foreign country

You can download these apps in Apple's app store or Google's Play app store.

ProgenyHealth®

Download the Pregnancy Mobile App Today!

Follow these easy steps to get started:

1. **Tap** the App Store logo for your mobile device and search for ***Ovia Health™***

   OR

   Scan the Apple Store or Google Play QR code to go directly to the ***Ovia Pregnancy Tracker*** app

Download on the App Store

GET IT ON Google Play

2. **Download** the ***Ovia Pregnancy Tracker*** app

3. **Open** to create your profile. Accept Ovia Health terms

4. **Choose** HAP and HAP Empowered as your *Health Plan*

5. **Complete** the Pregnancy Health Assessment

Call us today to talk to a ProgenyHealth Case Manager
TOLL FREE: 1-855-231-4730 8:30 AM - 5:00 PM
www.hap.org/maternity

hap | Progeny HEALTH®

Dental Insurance

DELTA DENTAL®

Deductible	In-Network PPO Dentist	In-Network Premier Dentist
Individual	$50 for Class II and IIi services	$50 for Class II and III services
Family	$150 for Class II and III services	$150 for Class II and III services
Maximum Benefit		
Annual Maximum	$1,000 per member per calendar year	$1,000 per member per calendar year
Orthodontia Lifetime Maximum	$1,000 per member per lifetime	$1,000 per member per lifetime
Class I Services: Preventive & Diagnostic (Deductible does not apply)		
Routine Oral Exam	100%	100%
Routine Cleanings	100%	100%
Radiographs- X-rays	100%	100%
Emergency Palliative Treatment	100%	100%
Class II Services: Basic Restorative (Deductible applies)		
Minor Restorative Services	90%	80%
Oral Surgery	90%	80%
Endodontic Services	90%	80%
Relines and Repairs	90%	80%
Periodontics Services	90%	80%
Other Basic Services	90%	80%
Class III Services: Major Restorative (Deductible applies)		
Major Restorative Services	60%	50%
Prosthodontic Services	60%	50%
Orthodontic Services		
Braces- Up to age 19	50%	50%

Delta Dental Online Resources

Manage your dental plan online with Member Portal

Member Portal gives you easy, secure online access to your benefits information 24/7. Use this free service if you have Delta Dental dental benefits for:

- **Eligibility.** Review your specific benefits, including eligibility for dependents.
- **Up-to-date benefit information.** Find current information about your benefits, such as how much of your annual maximum has been used to date, how much is still available to use, and levels of coverage for specific dental services.
- **Claims information.** Review specific claims transactions, reimbursements, payments and pre-treatment estimates. You can also print a copy of your Explanation of Benefits (EOB) statements.
- **ID Cards.** Print a copy of your ID card to give to your dentist. Please note that ID cards are not required and do not verify eligibility, although many dental offices like to keep a copy on file.
- **Paperless EOBs.** Sign up for paperless delivery of your EOB statements.
- **Dentist search.** Search for participating dentists near you.

This tool uses highly secure encryption technology to protect your personal information. All users must first register to gain access to Member Portal.

Already registered?

Need an account?

NOTE:

Member Portal has replaced Consumer Toolkit.

If you currently have a Consumer Toolkit account, your username and password for Consumer Toolkit will work for Member Portal.

Upon logging in, we will ask you to update your security questions, phone number and email address. This information will ensure you are able to access your account in the future if you forget your username or password.

Scan the QR code to view a tutorial on how to set up your member portal.

Vision Insurance

VSP Vision care for life

Services	In-Network
Eye Exam	$20 Copay
Frequency: Once every 12 months	
Lenses	
Glasses:	$20 Copay
Single Vision	Included
Bifocal	
Trifocal	
Standard Progressive	$0 Copay
Premium Progressive	$95-$105 Copay
Custom Progressive	$150-$175 Copay
Frequency: Once every 12 months	
Frames	
Allowance	$130 allowance for a wide selection of frames $180 allowance for featured frame brands 20% savings on the amount over your allowance
Frequency: Once every 24 months	
Contacts	
Contact lens exam (fitting and evaluation)	Up to $60
Allowance	$130 allowance for contacts; Copay does not apply
Frequency: Once every 12 months (in lieu of lenses)	

VSP Online Resources

Are eye exams a part of your wellness routine? If not, they should be!

There are many reasons people may put off having an eye exam. You may feel your vision is fine, feel intimidated when it comes to going to the eye doctor, aren't sure what to expect at an eye exam, or know where to start. But eye exams are about more than just vision correction—making them an essential part of your wellness routine.

Eyewear and Wellness
Did you know eye exams can help detect serious health conditions such as diabetes? Scan the QR code and get eye health tips, learn about choosing lenses, find the latest in eyewear trends, and more.

Scan the QR code to read why you need an eye exam every year and provide important information to help you feel comfortable going to the eye doctor—so you can check this essential task off your annual to-do list.

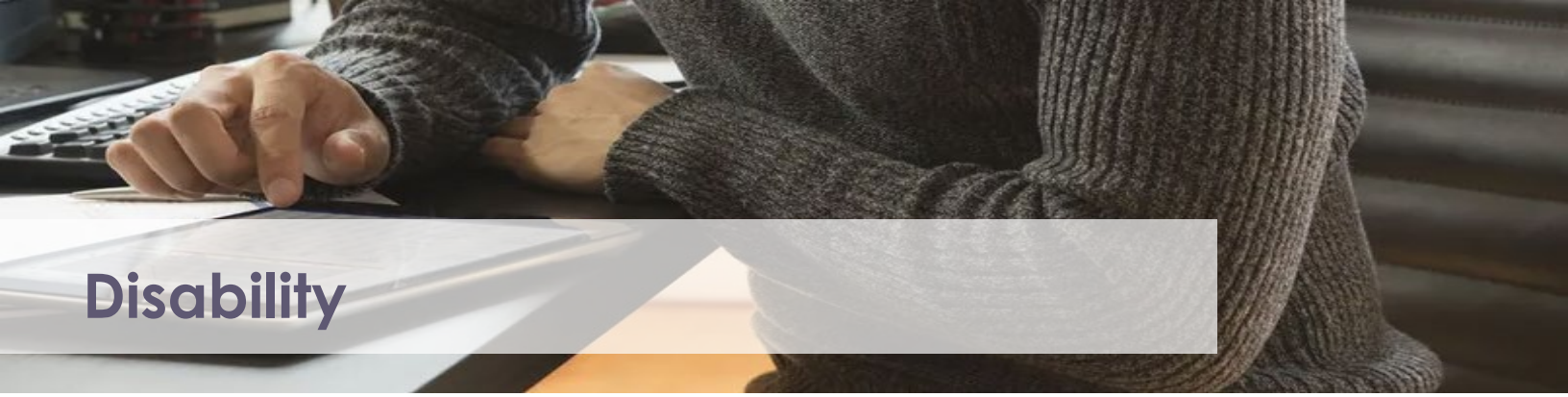
vsp™ vision care

Find a Doctor

There's no extra cost to visit a Premier Edge location. Find one near you today.

Member Log In

Create an account and log in to get personalized information about your vision coverage, access your Member ID Card, and more.



Disability

Lincoln Financial Group®

Short-Term Disability (STD)

Everyday illnesses or injuries can interfere with your ability to work. Even a few weeks away from work can make it difficult to manage household costs. Short Term Disability coverage provides financial protection for you by paying a portion of your income, so you can focus on getting better and worry less about keeping up with your bills.

Employer Funded	• Maximum weekly benefit: $500 • Benefits begin on the 1st day of total disability due to accidental injury and 8th consecutive day due to sickness • Duration of benefit: 13 weeks **Definition of Disability:** • Total disability means your inability, due to sickness or Injury, to perform each of the main duties of your own occupation. A person engaging in any employment for wage or profit is not totally disabled. The loss of a professional license, an occupational license or certification, or a driver's license for any reason does not, by itself, constitute total disability. • Partial disability means that, due to an injury or sickness, you: (1) are unable to perform one or more of the main duties of your own occupation, or are unable to perform such duties full-time; and (2) are engaged in partial disability employment.

Employee Assistance Program

Help and support for personal and work-life matters

EmployeeConnect Plus℠ gives you and your loved ones the support, resources and information you need to handle life's demands.

GuidanceConsultants℠

When going through a difficult time, having someone to talk to can make a big difference in your state of mind. You and your loved ones have access to confidential counseling from trained counselors for:

- Stress, anxiety and depression
- Relationship/marital conflicts
- Parenting questions
- Job pressures
- Grief and loss
- Substance abuse

GuidanceResources® Online

Whenever you need guidance on important life matters, visit GuidanceResources.com or download the GuidanceNow℠ mobile app. You'll find help on relationships, work, school, children, legal, financial concerns and more. You have access to:

- Timely articles, HelpSheets℠, tutorials, streaming videos and self-assessments
- "Ask the Expert" personal responses to your questions
- Child care, elder care, attorney and financial planner searches
- Pet insurance discounts and care locator

Financial services

Everyone needs a bit of financial advice now and then. With *EmployeeConnect Plus*, you can speak with a ComPsych® financial expert to discuss:

- Managing personal financial challenges
- Credit card and debt management
- Budgeting
- Tax questions
- Financing for college
- Estate planning
- Investment options
- Mortgages, loans and refinancing
- Retirement planning

Lincoln Financial Group®

Your employer offers this service at no additional cost to you! Available to you, your spouse and your dependents.

You get

Unlimited phone access to legal, financial and work-life services

In-person help with short-term issues

Up to six in-person sessions per person, per issue, per year

EmployeeConnect Plus℠

EMPLOYEE ASSISTANCE PROGRAM SERVICES

24 hours a day, 7 days a week. Call 855-327-4463, or visit us online at www.GuidanceResources.com (Web ID = Lincoln)

- Family
- Parenting
- Addictions
- Emotional
- Legal
- Financial
- Relationships
- Stress

Federal Mandated Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, contact the Plan Administrator.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, 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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Iman Alkhalaf, HR Coordinator, 248-327-7673, iman.alkhalaf@emanschools.net.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

HIPAA NOTICE OF PRIVACY PRACTICES

This notice of privacy practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. HIPAA requires us to provide this Notice of Privacy Practices to you.

Federal Mandated Notices

The HIPAA Privacy Rule protects certain medical information known as “protected health information.” Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

- your past, present or future physical or mental health or condition;
- providing health care to you; or
- making past, present or future payments for providing health care to you.

If you have any questions about this Notice or about our privacy practices, please contact Iman Alkhalaf, HR Coordinator, 248-327-7673, iman.alkhalaf@emanschools.net.

Effective Date
This Notice is effective 10/10/2023.

Our Responsibilities
We are required by law to:

- maintain the privacy of your protected health information;
- notify you of any breach of unsecured protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

How We May Use and Disclose Your Protected Health Information
We may use or disclose your protected health information in certain situations without your permission.
The main reasons for which we may use and may disclose your Protected Health Insurance are to evaluate and process any requests for coverage and claims for benefits. Your Protected Health Information (PHI) may be used:

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may share your protected health information with health care provider in connection with the payment of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for plan operations. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. If medical information is used for underwriting, genetic information may not and will not be used or disclosed for this purpose.

Federal Mandated Notices

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to follow appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

To Plan Sponsors. We may disclose protected health information to certain employees of the Employer so that they can administer the plan. Those employees will only use or disclose PHI as needed to perform plan administration functions or as otherwise required by HIPAA, unless you have specifically authorized other disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

Special Situations
Although unlikely, it is also possible that we may use and disclose your protected health information in these situations:

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs.
Public Health Risks. We may disclose your protected health information for public health actions. These actions generally would be:

- to prevent or control disease, injury, or disability;
- to report births and deaths;

Federal Mandated Notices

- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Research. We may disclose your protected health information to researchers when:

- the individual identifiers have been removed; or
- when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

We are required to make disclosures of your protected health information in these situations:

Government Audits. We must disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. If you request, we must disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. If you request, we also must provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed due to your specific authorization.

- you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or
- treating such person as your personal representative could endanger you; and
- in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative

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Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

To request restrictions, you must make your request in writing to the Employer Contact listed at the end of this Notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Employer Contact listed at the end of this Notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Employer Contact listed at the end of this Notice.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., if you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact Iman Alkhalaf, HR Coordinator,
248-327-7673, iman.alkhalaf@emanschools.net. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

We may change the terms of this Notice and make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any significant change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by regular mail and/or electronically.

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Employer Contact: Iman Alkhalaf
HR Coordinator
P: 248-327-7673
E: iman.alkhalaf@emanschools.net

Date: 10/10/2023

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

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

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to EMAN, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

Notice Procedure
Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. Electronic notices (email or fax) are not acceptable. COBRA Continuation coverage for the Plan is administered by a COBRA Administrator. You must therefore, mail all notices to the COBRA Administrator at the following address:

Iman Alkhalaf
EMAN
27704 Franklin Rd
Oakland, MI 49034
Iman.alkhalaf@emanschools.net

Your notice must be complete and must be postmarked no later than the last day of the required notice period. Any notice you provide must state the name and address of the Employer, the name of the group health plan, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the signature, name and contact information of the individual sending the notice. Your notice must also name the qualifying event and the date it happened.

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If the qualifying event is a divorce, your notice must include a copy of the divorce decree.
Your notice of a child's loss of dependent status must include documentation of the date of the qualifying event (i.e. a birth certificate). This will allow the Plan Administrator to determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA.

Your notice of a second qualifying event must also name the event and the date it happened. If the second qualifying event is a divorce, your notice must include a copy of the divorce decree.
Your notice of disability or cessation of disability must also include the name of the disabled qualified beneficiary, the date when the qualified beneficiary became disabled or ceased to be disabled and the date the Social Security Administration made its determination.
Your notice of disability or cessation of disability must include a copy of the Social Security Administration's determination.

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

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. This notice must be postmarked within 60 days of the determination and should be sent along with a copy of the Social Security Administration's determination to the COBRA administrator at the following address:

Flex Administrators
3980 Chicago Dr SW #230
Grandville, MI 49418

If there is a final determination that the qualified beneficiary is no longer disabled, the qualified beneficiary must notify the Plan Administrator within 30 days of the final determination. In this event, continuation coverage for the additional 11-month period for the disabled qualified beneficiary and the qualified beneficiaries who are his or her dependents will terminate as of the first day of the month beginning more than 30 days after the date of the final determination, or on the date continuation coverage would otherwise terminate.

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

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

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In all of the cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the COBRA administrator at the following address:

Flex Administrators
3980 Chicago Dr SW #230
Grandville, MI 49418

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

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

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

Plan contact information

Plan Administrator:	COBRA Administrator:
EMAN	Flex Administrators
27704 Franklin Rd	3980 Chicago Dr SW #230
Oakland, MI 49034	Grandville, MI 49418
248-327-7673	616-456-7908

PATIENT PROTECTION DISCLOSURE

Health Alliance Plan (HAP) generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, HAP designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact:

Health Alliance Plan (HAP)
www.hap.org
800-422-4641

For children, you may designate a pediatrician as the primary care provider.

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You do not need prior authorization from Health Alliance Plan (HAP) or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact:

Health Alliance Plan (HAP)
www.hap.org
800-422-4641

Federal Mandated Notices

Notice of Qualified Health Coverage for Purposes of Michigan No-Fault Auto Law (Michigan Residents Only)

This Notice contains important information that you'll need to know when you purchase or renew an auto insurance policy in the State of Michigan. You should show this Notice to your auto insurance agent so that he or she can help you construct a policy that meets your needs.
Under Michigan no-fault auto law, when you purchase or renew your auto insurance policy you won't automatically receive unlimited, lifetime Personal Insurance Protection (PIP) medical coverage. Instead, you'll be able to choose from a menu of PIP medical coverage levels. Your auto insurance agent will be able to explain the pros and cons of each one. When considering how much PIP medical coverage to purchase, it's critical to keep these points in mind:

• As of November 1, 2023, Education Management & Networks health plan (the "Plan") pays primary on Michigan enrollees' auto-related claims, and given current deductible requirements constitutes "qualified health coverage" as defined in Michigan Compiled Laws 500.3107d(7)(b)(i).

• Coverage of auto accident-related claims under any employment-based plan is available only as long as you remain employed/enrolled AND that plan continues to cover Michigan enrollees' auto claims. In contrast, the amount of PIP medical coverage on your policy at the time of an auto accident remains available to you until the maximum payout per accident (if any) is exhausted, no matter how long that takes.

• Most types of care are covered under both the Plan and PIP medical. However, PIP medical covers additional services that employment-based plans typically do not. Your auto insurance agent can explain what those services are.

You're urged to carry enough PIP coverage on your auto policy to protect yourself and your family from financial catastrophe in the event that there are claims for auto accident-related services that the Plan doesn't cover, or if you or any of your family members cease to be enrolled in the Plan.
Contact your auto insurance agent immediately if you or any of your family members cease to be enrolled in the Plan, or if the Plan ceases to constitute "qualified health coverage." An adjustment to your auto policy may be required, and you may have a limited amount of time to make it.
NOTE: This Notice is correct at the time of this writing but may not reflect recent changes to plan coverage.

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Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

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You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the U.S. Department of Labor at (866) 444-3272 or the Michigan Department of Insurance and Financial Services at (833) 275-3437/

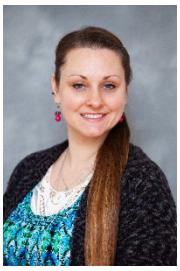
Visit www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

Visit www.michigan.gov/difs/0,5269,7-303-13222_13250-561696--,00.html for more information about your rights under Michigan law.

Patient Advocacy

Call to speak with a Patient Advocate to:

- Navigate your healthcare bills
- Understand your EOBs
- Assist with pharmacy charges












We find the errors, contact the provider and insurance carriers to resolve any misbillings that can cost you money.
We've saved members **$13 million** dollars from misbilled claims

NEED HELP WITH CLAIMS ISSUES?

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