



378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorioles.com



Benefits Summary

Prepared for Charlotte Public Schools
July 2024



NIS

National Insurance Services

Client Focused. Solution Driven.

NIS Corporate Headquarters: 250 North Corporate Drive, Suite 300, Brookfield, WI 53045-5804

Offices Nationwide: 800.627.3660 | www.NISBenefits.com

Our Employees Are Our Most Valuable Asset

At Charlotte Public Schools, we are committed to offering a comprehensive employee benefits program that helps our employees stay healthy, feel secure, and maintain a work-life balance.

Stay Healthy

- Medical, Dental, Vision
- Flexible Spending Accounts
- Health Savings Accounts
- Healthiest You

Feeling Secure

- Disability Insurance
- Life and Accidental Death & Dismemberment Insurance
- Retirement Benefits

Work-Life Balance

- Employee Assistance Program
- Paid Time Off
- Pet Insurance
- Voluntary Benefits



Contact Information for Benefit Vendors

Health Insurance.....6

Blue Cross Blue Shield of Michigan
313-225-9000
www.bcbsm.com

Healthiest You.....27

866-703-1259
<https://member.healthiestyou.com/login>

Prescription Coverage.....34

EHIM
800-311-3446
www.ehimrx.com

Elect Rx
855-353-2879
www.electrx.com

Health Savings Account.....39

Independent Bank
800-355-0641
www.independentbank.com

Dental Insurance.....41

ADN
248-901-3705
www.adndental.com



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Vision Insurance.....	44
NVA	
800-672-7723	
www.e-nva.com	
Long Term Disability Insurance.....	48
Madison National Life	
800-356-9601	
www.madisonlife.com	
Life and AD&D Insurance.....	50
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800-356-9601	
www.madisonlife.com	
Flexible Spending Account.....	52
Varipro	
800-732-3412	
www.varipro.com	
Employee Assistance Program.....	55
LifeWorks	
866-451-5465	
www.niseap.com	
Pet Insurance.....	59
Pet Partners	
866-774-1113	
www.petpartners.com	



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Voluntary Benefits.....59

Horace Mann
800-999-1030
www.horacemann.com

Long Term Care.....59

Trustmark
800-918-8877
www.trustmarkbenefits.com

Retirement Benefits.....68

Office of Retirement Services
800-381-5111
www.Michigan.gov/orsschools

403(b) and 457(b): US OMNI & TSA Consulting Group Compliance Services
888-796-3786
www.tsacg.com

Michigan Retirement Investment Consortium
616-365-2218
<https://mric.myfinancialwellnesscenter.com>



Health Insurance & Prescription Coverage

Who is Eligible and When:

Employees working 30+ hours per week effective first of the month following date of hire or by collective bargaining agreement

Medical Carrier Name and Website Address

Blue Cross Blue Shield of Michigan

www.bcbsm.com

Prescription Provider Name and Website Address

EHIM

www.ehimrx.com

Benefits You Receive:

See attached benefit summary





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517-541-5100

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Health Plan Option 1

Simply Blue PPO HSA \$1,600/3,200

\$10/\$40/\$80 Prescription



A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

CHARLOTTE PUBLIC SCHOOLS

0070034170008 - 0B6V0

Effective Date: 07/01/2024

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Note: A list of services that require approval **before** they are provided is available online at bcbsm.com/importantinfo. Select **Approving covered services**.

Pricing information for various procedures by in-network providers can be obtained by calling the customer service number listed on the back of your BCBSM ID card and providing the procedure code. Your provider can also provide this information upon request.

Preauthorization for Specialty Pharmaceuticals - BCBSM will pay for FDA-approved specialty pharmaceuticals that meet BCBSM's medical policy criteria for treatment of the condition. The prescribing physician must contact BCBSM to request preauthorization of the drugs. If preauthorization is not sought, BCBSM will deny the claim and all charges will be the member's responsibility.

Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "low access area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Eligibility Information

Member	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> Subscriber's legal spouse Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Note: Member cost-sharing requirements are administered on a plan year basis. Your plan year begins on July 1 and ends the following year on June 30.

Benefits	In-network	Out-of-network
Deductibles Note: Your deductible combines deductible amounts paid under your Simply Blue HSA medical coverage and your prescription drug coverage under another insurer. Note: The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.	\$1,600 for a one-person contract or \$3,200 for a family contract (two or more members) each benefit year (no 4th quarter carry-over) Deductibles are based on amounts defined annually by the federal government for Simply Blue HSA-related health plans. Deductibles may increase annually. Please call your customer service center for an annual update.	\$3,200 for a one-person contract or \$6,400 for a family contract (two or more members) each benefit year (no 4th quarter carry-over)
Flat-dollar copays	None	None
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	None	<ul style="list-style-type: none"> 20% of approved amount for most covered services
Annual out-of-pocket maximums - applies to deductibles and coinsurance amounts for all covered services Note: Your annual out-of-pocket maximum include amounts you paid for covered services under your BCBSM certificate and your prescription drug coverage under another insurer.	\$4,000 for a one-person contract or \$8,000 for a family contract (two or more members) each benefit year	\$8,000 for a one-person contract or \$16,000 for a family contract (two or more members) each benefit year
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per benefit year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered

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Benefits	In-network	Out-of-network
Gynecological exam	100% (no deductible or copay/coinsurance), two per member per benefit year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per benefit year	Not covered
Voluntary sterilization of female reproductive organs	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Well-baby and Well-child visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per benefit year under the health maintenance exam benefit 	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per benefit year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per benefit year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per benefit year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	80% after out-of-network deductible Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
One per member per benefit year		

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Benefits	In-network	Out-of-network
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for routine colonoscopy Note: Medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.	80% after out-of-network deductible
One per member per benefit year		

Physician office services		
Benefits	In-network	Out-of-network
Office visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Online visits - by physician must be medically necessary Note: Online visits by a vendor are not covered. Not all services delivered virtually are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the applicable cost share associated with the service provided.	100% after in-network deductible	80% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Office consultations - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible
Urgent care visits - must be medically necessary	100% after in-network deductible	80% after out-of-network deductible

Emergency medical care		
Benefits	In-network	Out-of-network
Hospital emergency room	100% after in-network deductible	100% after in-network deductible
Ambulance services - must be medically necessary	100% after in-network deductible	100% after in-network deductible

Diagnostic services		
Benefits	In-network	Out-of-network
Laboratory and pathology services	100% after in-network deductible	80% after out-of-network deductible
Diagnostic tests and x-rays	100% after in-network deductible	80% after out-of-network deductible
Therapeutic radiology	100% after in-network deductible	80% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife		
Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible

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Benefits	In-network	Out-of-network
Postnatal care	100% (no deductible or copay/coinsurance)	80% after out-of-network deductible
Delivery and nursery care	100% after in-network deductible	80% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	100% after in-network deductible	80% after out-of-network deductible
	Unlimited days	

Note: Nonemergency services must be rendered in a **participating** hospital.

Inpatient consultations	100% after in-network deductible	80% after out-of-network deductible
Chemotherapy	100% after in-network deductible	80% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	100% after in-network deductible	100% after in-network deductible
	Limited to a maximum of 90 days per member, per benefit year	
Hospice care	100% after in-network deductible	100% after in-network deductible
	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	
Home health care:	100% after in-network deductible	100% after in-network deductible
<ul style="list-style-type: none"> must be medically necessary must be provided by a participating home health care agency 		
Infusion therapy:	100% after in-network deductible	100% after in-network deductible
<ul style="list-style-type: none"> must be medically necessary must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) may use drugs that require preauthorization - consult with your doctor 		

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible

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Benefits	In-network	Out-of-network
Voluntary sterilization of male reproductive organs	100% after in-network deductible	80% after out-of-network deductible
Note: For voluntary sterilization of female reproductive organs, see "Preventive care services."		
Voluntary abortions	100% after in-network deductible	80% after out-of-network deductible

Human organ transplants		
Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	100% after in-network deductible - in designated facilities only
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% after in-network deductible	80% after out-of-network deductible
Specified oncology clinical trials	100% after in-network deductible	80% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	100% after in-network deductible	80% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)		
Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance use disorder treatment	100% after in-network deductible	80% after out-of-network deductible
Unlimited days		
Residential psychiatric treatment facility: <ul style="list-style-type: none"> covered mental health services must be performed in a residential treatment facility treatment must be preauthorized subject to medical criteria 	100% after in-network deductible	80% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic 	100% after in-network deductible	100% after in-network deductible in participating facilities only
<ul style="list-style-type: none"> Online visits Note: Online visits by a vendor are not covered.	100% after in-network deductible	80% after out-of-network deductible
<ul style="list-style-type: none"> Physician's office 	100% after in-network deductible	80% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities only	100% after in-network deductible	80% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

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Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavior analysis (ABA) treatment - when rendered by an approved licensed behavior analyst - subject to preauthorization	100% after in-network deductible	100% after in-network deductible
Note: Prior to seeking ABA treatment, the member must be evaluated by an interdisciplinary team including, but not limited to, a physician, behavioral health specialist, and a speech and language specialist for the services to be authorized. This interdisciplinary evaluation can be performed at an approved autism evaluation center (AAEC).		
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible
	Physical, speech and occupational therapy with an autism diagnosis is unlimited	
Other covered services, including nutritional counseling and mental health services, for autism spectrum disorder	100% after in-network deductible	80% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)	100% after in-network deductible	80% after out-of-network deductible
Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider.		
Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.		
Allergy testing and therapy	100% after in-network deductible	80% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	100% after in-network deductible	80% after out-of-network deductible
	Limited to a 38-visit maximum per member per benefit year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	100% after in-network deductible	80% after out-of-network deductible
		Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a combined 60-visit maximum per member, per benefit year	
Durable medical equipment	100% after in-network deductible	100% after in-network deductible
Note: DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM.		
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing care	100% after in-network deductible	80% after out-of-network deductible
Prescription drugs	Not covered	Not covered

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Hearing Care Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Member's responsibility (deductible and copay)

Benefits	Participating provider	Nonparticipating provider
Deductible Note: You are required to meet the annual calendar year deductible under your Simply Blue HSA coverage <u>before</u> using your hearing care benefits	Your Simply Blue HSA hearing care benefits are subject to the same deductible required under your Simply Blue HSA medical coverage. Hearing care benefits are not payable until after you have met the Simply Blue HSA annual deductible.	Not applicable
Copay/coinsurance	Your Simply Blue HSA hearing care benefits are subject to the same coinsurance required under your Simply Blue HSA medical coverage.	Not applicable

Covered services

You **must** receive the following services from a **hearing participating provider**. Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan **and** the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services. In this case, BCBSM will pay the approved amount for hearing aids and related covered services obtained from a nonparticipating provider. You may be responsible for charges that exceed our approved amount.

If you select a digitally controlled programmable hearing device, you may be responsible for charges that exceed the cost of a covered hearing aid.

Benefits	Participating provider	Nonparticipating provider
Audiometric exam - one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Hearing aid evaluation- one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Ordering and fitting the hearing aid (a monaural hearing aid only) - one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Hearing aid conformity test- one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered

Note: You **must** obtain a medical evaluation (sometimes called a medical clearance exam) of the ear performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. **This evaluation is not covered under your hearing care coverage, so you must pay for this exam unless your medical coverage includes coverage for office visits.**

A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified or in the process of being board certified as an otolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.

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Health Plan Option 2

Simply Blue PPO HSA \$2,000/\$4,000

\$10/\$40/\$80 Prescription



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CHARLOTTE PUBLIC SCHOOLS

0070034170009 - 09G95

Effective Date: 07/01/2023

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Specialty pharmaceuticals are biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include medications to treat asthma, rheumatoid arthritis, multiple sclerosis, and many other diseases as well as chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.

Blue Cross provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

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Services from a provider for which there is no Michigan PPO network and services from an out-of-network provider in a geographic area of Michigan deemed a "lowaccess area" by BCBSM for that particular provider specialty are covered at the in-network benefit level. If you receive care from a nonparticipating provider, even when referred, you may be billed for the difference between our approved amount and the provider's charge.

Eligibility Information

Member	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> Subscriber's legal spouse Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Note: If an in-network provider refers you to an out-of-network provider, all covered services obtained from that out-of-network provider will be subject to applicable out-of-network cost-sharing.

Note: Member cost-sharing requirements are administered on a plan year basis. Your plan year begins on July 1 and ends the following year on June 30.

Benefits	In-network	Out-of-network
Deductibles Note: Your deductible combines deductible amounts paid under your Simply Blue HSA medical coverage and your prescription drug coverage under another insurer. Note: The full family deductible must be met under a two-person or family contract before benefits are paid for any person on the contract.	\$2,000 for a one-person contract or \$4,000 for a family contract (two or more members) each benefit year (no 4th quarter carry-over)	\$4,000 for a one-person contract or \$8,000 for a family contract (two or more members) each benefit year (no 4th quarter carry-over)
Flat-dollar copays	None	None
Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	<ul style="list-style-type: none"> 20% of approved amount for most covered services 	<ul style="list-style-type: none"> 40% of approved amount for most covered services
Annual out-of-pocket maximums - applies to deductibles and coinsurance amounts for all covered services Note: Your annual out-of-pocket maximum include amounts you paid for covered services under your BCBSM certificate and your prescription drug coverage under another insurer.	\$4,000 for a one-person contract or \$8,000 for a family contract (two or more members) each benefit year	\$8,000 for a one-person contract or \$16,000 for a family contract (two or more members) each benefit year
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per benefit year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), two per member per benefit year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered

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Benefits	In-network	Out-of-network
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per benefit year	Not covered
Voluntary sterilizations for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> 8 visits, birth through 12 months 6 visits, 13 months through 23 months 6 visits, 24 months through 35 months 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per benefit year under the health maintenance exam benefit 	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per benefit year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per benefit year	Not covered
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per benefit year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) <p>Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable.</p>	60% after out-of-network deductible <p>Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.</p>
	One per member per benefit year	
Routine screening colonoscopy	100% (no deductible or copay/coinsurance) for routine colonoscopy <p>Note: Medically necessary colonoscopies performed during the same calendar year are subject to your deductible and coinsurance, if applicable.</p>	60% after out-of-network deductible
	One per member per benefit year	

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Physician office services		
Benefits	In-network	Out-of-network
Office visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Online visits - by physician must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Note: Online visits by a vendor are not covered.		
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Urgent care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible

Emergency medical care		
Benefits	In-network	Out-of-network
Hospital emergency room	80% after in-network deductible	80% after in-network deductible
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services		
Benefits	In-network	Out-of-network
Laboratory and pathology services	80% after in-network deductible	60% after out-of-network deductible
Diagnostic tests and x-rays	80% after in-network deductible	60% after out-of-network deductible
Therapeutic radiology	80% after in-network deductible	60% after out-of-network deductible

Maternity services provided by a physician or certified nurse midwife		
Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

Hospital care		
Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	80% after in-network deductible	60% after out-of-network deductible
		Unlimited days

Note: Nonemergency services must be rendered in a participating hospital.

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Benefits	In-network	Out-of-network
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	80% after in-network deductible Limited to a maximum of 90 days per member, per benefit year	80% after in-network deductible
Hospice care	80% after in-network deductible Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)	80% after in-network deductible
Home health care: • must be medically necessary • must be provided by a participating home health care agency	80% after in-network deductible	80% after in-network deductible
Infusion therapy: • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor	80% after in-network deductible	80% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	80% after in-network deductible	60% after out-of-network deductible
Voluntary sterilization for males	80% after in-network deductible	60% after out-of-network deductible
Note: For voluntary sterilizations for females, see " Preventive care services. "		
Voluntary abortions	80% after in-network deductible	60% after out-of-network deductible

Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	80% after in-network deductible - in designated facilities only
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible

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Benefits	In-network	Out-of-network
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance treatment	80% after in-network deductible	60% after out-of-network deductible
Unlimited days		
Residential psychiatric treatment facility: <ul style="list-style-type: none"> covered mental health services must be performed in a residential treatment facility treatment must be preauthorized subject to medical criteria 	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic 	80% after in-network deductible	80% after in-network deductible in participating facilities only
<ul style="list-style-type: none"> Online visits 	80% after in-network deductible	60% after out-of-network deductible
Note: Online visits by a vendor are not covered.		
<ul style="list-style-type: none"> Physician's office 	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities only	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavior analysis (ABA) treatment - when rendered by an approved licensed behavior analyst - subject to preauthorization	80% after in-network deductible	80% after in-network deductible
Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.		
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
Physical, speech and occupational therapy with an autism diagnosis is unlimited		
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

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Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP) Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.	80% after in-network deductible	60% after out-of-network deductible
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	80% after in-network deductible	60% after out-of-network deductible
Limited to a 38-visit maximum per member per benefit year		
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
Limited to a combined 60-visit maximum per member, per benefit year		
Durable medical equipment Note: DME items required under the preventive benefit provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that PPACA requires to be covered at 100%, call BCBSM.	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	80% after in-network deductible	60% after out-of-network deductible
Prescription drugs	Not covered	Not covered

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Hearing Care Coverage

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits please see the applicable BCBSM certificates and riders, if your group is underwritten. If your group is self-funded, please see any other plan documents your group uses. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Member's responsibility (deductible and copay)

Benefits	Participating provider	Nonparticipating provider
Deductible Note: You are required to meet the annual calendar year deductible under your Simply Blue HSA coverage <u>before</u> using your hearing care benefits	Your Simply Blue HSA hearing care benefits are subject to the same deductible required under your Simply Blue HSA medical coverage. Hearing care benefits are not payable until after you have met the Simply Blue HSA annual deductible.	Not applicable
Copay/coinsurance	Your Simply Blue HSA hearing care benefits are subject to the same coinsurance required under your Simply Blue HSA medical coverage.	Not applicable

Covered services

You **must** receive the following services from a **hearing participating provider**. Hearing care services are **not** covered when performed by nonparticipating providers unless the services are performed outside of Michigan **and** the local Blue Cross and Blue Shield plan does **not** contract with providers for hearing care services. In this case, BCBSM will pay the approved amount for hearing aids and related covered services obtained from a nonparticipating provider. You may be responsible for charges that exceed our approved amount.

If you select a digitally controlled programmable hearing device, you may be responsible for charges that exceed the cost of a covered hearing aid.

Benefits	Participating provider	Nonparticipating provider
Audiometric exam - one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Hearing aid evaluation- one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Ordering and fitting the hearing aid (a monaural hearing aid only) - one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered
Hearing aid conformity test- one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered

Note: You **must** obtain a medical evaluation (sometimes called a medical clearance exam) of the ear performed by a physician-specialist before you receive your hearing aid. If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation. **This evaluation is not covered under your hearing care coverage, so you must pay for this exam unless your medical coverage includes coverage for office visits.**

A physician-specialist is a licensed doctor of medicine or osteopathy who is also board certified or in the process of being board certified as an otolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.

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Connect with a licensed therapist by phone/video. Explore skill building
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Relieve your back pain through guided videos with a certified
health coach



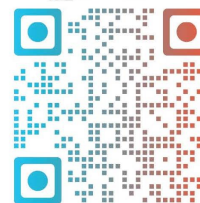
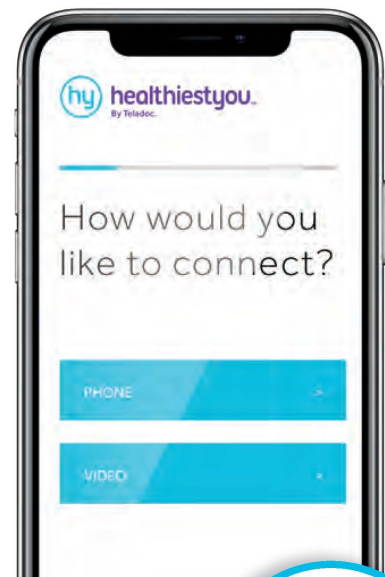
Dermatology **\$0 visit fee - Unlimited Visits**

Upload photos of your condition to the app and get a treatment
plan from a dermatologist within two business days



Nutrition **\$0 visit fee - Unlimited Visits**

Connect with a certified dietitian and start
meeting your nutrition goals today!



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app today.

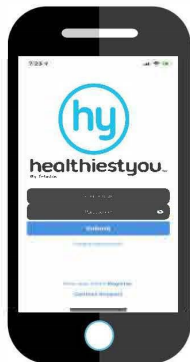


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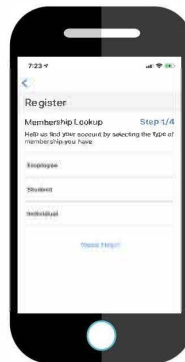
HealthiestYou is now part of Teladoc Health, the global leader in virtual care. Teladoc Health, Inc., on its own behalf and on behalf of its affiliates and/or wholly owned subsidiaries including but not limited to Best Doctors, Inc.; HealthiestYou, Inc.; Teladoc Physicians, P.A., and Teladoc Behavioral Health, P.A. (collectively referred to as "Teladoc Health," "we," "us," or "our"), owns and operates the websites located at www.teladoc.com, www.bestdoctors.com, www.askbestdoctor.com, members.bestdoctors.com, www.healthiestyou.com, and various mobile applications (collectively, the "site" or "sites"). Through these sites we operate various online services that enable eligible individuals ("members") to receive various types of healthcare information and telehealth services ("services"). The sites also have public portions that allow anyone to educate themselves on the services available from Teladoc Health. 10E-207B_249105700_07272018

How to register and get started with **HealthiestYou!**



Step 1

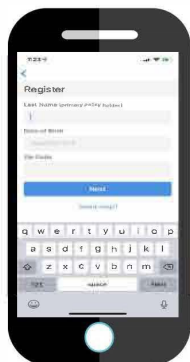
Search and download
“HealthiestYou” or “HY” in
the app store or Google Play!
Available on your iPhone or
Android devices!



Step 2

Select “First time here? Register
Now”. Select employee as your
membership type.

You will not be able to register
until your start date



Step 3

Enter the Primary Member's
Information:

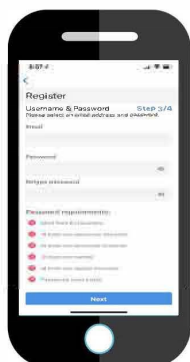
- Last Name
- D.O.B.
- Zip Code



Step 4

A list of names associated with the
account will appear. Select your
name.

- Dependents under 18 will appear
on the primary member's profile.
- Dependents over 18 will need to
register their own account with a
separate email.



Step 5

Enter in a valid email address
and password.

Password must meet the listed
requirements.



Step 6

Enter in the best number to reach
you. Our doctors will use this num-
ber to contact you.

Select your preferred language.

Click “I Accept Terms & Conditions.”

Click Finish.

**Download the App
Today!**

member.healthiestyou.com

Need A Doctor? 866-703-1259 x1

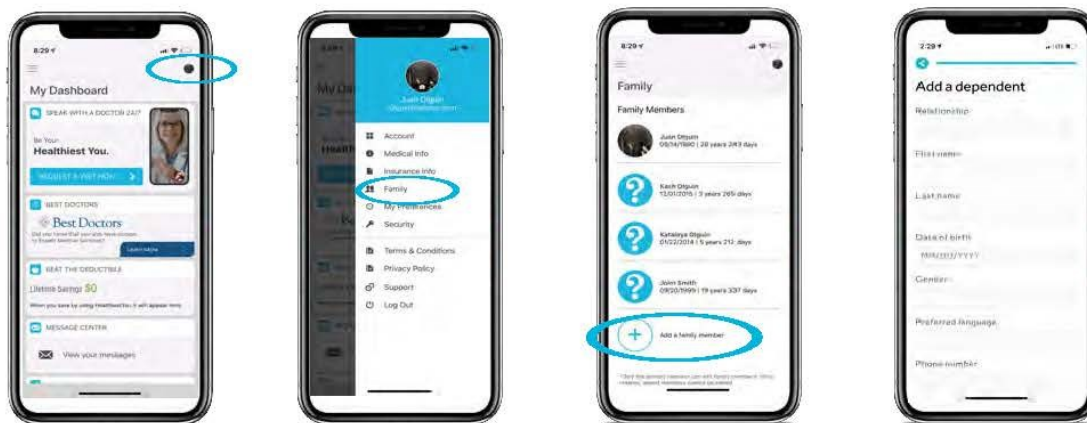
Account Help? 866-703-1259 x3



How to add dependents to your HealthiestYou account using the mobile app.

1. Open the "HealthiestYou" app and select the icon in the upper right hand corner.
2. Select "Family". The app will show display the names of anyone listed on your account.
3. Select "Add a Family member" to add a Spouse/Dependent that is not listed.
4. Complete the required fields. Once saved, your Spouse/Dependent will now be able to register their own mobile app profile.

Spouses and dependents over the age of 18, must register their own account using a separate email.



NOTE: Any Spouse/Dependent that is added, will need to wait 24 hours to become effective.

Set up your account today

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HealthiestYou

Frequently Asked Questions

What is HealthiestYou?

HealthiestYou is a healthcare service that offers convenient, confidential access to quality doctors 24/7, anytime, anywhere.

By scheduling a visit with one of our U.S. board-certified and licensed medical doctors, you can be diagnosed, treated, and prescribed medication if necessary.

What can I use HealthiestYou for?

HealthiestYou can help you with everyday, non-emergency healthcare issues, including sinus problems, allergies, flu symptoms, and much more. Skip the waiting room and the trip to the ER. We're here to help you feel better, faster, and get you back to living your life.

Does HealthiestYou replace my doctor?

No. HealthiestYou doesn't replace your primary care doctor. HealthiestYou should be used for non-emergency illnesses when it is not convenient to get to the doctor or it is outside of regular office hours.

How do I set up my account?

Download the HealthiestYou app, visit the website, or call the number below to set up your account.

Do I need to have my insurance information available?

No. HealthiestYou is a separate benefit, and your insurance information is not required to have a visit.

How do I access HealthiestYou?

The service can be accessed by app, web, or phone, and visits are available by phone or video.

Can my family use HealthiestYou?

This varies depending on your specific HealthiestYou plan. Most plan designs allow you to use the HealthiestYou service for you, your spouse, and your dependents. Dependents over 18 years old must call our service center to request a visit. For dependents under 18 years old, the primary account holder must request a visit on their behalf through the app, website, or by phone.

How much does it cost?

Free—there are no visit fees when using HealthiestYou for everyday medical care.

Is there a time limit when talking to the doctor? And am I charged more for taking longer?

There is no time limit for visits, and there is no extra charge for longer doctor visits.

Who are the HealthiestYou doctors?

HealthiestYou doctors are U.S. board-certified internists, family doctors, and pediatricians. They average 20 years of experience and are licensed to practice in your state.

Can HealthiestYou physicians prescribe medications?

Yes, when medically appropriate, doctors can prescribe medications. If a prescription is not required, the doctor may provide the member with instructions for managing symptoms or following up with their primary care doctor.

Can my primary care doctor get a record of my HealthiestYou visit?

With your consent, we'll send an electronic copy of your HealthiestYou visit to your primary care doctor.

Can I use HealthiestYou while traveling?

HealthiestYou is available in all 50 states, so you can use the service while traveling within the United States. Some restrictions may apply.

Who should I contact if I have questions or encounter an issue?

We aim to make your experience with us as seamless as possible. If you have any further questions or encounter an issue, please visit our website at HealthiestYou.com or call our member services team at 1-866-703-1259.



Download the app to talk to a doctor 24/7

Visit HealthiestYou.com

Call 1-866-703-1259 | Download the app  

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378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorioles.com

Prescription Coverage

EHIM

\$10/\$40/80 Prescription

Effective: 07/01/2023

Please note that your prescription benefits are going to be changing. This summary highlights the changes that will take effect. In addition to the plan changes, we have summarized your current prescription benefit in its entirety for your reference.

Summary of Changes

- New OOP Maximum due to move to BCBS.
- Members will receive EHIM ID Cards.

Summary of Copayments

Copayments are the dollar amount which will be collected at the pharmacy every time you receive a prescription. Generally, your copayment will be the lowest for generic prescriptions and highest for medications that are considered Non-Preferred under your plan design. Below highlights your plan's copay levels:

Customer Service

800-311-3446 • 24/7/365

As a reminder, EHIM's main goal is that our members receive the best customer service possible. Your understanding of your prescription benefit plan is most important to EHIM. We strongly encourage you to ask as many questions regarding your coverage so there are no surprises as you fill your prescriptions at the pharmacy. For your convenience, our help desk has a representative available **24 hours a day, 7 days a week, 365 days a year.**

\$10	Copayment on any generic medication
\$40	Copayment on any Preferred Brand Medication
\$80	Copayment on any Non-Preferred Brand Medication
\$80	Copayment on any Multi-Source Brand Medication (Brand Name Drugs that are dispensed when an exact generic is available) The <i>physician</i> will indicate "DAW" or "Dispense as Written" on the prescription.
\$80	Copayment plus the difference in cost between the brand & generic on any Multi-Source Brand Prescription (Brand Name Drugs that are dispensed when an exact generic is available) The <i>patient</i> indicates the brand to be dispensed. DAW penalty does not count towards the OOP Max
\$10	Copayment on any medication covered under the EHIM OTC program
Generic 2x Brand 2x NP Brand 2x	Standard Copayment for all eligible maintenance medication filled in a three month supply. Brand & Generic eligible maintenance medications can be filled through the Local Retail Pharmacy or through Mail Order in order to obtain them in a 3 month supply.
Single \$4,000 Family \$8,000	Out of Pocket Maximum: Once a member/contract spends the maximum in medical spend and pharmacy copays that member/contract will have a \$0 copay on all covered medications for the rest of the plan year. One person in a 2-person/Family contract can meet the full family amount.

Important Note Regarding Copayments: Any form of patient assistance (e.g. manufacturers' coupons, copay cards, copay assistance program) will NOT be considered as true-out-of-pocket costs for members and will NOT accumulate toward member deductibles and out-of-pocket maximums.

Please note: The Copays listed above apply once the combined Medical/Rx deductible has been satisfied and are the same regardless of HSA Plan.

Quantity Limits for Certain Medications

Certain medications under your program may be subject to quantity limits. Medications that are subject to quantity limits are to help ensure these medications are not utilized inappropriately or recommended maximum dosages are not exceeded. EHIM's Quantity Limitations are based on FDA-approved dosing recommendations, pharmaceutical guidelines and have been reviewed and approved by our licensed, clinical staff.

Alliance Walgreen's + Prime Mail Order

EHIM offers a mail order program through Alliance Walgreen's + Prime Mail Order which allows you to receive a three month supply (61-90 days maximum) for the plan's designated number of copays. The program includes maintenance medications covered under the Prescription Plan. Prescriptions can be ordered through the Alliance Walgreen's + Prime website (www.walgreens.com/mailorder) or by completing a hard copy prescription order form. You must complete a registration form for Alliance Walgreen's + Prime prior to your prescription being filled. Included in the mail order brochure are step by step instructions on how to fill your first prescription. You may contact EHIM at 800-311-3446 for assistance with registering with Alliance Walgreen's + Prime, or you may contact Alliance Walgreen's + Prime directly at 800-345-1985.

Non-Preferred Drug List

Some medications under this program are classified as "Non-Preferred". This means there are alternative medications which are therapeutically equivalent. If your physician writes for a medication that is part of our Non-Preferred List, you may want to discuss alternative medications that are just as effective.

EHIM Pharmacy Network

EHIM has over 62,000 participating pharmacies across the country including all of the major chain pharmacies, regional pharmacies and most independent pharmacies. You may visit our website at www.ehimrx.com for our National Pharmacy Directory and Pharmacy Locator tool.

EHIM Pharmacy Help Desk

EHIM's Pharmacy Help Desk is available for your convenience 24 hours a day, 7 days per week, 365 days per year. Our toll free number is (800) 311-3446 and will be printed on the back of your ID card and on all of our communication pieces. If you have any questions regarding your benefits or just need help finding a participating pharmacy, please contact our Pharmacy Help Desk. You may also contact our helpdesk through our website at www.ehimrx.com.



378 State St.

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517-541-5100

www.charlotteorioles.com

Elect Rx

Discount program available for high cost prescriptions.

To all Charlotte Public Schools employees
enrolled in the group medical plan.



Charlotte Public Schools has partnered with ElectRx in conjunction with your pharmacy benefit manager EHIM, to provide a solution to the high cost of many medications. If you are taking a high cost drug you may be eligible to receive this covered medication at a greatly reduced price if you are on a high deductible health plan. Once your deductible is met on a high deductible health plan the cost to you would be zero.

If you are taking any of the medications on the list below or any other high qualifying drug and you enroll in the ElectRx program to receive your medication, you may be eligible to receive a financial reward.

Call ElectRx's confidential customer concierge service at (844) 779-2678 to order your medication or to see if your medication is available under this cost savings program. ElectRx is an independent third party and your information is completely confidential. We look forward to servicing you.

Drugs include but not limited to:

- | | |
|-------------|----------------|
| • HUMIRA | • ENBREL |
| • OTEZLA | • TECFIDERA |
| • STELARA | • GILENYA |
| • XELJANZ | • JANUMET XR |
| • PULMOZYME | • AVONEX |
| • COSENTYZ | • JANUVIA |
| • MYRBETRIQ | • NOVOLOG |
| • TRULICITY | • JARDIANCE |
| • TRUVADA | • XARELTO |
| • HUMALOG | • MANY MORE... |





378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorioles.com

Health Savings Account

Health Savings Account

Who is Eligible and When:

Employees who participate in the medical plan

Using an HSA

- A Health Savings Account (HSA) is managed by the account holder, giving you the choice of when to use your HSA dollars. You can begin using your HSA money as soon as your account is activated and contributions have been made. Contributions to your HSA can be made by anyone, including you, your employer, or a family member; the combined contributions of you and your employer (and anyone else making contributions to your HSA) cannot exceed the HSA maximum contribution limit. For 2024, the maximum is \$4,150 for single coverage and \$8,300 for family coverage. Individuals who are age 55 and older can also make additional “catch-up” contributions of up to \$1,000 annually.
- You can use your HSA account for any purpose, including paying expenses that are not qualified medical expenses. However, you only get the tax benefits of an HSA when you use the account for qualified medical expenses. If you use it for another purpose, you will be required to pay income tax on the withdrawal, and you may also be required to pay another 20 percent tax, unless you make the withdrawal after you reach age 65, become disabled or after your death.





378 State St.

Charlotte, MI 48813

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www.charlotteorioles.com

Dental Insurance

Dental Insurance

Who is Eligible and When:

See applicable collective bargaining agreement.

Carrier Name and Website Address

ADN Dental

www.adndental.com

Network Names and Website Address

ADN and DenteMax

www.adndental.com/ProviderSearch.aspx

Benefits you receive:

See attached benefit summary



CHARLOTTE PUBLIC SCHOOLS Dental Benefits Plan

Administrators, Administrative Staff, Building Administration, Central Office, Custodial, Instructional, Non-Instructional, Secretaries, Social Worker, Superintendent, Transportation

The Plan-at-a-Glance

PPO Networks: ADN Dental Network, DenteMax

Maximum Benefits

July 1st through June 30th

Annual Maximum
Lifetime Maximum
TMJ Services

\$1,000 per eligible individual for covered class I, II and III services.
\$1,500 per eligible individual for covered class IV services
Applies to annual maximum, up to lifetime maximum of \$1000

Class I Preventive Services – 80%

Routine Oral Examinations
Prophylaxis (Cleaning), Periodontal Maintenance
Topical Application of Fluoride
Bitewing X-Rays
Full-Mouth Series or Panoramic X-Rays
All Other X-Rays

Twice per plan year
Twice per plan year
Twice per plan year to age 18
Twice per plan year
Once per 36 months

Class II Restorative Services – 80%

Composite and Amalgam fillings**
Space Maintainers
Root Canal Therapy
Periodontal Root Planing
Periodontal Surgery
Oral Surgery and Extractions
General Anesthesia or IV Sedation
Occlusal Guards
TMJ Appliances and Services

Up to age 14

Medical plan primary for certain procedures
With covered oral surgery or medically necessary
For Bruxism Only

Class III Major Services – 80%

Inlays, Onlays and Crowns
Complete and Partial Removable Dentures
Fixed Partial Dentures (Bridges)
Denture Repair and Adjustment
Denture Reline or Rebase
Addition of Teeth to Partial Dentures

Class IV Orthodontic Services – 80%

Limited and Interceptive Treatment
Comprehensive Treatment

Removable and Fixed Appliance Therapy, up to age 19
Fixed Appliance Therapy, up to age 19

Not Covered

Sealants Implants and Related Restorations Cosmetic Treatment

Deductible – None
Missing Tooth Clause – None
12 Month Billing Limitation
Waiting Periods – None
COB – Standard

**Composite and resins are not covered for posterior teeth, alternate benefit applies
**Prosthetics are considered on delivery date

****Note – Quotes of benefits do not constitute a guarantee of payment. Eligibility is determined at time of service. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitation. Benefits are payable at the applicable percentage level of the Usual and Customary or PPO Fee Schedule allowed amount for the procedure rendered. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding \$250.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**



378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorioles.com

Vision Insurance

Vision Insurance

Who is Eligible and When:

See applicable collective bargaining agreement.

Carrier Name, Network Provider, and Website Address

NVA

www.e-nva.com

Benefits You Receive

See attached benefit summary



Get a Better View

For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price. Fixed prices are available in-network only. Discounts are not insured benefits. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers. Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:

-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent

-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations: The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Hearing Discount: You will receive up to 60% savings at participating provider locations through NationsHearing®.

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

Your NVA EyeEssential® Plan Discount – In Network Only		
Service	Participating Provider	Lens Options
Eye Examination:	Member Cost: Retail Less \$10	\$12 Solid Tint/ Gradient Tint \$50 Standard Progressive Lenses \$75 Polarized Lenses \$65 Transitions Single Vision Standard \$70 Transitions Multi-Focal Standard \$15 Standard Scratch Coating \$12 UV Coating \$35 Polycarbonate \$45 Standard Anti-Reflective
Contact Lens Fitting:	Retail Less 10%	
Lenses:	Glass or Plastic	
Single Vision	\$35.00	
Bifocal	\$55.00	
Trifocal or Lenticular	\$70.00	
Frame:	Retail Less 35%	
Contact Lenses*:	Member Cost:	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U and C) price.

Wal-Mart / Sam's Club and Lenscrafters stores do not provide additional discounts.

Some optometrist affiliated with Optical Retail locations (i.e., LensCrafters, Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

At NVA, We Work Only for Our Clients.

Insurance coverage provided by National Guardian Life Insurance Company (NGLIC), 2E Gilman, Madison, WI 53703. Policy NVIGRP 507. NGLIC is not affiliated with the Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life. A full description of your coverage, its limitations, exclusions and conditions is contained in the Insurance Policy issued to your Plan Sponsor at its place of business. That full description in the form of a Certificate of Coverage can be made available to you by requesting it from your Plan Sponsor.

Exclusions / Limitations: No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

National Vision Administrators, L.L.C. • PO Box 2187 • Clifton, NJ 07015

Web: www.e-nva.com • Toll-Free: 1.800.672.7723

NVA® and EyeEssential® are registered marks of National Vision Administrators, L.L.C.

This document is intended as a program overview only and is not a certified document of the individual plan parameters.





378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorioles.com

Long Term Disability

Long Term Disability Insurance

Charlotte Public Schools understands that financial hardships caused by the loss of income resulting from disability can be staggering to employees and their families. This is why we work with Madison National Life to provide you with Group Long Term Disability to support you and your family in the time of need.

Who is Eligible and When:

See applicable collective bargaining agreement.

Individual Effective Date:

First of the month following date of hire.

Monthly Benefit:

The Monthly Benefit is an amount equal to 66 2/3% of Covered Monthly Earnings.

Carrier Name and Website Address

Madison National Life

www.madisonlife.com





378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorioles.com

Life and AD&D Insurance

Life and AD&D Insurance

Charlotte Public Schools understands that financial hardships caused by the loss of a loved one can be staggering to employees and their families. This is why we work with Madison National Life to provide you with Group Term Life Insurance and Accidental Death and Dismemberment Insurance to support you and your family in the time of need.

Who is Eligible and When:

See applicable collective bargaining agreement.

Carrier Name and Website Address

Madison National Life

www.madisonlife.com





378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorioles.com

Flexible Spending Account

Flexible Spending Account

Open Enrollment Period:

All employees are able to elect a flexible spending account (FSA) in November.

Who is Eligible and When:

All employees regularly employed by Charlotte Public Schools who elect to contribute to an account.

Benefits You Receive:

Flexible Spending Accounts (FSAs) provide you with an important tax advantage that can help you pay for health care and dependent care expenses on a pre-tax basis. By estimating your family's health care and dependent care costs for the next year, you can lower your taxable income and save money.

Health Care Reimbursement FSA

This program lets employees pay for certain IRS-approved medical care expenses with a prescription not covered by their insurance plan with pre-tax dollars. The current limit on salary reduction contributions to a health FSA offered under a cafeteria plan is \$3,050 and is applicable to both grandfathered and non-grandfathered health FSAs. This limit is indexed for cost-of-living adjustments in subsequent years. Some examples of eligible expenses include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations, and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription contraceptives



Flexible Spending Account, cont.

Dependent Care FSA

The Dependent Care FSA lets employees use pre-tax dollars toward qualified dependent care such as caring for children under the age of 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is \$5,000 (or \$2,500 if married and filing separately) per calendar year. This is a use it or lose it account, no carry over to future years. This is a tax savings benefit. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)





378 State St.

Charlotte, MI 48813

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www.charlotteorioles.com

Employee Assistance Program

Employee Assistance Program

Who Is Eligible and When

Employees regularly employed by Charlotte Public Schools effective first of the month following date of hire.

Benefits You Receive:

When you are dealing with personal situations , it can be difficult to be your best at work or at home. That's why Charlotte Public Schools offers the Employee Assistance Program (EAP) administrated by LifeWorks. The EAP gives you a place to turn for support any time of the day, or night, and 365 days a year. Support is available for whatever issues employees might be facing, including depression, marriage and relationships, legal issues, child/elder care challenges, parenting issues, financial concerns, grief management or substance abuse. This plan also includes access to virtual fitness.

You can contact our FREE Employee Assistance Program toll-free at 866-451-5465, or you can visit the website at www.niseap.com.





Embedded Employee Assistance Program (EAP) with Claimant Assist

Support for Employees* with Life or Disability Insurance Through National Insurance Services



The EAP Program

Everyday life can be stressful and can affect your health, well-being, and performance. Fortunately, our Employee Assistance Program can aid in finding solutions. When facing personal problems, you might struggle with where to turn for help. The first step is usually the hardest, and guidance is often the key. That's why National Insurance Services (NIS) offers an Employee Assistance Program (EAP). An EAP offers a confidential place to find the answers that work for you.

Your EAP Service Provider

LifeWorks is a leader in the field of Employee Assistance and has been providing employee assistance services for over 40 years. LifeWorks has the experience to provide the broad range of services and guidance that is paramount to an EAP – whether it's help with day-to-day concerns or guidance through a challenging crisis. The information you discuss through the EAP is kept confidential in accordance with federal and state laws.

The EAP Process

When you access the EAP, LifeWorks counselors listen and take

action toward finding solutions. The next step may include meeting with a mental health counselor for up to three face-to-face visits, negotiating health insurance benefits, or referrals to community resources for legal and financial services.

Referrals and Resources

You can receive information and a listing of childcare and eldercare resources with confirmed vacancies meeting your specifications. If face-to-face mental health counseling sessions are required, LifeWorks counselors will refer you for counseling at a location that is convenient to your home or work. LifeWorks counselors can also refer you to self-help groups such as Alcoholics Anonymous or Gamblers Anonymous and community financial and legal resources for debt management.

Claimant Assist

NIS's Claimant Assist program offers special services to Long Term Disability claimants or Life Insurance beneficiaries at no charge. If you have Disability insurance coverage through NIS, our Long Term Disability Claimant Services are available to guide and counsel claimants and their immediate family

Under our EAP you can receive no-cost, confidential help for a wide variety of needs and concerns:

- Alcohol or Drug Addictions
- Anxiety
- Childcare
- Depression
- Eating Disorders
- Eldercare
- Family Conflict
- Financial or Legal Concerns
- Marital Difficulties
- Parenting Concerns
- Problem Gambling
- Relationship Problems
- Stress Management

EAP Services Are Available to You Two Ways:

Phone: 866.451.5465

Online: www.niseap.com
Login: NISEAP | **Password:** EAP
(Note: Password Is Case-Sensitive)

Claimant Assist Services Are Available:

866.472.2734

(over)

members. If you have Life insurance coverage through NIS, our Beneficiary Services Program provides counseling and assistance to beneficiaries when faced with the challenge of coping with loss.

Virtual Fitness

You have access to a virtual fitness platform through the EAP. LIFT session, one of the leading fitness providers, provides you with an easily accessible, effective and affordable way to reach your fitness goals anytime, anywhere for better health and well-being.

You can work out on your own with personalized programs and access coaches if you have questions, or choose to work under the live supervision of a coach online, in 1-1 personal or group sessions.

Access to Masters-Degreed Counselors 24-Hours a Day Through a Toll-Free Number Up to three in-person assessment and counseling sessions.

- **Legal Assistance:** Counselors may refer you to a telephone and/or one in-person consultation with an attorney.
- **Financial Assistance:** Telephone consultation with a financial consultant to address questions on budgeting, taxes, and debt consolidation.
- **Eldercare Assistance:** Our specialists can help you locate eldercare options, such as residential care or in home care, provide support in dealing with the emotions of retirement, or legal aspects like estate planning. Use our website to find resources on retirement, from financial planning and calculators, to articles on coping with retirement stress, and filing your retirement days with meaningful activities.
- **Childcare Assistance:** Telephone consultation with a work-life professional to provide information, referrals, and resources related to childcare concerns.
- **Memorial Planning Assistance:** Telephone consultation with a work-life specialist to assist with memorial and funeral planning. Services include identifying potential locations, associated costs for services, and providing information to help coordinate logistics (Available to Life insurance beneficiaries only).

Your EAP and Claimant Assist Administrator:



134 North LaSalle Street, Suite 2200
Chicago, IL 60602

Telephone Assistance:

EAP: 866.451.5465

Claimant Assist: 866.472.2734

Online:

www.niseap.com | Login: NISEAP | Password: EAP
(Note: Password Is Case-Sensitive)

***The EAP is for use by the covered employee only. While issues may concern family members, all contacts to the EAP must be made by the employee.**



378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorioles.com

Pet Insurance

Pet Insurance

Employees can elect to purchase pet insurance through Pet Partners.

Payment Information

Monthly premiums will be deducted equally between bi-monthly paychecks.



New PetPartners Group Pet Insurance

Underwritten by Independence American
Insurance Company

Employer Group Pet Insurance Renewal Proposal

Date: 4/16/2024

Employer Name: Charlotte Public Schools

Proposal Name: Charlotte Public Schools - Renewal --
RENEWAL W/RATES

Broker: Scott Fritz
NIS Benefits

Distributed by:



Terms are illustrative only and describe benefits, limitations, and rates widely available. There may be state specific variations based on state legal requirements and regulatory approvals. Please refer to disclosure forms, your declarations page, and policy documents for specific details.

Dual Choice: Accident & Illness and Accident Only Insurance - per covered pet

Underwritten by Independence American Insurance Company

Accident & Illness Coverage

Subject to any applicable Deductible, Coinsurance and Annual Limit

Medically Necessary Supplies and Treatment, including emergency care and prescription medications (when dispensed directly by a veterinarian or compounded by a pharmacist under guidance of a veterinarian, excluding over-the-counter medications) performed for conditions that started after the Benefit Waiting Period, if any, and during the Coverage Period, resulting from:

- Accidents, such as, an automobile Accident, ingestion of a foreign body, poisoning, animal bites, dental trauma, burns and fractures.
- Illnesses

Accident Only Coverage

Subject to any applicable Deductible, Coinsurance and Annual Limit

Medically Necessary Supplies and Treatment, including emergency care and prescription medications (when dispensed directly by a veterinarian or compounded by a pharmacist under the guidance of a veterinarian, excluding over-the-counter medications) as a result and a direct consequence of an Injury that started after the Benefit Waiting Period, if any, and during the Coverage Period, resulting from:

- Accidents, such as, an automobile Accident, ingestion of a foreign body, poisoning, animal bites, dental trauma, burns and fractures.

Base Plan

	ACCIDENT ONLY	ACCIDENT & ILLNESS
Annual Deductible	\$500	\$500
Coinsurance (% the policy pays)	80%	80%
Annual Limit	\$10000	\$10000
Diminishing Deductible <i>Deductible is reduced by specified dollar amount each year pet is claim free while continuously covered</i>		Not Included

Minimum Issue Age of Pet at Effective Date	8 Weeks	
Maximum Issue Age of Pet at Effective Date	No Maximum Age Limit	No Maximum Age Limit
Expiration Age of Pet	None	

Benefit Waiting Periods:		
Injuries	Waived	Waived
Illnesses		Waived
Cruciate Ligament	6 Months	
Pre-Existing Condition	Covered after 12 months (look back period is from date of birth)	6 months look back, then covered after 12 months
Prior Coverage Credit		Included
<i>Credit toward satisfying the Benefit Waiting Periods and the Pre-Existing Condition provision for comparable, prior pet insurance which was in effect immediately before the Effective Date</i>		
Continuity of Coverage <i>In the event you are no longer eligible for coverage under this group plan, don't worry! You may apply for individual pet insurance through PetPartners, Inc and receive credit for the time covered under the group pet insurance plan. This means that credit will be given for the time covered under the group pet insurance plan toward satisfying the Pre-Existing Condition waiting period and the Benefit Waiting Periods. You must have no lapse in coverage between the two plans in order to qualify.</i>		

Optional Benefits (Riders)

Office Exams and Telehealth Consult	Included - Subject to Deductible & Coinsurance	Included - Subject to Deductible & Coinsurance
Rehabilitation and Physical Therapy	Included - Subject to Deductible & Coinsurance	Included - Subject to Deductible & Coinsurance
Inherited and Congenital Care <i>-- not available for Accident Only</i>		Included Subject to Deductible and Coinsurance, and 30-day Benefit Waiting Period
Alternative and Behavioral Care <i>Acupuncture, Chiropractic, Homeopathy, Herbal Therapy, Naturopathy, and Vitamins/Supplements (Behavioral Care not available for Accident Only)</i>	Included Subject to Deductible & Coinsurance	Included Subject to Deductible & Coinsurance Behavioral Care subject to \$1,000 Annual Limit and 14-day Benefit Waiting Period

Final Respects <i>(Cremation/ Burial/ Remains Disposal Only)</i>	Included \$300 Limit Paid in excess of Annual Limit Not subject to Deductible or Coinsurance	Included \$300 Limit Paid in excess of Annual Limit Not subject to Deductible or Coinsurance
Routine Dental	Not Included	Not Included

[This space intentionally left blank.]



Definitions

Accident – a sudden, unexpected, unintended, or unpreventable event, which is specific as to place and time that causes physical Injury

Coverage Period – begins on pet's effective date coverage and ends on renewal date of group policy or date pet is no longer covered under policy

Illness(es) – sickness, disease, or any change in a pet's normal, healthy state, which is not caused by Injury to pet

Inherited – an Illness, disease or condition whose presence is determined by genetic factors

Injury – physical harm or damage to pet, caused by an Accident

Medically Necessary – medical services, Supplies or care provided to treat pets which are consistent with Symptoms or diagnosis, accepted as good veterinary practice standards, not for ease or convenience of pet owner or veterinarian, and consistent with proper supply or level of services which can be safely provided to pets

Pre-Existing Condition – an Injury or Illness* which occurred, reoccurred, existed, or showed Symptoms whether diagnosed and/ or treated by a veterinarian for time period specified above prior to Effective Date or during Benefit Waiting Period

Supplies – any item that is Medically Necessary and provided by veterinarian that is safe and effective for its intended use, and that omission would adversely affect the pet

Symptoms – first departure from normal function or feeling which is noticed by Insured or Insured's veterinarian, reflecting presence of an Injury or Illness*

Treatment – any laboratory test, x-rays, medication, surgery, hospitalization, nursing and care provided or prescribed by a veterinarian

**Illness is not covered under Accident Only*

Summary of Exclusions

- Treatment not medically necessary or considered experimental or performed prior to Effective Date or during a Benefit Waiting Period
- Pre-Existing Conditions including, but not limited to a Bilateral Condition, presenting on one side of body (i.e., a cruciate tear in left leg that showed Symptoms prior to Coverage Period or during a Benefit Waiting Period, a subsequent cruciate tear in right leg will be considered Pre-Existing)
- IVDD (Intervertebral Disc Disease) if diagnosed, treated, or showing Symptoms prior to Coverage Period or during a Benefit Waiting Period and any further episodes of IVDD or any future occurrence of this condition
- Services not performed by or under direct supervision of a licensed veterinarian
- Conditions related to racing, security, law enforcement, working dogs and organized fighting, including intentional acts, neglect, or deliberate endangerment
- More than one Injury per coverage period arising from a repetitive and specific activity or similar activity that has previously occurred (i.e., foreign body ingestion, dog fights and toxin ingestion)
- Missed appointment fees, training, and cost of treatment for failure to follow veterinarian's recommendations

- Natural supplements and vitamins
- Obesity unrelated to an underlying medical condition
- Transportation costs, including but not limited to non-emergency ground or air pet ambulance, and emergency air pet ambulance
- Treatment of breeding, pregnancy, whelping or queening, including complications

Accident Only – per Covered Pet

Frequency: Monthly – 12

\$11.56

Accident & Illness – per Covered Pet

Frequency: Monthly – 12

		Adult Weight in Pounds
Dog	Age	0 - 90+
	Age 0 - 14+	\$57.66
Cat	Age	
	Age 0 - 14+	\$32.17



About PetPartners, Inc.

Headquartered in Raleigh, NC, PetPartners offers pet health insurance in all 50 states of the United States, underwritten by Independence American Insurance Company (in WA by American Pet Insurance Company). Since 2003, PetPartners has been the exclusive provider of pet health insurance protection to registrants of the American Kennel Club through the AKC Pet Insurance brand. Coverage administered by PetPartners provides access to the quality of medical care your pet needs, through the licensed veterinarian of your choice. Please visit www.petpartners.com for additional information.

About Independence American Insurance Company:

Independence American Insurance Company is domiciled in Delaware and licensed to write property and/or casualty insurance in all 50 states and the District of Columbia.



378 State St.

Charlotte, MI 48813

517-541-5100

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Voluntary Benefits

CRITICAL ILLNESS

BENEFIT HIGHLIGHTS AND KEY FEATURES

Underwriting	Guaranteed Issue
Annual Enrollment	Limited to one annual enrollment in a 12-month period
Premium Contribution	Voluntary
Critical Illness Benefit Amount	\$30,000 - Insured: 100% Spouse: 100% Child: 50%
Critical Illness Benefit Amount Multiplier	<p>2 times the Critical Illness Benefit Amount</p> <p>*Each Covered Condition with a * in this proposal is payable up to two times. When there is a recurrence of the same Covered Condition, the applicable Benefit Separation Period must be satisfied.</p> <p>The sum of all Benefit payments for Covered Conditions will not exceed 2 times the Critical Illness Benefit Amount. If the remaining balance of the second Critical Illness Benefit Amount is less than the amount payable for a Covered Condition, then a partial Benefit payment will be made for that Covered Condition.</p>
Benefit Separation Period	Not Applicable, this Period does not apply
Benefit Waiting Period	30 days
Pre-Existing Conditions Exclusion	12 months prior to effective date / 12 months after effective date
Continuation of Insurance and Pre-existing Conditions	In calculating the insurance period for determining whether the Pre-existing Condition Exclusion applies, We include any period of continuous insurance under the Group's Prior Plan providing similar critical illness benefits, immediately preceding the date the person became insured under the Certificate.
Benefit Age Reduction	50% at age 70 for Insured and Spouse
Insurance Ends	Insured and Spouse at age 80 / Child at age 26
Rate Guarantee	1 Year
Insurance Portability	Enables Insureds who have been continuously covered for 12 months prior to termination, and under age 60, to continue insurance with the required premium payment until the group policy terminates or Insured attains age 80.

COVERED CONDITIONS

Benefit payments accumulate toward the Critical Illness Amount

Benefit availability will vary by state

Cancer*	Invasive Cancer	100%
	Benign Brain Tumor	100%
	Bone Marrow Transplant	25%
Expanded Cancer*	Non-Invasive Cancer	5%
	Skin Cancer	5%
	Prostate Cancer	5%
	Breast Cancer	5%
Heart*	Heart Attack	100%
	Stroke	100%
	Aneurysm	25%
Expanded Heart*	Heart Valve Replacement	25%
	Coronary Artery Bypass Grafting	25%
	Angioplasty/Stent	25%
	Aorta Surgery	25%
Organ*	End State Renal Disease	100%
	Major Organ Transplant	100%
Loss of Movement or Consciousness*	Coma	100%
Complete Sensory Loss	Loss of Speech	50%
	Loss of Sight	100%
	Loss of Hearing	50%
Neurological Disease	Multiple Sclerosis	20%
	Muscular Dystrophy	20%
	Amyotrophic Lateral Sclerosis (ALS)	20%
Expanded Neurological Disease	Alzheimer's	20%
	Parkinson's	20%

CRITICAL ILLNESS INSURANCE

Semimonthly Issue Age Rates

Age	18-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Non-Tobacco	2.01	4.10	6.68	10.84	17.10	25.24	34.05	41.82	55.59
Tobacco	3.55	7.24	11.80	19.13	30.17	44.53	60.08	73.80	98.11

Spouse & Child Rates

Age	18-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Non-Tobacco	2.23	4.54	7.42	12.05	19.11	28.68	39.87	50.71	68.48
Tobacco	3.93	8.01	13.09	21.26	33.72	50.61	70.37	89.48	120.85
Child	1.66	Child rate covers all Eligible Dependent Children							

Specific Details

Details will vary by state

Guaranteed Issue – the amount of insurance that is available to insureds and dependents who apply for insurance within 31 days from the date they satisfy the eligibility requirements or become eligible during a Special Enrollment Period.

Annual Enrollment – offered once annually, late enrollees may enroll for Guaranteed Issue insurance during this period.

Special Enrollment – Eligible Persons and Dependents may apply upon loss of other Critical Illness benefits and eligibility changes.

Benefit Waiting Period – the time period the Insured Person must wait before Benefits are payable.

Pre-existing Condition – a physical condition, whether or not diagnosed, where an Insured Person did one or more of the following at any time during the Pre-existing Condition Period just before his or her effective date of insurance or the effective date of any subsequent increase in insurance:

1. consulted a Physician or other licensed medical professional;
2. received medical treatment, services or advice;
3. underwent diagnostic procedures, including self-administered tests (excluding blood) or procedures; or
4. took prescribed medications.

No Coordination – benefits paid are not offset or coordinated with other health insurance or medical plan.

Supplemental Only – this insurance provides a limited benefit for certain critical illnesses. It is not intended to qualify as the minimum essential coverage required by the Affordable Care Act (ACA).

EXCLUSIONS (each exclusion may not be applicable in every state)

Benefits are not payable if the Critical Illness is caused or contributed by, including, but not limited to: war or act of war, committing or attempting to commit a felony or being engaged in an illegal occupation, being confined in a penal or correctional facility, being on active duty or training in the military, being intoxicated or under the influence of any narcotic (unless administered on the advice of a Physician), an intentional self-inflicted injury, attempted suicide or voluntarily taking poison or inhaling gas, and handling or using an illegal weapon.

This Proposal section is for Certificate form number GCI-C-0519.

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ACCIDENT

BENEFIT HIGHLIGHTS AND KEY FEATURES

Underwriting	Guaranteed Issue
Premium Contribution	Voluntary
Benefit Payments	Insured: 100% Spouse: 100% Child: 100%
Accident Limit	5 accidents during each group policy year
Job Coverage	24-Hour, both on and off the job
Benefit Waiting Period	0 days
Insurance Ends	Insured & Spouse at age 80 / Children at 26
Annual Enrollment	Limited to one annual enrollment in a 12-month period.
Rate Guarantee	1 Year
Insurance Portability	Enables insureds who have been continuously covered for 12 months prior to termination and under age 60 to continue insurance with the required premium payment until the group policy terminates, or Insured attains age 80.

BENEFIT SUMMARY PER ACCIDENT, PER CALENDAR YEAR

Benefit availability will vary by state

Initial Care & Treatment	Transfusion of Blood, Plasma & Platelets	\$300, limit 1
	Ambulance	
	Ground	\$300
	Air	\$500
	Outpatient Physician Office/Urgent Care	\$50, limit 1 visit
	Emergency Room	\$250 per visit, limit 1 per year
	Medical Appliances	\$250
	Therapy Services (physical, speech, occupational)	\$25 per visit, limit 1 visit
	Outpatient X-Ray	\$50

BENEFIT SUMMARY (cont'd) PER ACCIDENT, PER CALENDAR YEAR

Benefit availability will vary by state

	Advanced Diagnostic Imaging	\$250
	Outpatient Surgery	\$800
Inpatient Hospital Care	First Day Hospital Admission	\$2,000 per first day, limit 1 per 12 months
	Hospital Stay	\$500 per day, limit 30 days
	ICU Stay	\$1,000 per day, limit 30 days
	Rehabilitation	\$50 per day, limit 5 days
	Miscellaneous Hospital Services	\$100
Follow Up Care & Treatment	Prosthesis Device/Artificial Limb (one or multiple)	\$500 minimum per day, \$2,500 maximum per day
	Telemedicine Consult	\$10 per encounter, limit 1 encounter
	Outpatient Physician Office and Urgent Care	\$25 per visit, limit 2 days
	Chiropractic Treatment	\$25 per visit, limit 5 visits
	Pain Management (epidural anesthesia)	\$100
	Home Health Care	\$25 per visit, limit 5 visits
Fractures (complete break of bone)	Hip or Thigh	\$3,500
	Vertebrae	\$1,500
	Pelvis (except the tailbone)	\$1,500
	Skull	
	Dented	\$5,000
	Cracked	\$2,500
	Leg	\$1,500
	Foot, Ankle or Kneecap	\$700
	Forearm, Hand or Wrist (except fingers)	\$700
	Lower Jaw	\$700
	Shoulder Blade or Collar Bone	\$700
	Upper Arm or Upper Jaw	\$700
	Facial Bones (except teeth)	\$700
	Vertebral Processes	\$700
	Tailbone	\$500
	Rib (one or more)	\$500
	Finger	\$100

BENEFIT SUMMARY (cont'd) PER ACCIDENT, PER CALENDAR YEAR

Benefit availability will vary by state

	Toe	\$100
Dislocations (bone separation at the joint)	Hip	\$2,500
	Knee (except knee cap)	\$1,500
	Shoulder	\$500
	Foot or Ankle	\$750
	Hand	\$500
	Lower Jaw	\$500
	Wrist	\$500
	Elbow	\$500
	Finger or Toe	\$250
	Collar Bone	
	Treated near the center of chest	\$750
	Treated near the shoulder	\$250
Lacerations	Over 6 inches	\$750
	2 inches to 6 inches	\$100
	Under 2 inches	\$75
	Lacerations – no stitches	\$75
Injuries	Concussions (once per 12-month period)	\$500
	Coma	\$15,000
	Emergency Dental Work	
	Repair with Crown	\$300
	Extraction	\$100
	Quadriplegia	\$15,000
	Paraplegia	\$7,500
	Hemiplegic	\$7,500
Injuries Requiring Surgery	Eye Injury requiring surgical repair	\$500
	Eye Injury Removal of Foreign Body	\$100
	Tendons, Ligaments, Rotator Cuff, Knee Cartilage	
	Single	\$200
	Multiple	\$500
	Ruptured / Herniated Disc	\$250
	Joint Replacement	\$4,000
	Exploratory / Arthroscopic (without repair)	\$200

BENEFIT SUMMARY (cont'd) PER ACCIDENT, PER CALENDAR YEAR

Benefit availability will vary by state

	Hernia	\$200
	Cranial, Abdominal, Thoracic (chest)	\$500
Burns	Second Degree less than 10%	\$100
	Second Degree 10-34%	\$300
	Second Degree 35% or more	\$500
	Third Degree less than 10%	\$750
	Third Degree 10-34%	\$1,000
	Third Degree 35% or more	\$10,000
Additional Accident Benefits	Organized Sports (for a Dependent Child only) (a one-time benefit per Accident)	\$150
	Accidental Death	Employee: \$25,000 Spouse: \$25,000 Child: \$12,500
	Accidental Death - Common Carrier (Public Transportation)	Equal to 3X Accidental Death Benefit
	Accidental Dismemberment: Loss of One Hand, Foot or entire eyesight in one Eye (each loss)	\$10,000
	Accidental Dismemberment: Loss of Multiple Hands, Feet or Eyesights	\$20,000

ACCIDENT INSURANCE

Semimonthly Rates

Employee	4.84
Employee + Spouse	8.88
Employee + Child	13.22
Family	19.40

Specific Details

Details will vary by state

Guaranteed Issue – the amount of insurance that is available to insureds and dependents who apply for insurance within 31 days from the date they satisfy the eligibility requirements or become eligible during a Special Enrollment Period.

Annual Enrollment – offered once annually, late enrollees may enroll for Guaranteed Issue insurance during this period.

Special Enrollment – Eligible Persons and Dependents may apply upon loss of other accident benefits and eligibility changes.

No Coordination – benefits paid are not offset or coordinated with other health insurance or medical plan.

Supplemental Only – this insurance provides a limited benefit for certain accidents. It is not intended to qualify as the minimum essential coverage required by the Affordable Care Act (ACA).

EXCLUSIONS (each exclusion may not be applicable in every state)

Benefits are not payable if the Accident is caused or contributed by, including, but not limited to: war or act of war, committing or attempting to commit a felony or being engaged in an illegal occupation, being confined in a penal or correctional facility, being on active duty or training in the military, being intoxicated or under the influence of any narcotic (unless administered on the advice of a Physician), an intentional self-inflicted injury, attempted suicide or voluntarily taking poison or inhaling gas, and handling or using an illegal weapon.

This Proposal section is for Certificate form number GACC-C-0819.

FIXED INDEMNITY

BENEFIT HIGHLIGHTS AND KEY FEATURES

Underwriting	Guaranteed Issue
Premium Contribution	Voluntary
Annual Enrollment	Limited to one annual enrollment in a 12-month period.
Rate Guarantee	1 Year
Insurance Portability	Enables Insureds who have been continuously covered for 12 months prior to termination, and under age 60, to continue insurance with the required premium payment until the group policy terminates or Insured attains age 65.

PLAN SUMMARY

FOR SICKNESS AND ACCIDENT

Benefit availability will vary by state

INPATIENT

First Day Hospital	\$200 per day, limit 1 day per year
Hospital Inpatient	\$200 per day, limit 30 days per year
Hospital Intensive Care Unit (ICU)	\$400 per day, limit 30 days per year
Inpatient Mental Health Disorder	\$100 per day, limit 8 days per year
Inpatient Substance Use Disorder	\$100 per day, limit 8 days per year
Inpatient Skilled Nursing Facility	\$100 per day, limit 15 days per year
Inpatient Surgical	\$1,000 per day, limit 1 day per year
Inpatient Anesthesiology	\$200 per day, limit 1 day per year
Miscellaneous Inpatient Hospital Services	\$100 per day, limit 5 days per year

OUTPATIENT

Emergency Room (Illness Only)	\$100 per day, limit 1 day per year
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SERVICES / SUPPLIES

PLAN SUMMARY (cont'd) FOR SICKNESS AND ACCIDENT

Benefit availability will vary by state

Ground Ambulance

\$200 per day, limit 1 day per year

Fixed Indemnity

FIXED INDEMNITY

Semimonthly Rates

Employee	9.27
Employee + Spouse	18.54
Employee + Child	15.29
Family	25.04

Specific Details

Guaranteed Issue – the amount of insurance that is available to insureds and dependents who apply for insurance within 31 days from the date they satisfy the eligibility requirements or become eligible during a Special Enrollment Period.

Open Enrollment – offered once annually, late enrollees may enroll for Guaranteed Issue insurance during this period.

No Coordination of Benefits – benefits paid under this Policy are not offset or coordinated with other health insurance or medical plan.

Supplemental Only – this is not comprehensive medical insurance. This policy is designed to help pay for expenses that are not fully paid by other health insurance.

LIMITATIONS & EXCLUSIONS

Benefits are not payable if the loss is caused or contributed by: war or act of war, committing or attempting to commit a felony or being engaged in an illegal occupation, while on active duty in the military, being intoxicated or under the influence of any narcotic (unless administered on the advice of a Physician).

Additionally, benefits are not payable for: loss paid by Workers' Compensation or Occupational Disease Law, treatment that is not medically necessary, services where there is no charge incurred or requirement to pay, services or supplies supplied by the government or family member, weight control or treatment for obesity, tobacco cessation, missed appointments, voluntary abortion unless the life of the mother is in danger or complications of a voluntary abortion, fertility or sterilization, elective cosmetic procedures, breast augmentation unless due to sickness, weekend hospital admission for non-emergency procedures, loss insured outside the United States if traveling for longer than 90 days, and Custodial Care, Hospice and Home Health Care.

SHORT-TERM DISABILITY

BENEFIT HIGHLIGHTS AND KEY FEATURES

BENEFITS WILL VARY BY STATE

Underwriting	Guarantee Issue (GI). Evidence of Insurability required for amounts over GI limit or late enrollees
Elimination Period	0 days Injury / 14 days Physical Disease (Sickness)
Maximum Benefit Period	13 weeks
Weekly Benefit	Benefits are elected in increments of \$25, not to exceed the lesser of 60% of your weekly Pre-disability Earnings or \$1,400.
Minimum Benefit	\$25 per week
Guarantee Issue	\$700 per week
Rate Basis	Issue Age rates, for initial policy and benefit amount increases
Job Coverage	Non-Occupational, off the job only
Pregnancy	Covered the same as any Physical Disease (Sickness)
Pre-Existing Condition Period	12 months prior to effective date / 12 months after effective date
Annual Enrollment Period	Benefits can be added or increased up to the GI limit, subject to Pre-Existing Conditions without Evidence of Insurability
Waiver of Premium Benefit	Premiums are waived while Short-Term Disability benefits are payable
Integration	Pays in addition to Sick Pay for the first 10 days from the end of the Elimination Period, then pays up to 100% of Pre-Disability Earnings
Partial Disability Benefit	Pays up to 50% of the weekly benefit for up to 13 weeks
Rate Guarantee	1 Year
Insurance Portability	After at least 12 months of insurance, an Insured Person may continue insurance for up to 12 months if insurance under the Group Policy terminates

SHORT TERM DISABILITY INSURANCE

Semimonthly Issue Age Rates per Weekly Benefit

Weekly Benefits	\$100	\$125	\$150	\$175	\$200	\$225	\$250	\$275	\$300	\$325	\$350	\$375	\$400
18-39	2.63	3.28	3.94	4.59	5.25	5.91	6.56	7.22	7.88	8.53	9.19	9.84	10.50
40-49	3.29	4.11	4.94	5.76	6.58	7.40	8.23	9.05	9.87	10.69	11.52	12.34	13.16
50-59	4.19	5.23	6.28	7.32	8.37	9.42	10.46	11.51	12.56	13.60	14.65	15.69	16.74
60+	6.13	7.66	9.20	10.73	12.26	13.79	15.33	16.86	18.39	19.92	21.46	22.99	24.52

Age	\$425	\$450	\$475	\$500	\$525	\$550	\$575	\$600	\$625	\$650	\$675	\$700	
18-39	11.16	11.81	12.47	13.13	13.78	14.44	15.09	15.75	16.41	17.06	17.72	18.38	5.25
40-49	13.98	14.81	15.63	16.45	17.27	18.10	18.92	19.74	20.56	21.39	22.21	23.03	6.58
50-59	17.79	18.83	19.88	20.93	21.97	23.02	24.06	25.11	26.16	27.20	28.25	29.30	8.37
60+	26.05	27.59	29.12	30.65	32.18	33.72	35.25	36.78	38.31	39.85	41.38	42.91	12.26

Monthly Rates
per \$100 of
Weekly Benefit

Specific Details

Guarantee Issue (GI) – is the amount of insurance that is available without Evidence of Insurability. Guaranteed Issue is applicable to insureds who apply for insurance within 31 days from the date they satisfy the eligibility requirements.

Pre-Disability Earnings – the insured's earnings in effect on their last full day of active work prior to becoming disabled. This may include the insured's base rate of pay and deductions made for pre-tax contributions to a qualified deferred compensation arrangement, or, Section 125 plan including but not limited to, income received from commissions, bonuses, overtime pay, and any other extra compensation.

Elimination Period – a period of time an insured must be continuously disabled before benefits are payable. No benefits are payable during the Elimination Period.

Deductible Income – is income an Insured receives or is eligible to receive, while disability benefits are payable, which is deducted from the Insured's disability benefit. This includes but is not limited to: sick pay, severance pay, work earnings, Social Security, Workers' Compensation, a state retirement system or other sources as listed in the Certificate of Insurance that will be subtracted from an insured's disability benefit.

Definition of Disability – disabled and earning less than 20% of pre-disability earnings; or disabled and working, earning more than 20% but less than 80% of pre-disability earnings. (Definition of Disability varies by state).

Annual Enrollment – Insureds can add or increase insurance up to the GI limit during a specified annual enrollment period without Evidence of Insurability (EOI). Additions/increases are subject to pre-existing limitation provision.

SHORT TERM DISABILITY INSURANCE

Specific Details (cont'd)

LIMITATIONS & EXCLUSIONS

Pre-Existing Conditions – no benefits are payable for disabilities that commence within the Pre-existing Condition Period after the insured's effective date as shown in the benefit highlights that are caused or contributed by or resulting from a Pre-Existing Condition.

A Pre-Existing Condition is defined as a mental or physical condition whether or not diagnosed or misdiagnosed for which the insured has consulted a Physician or other licensed medical professional, received medical treatment, services or advice, undergone diagnostic procedures, including self-administered procedures, or taken prescribed drugs or medications during a set time period prior to the insured's effective date, as shown in the benefit highlights.

(May vary by state)

Disability Limitations – Benefits for Mental Disorder, Substance Abuse and *Special Conditions are limited to the Maximum of 12 months (for all Disabilities during your lifetime).

*** Special Condition** – a condition based on self-reported symptoms that is not verifiable using objective medical tests, procedures or clinical examinations standardly accepted in the practice of medicine. Special Conditions include but are not limited to the following: Musculoskeletal and connective tissue disorders of the neck and back, any disease or disorder of the cervical, thoracic and lumbosacral back and its surrounding soft tissue, chronic sprains and strains of joints and adjacent muscles, chronic headaches, chronic pain, Tinnitus (ringing of the ears), Hyperacusis (sensitivity to sound), Post Lyme disease syndrome, Chronic Fatigue Syndrome, Fibromyalgia, Environmental Allergic Sickness, chemical and environmental sensitivities, and Sick Building Syndrome. (May vary by state)

Exclusions – disabilities caused or contributed by, including but not limited to, (a) committing or attempting to commit a felony, or engaging in an illegal occupation; (b) intentionally self-inflicted or attempted suicide, while sane or insane; (c) confinement in a penal or correctional institution or under house arrest; (d) war or act of war whether declared or undeclared; (e) failure to be under the regular care of a physician; (f) voluntary taking of poison or inhaling of gas; or (g) riding in or driving any motor-driven vehicle in a race, stunt shown, or speed test; or while testing any vehicle on any racecourse or speedway. (Exclusions and limitations vary by state)

This Proposal section is for Certificate form number STD-C-0617.

TERM LIFE

BENEFIT HIGHLIGHTS AND KEY FEATURES

BENEFITS WILL VARY BY STATE

Underwriting	Guarantee Issue (GI). Evidence of Insurability required for amounts over GI limit or late enrollees
Life Benefit Amount	Insured: \$20,000 to \$500,000 in \$10,000 increments, not to exceed 5 times annual salary, rounded to next lower \$10,000. Spouse: \$10,000 to \$250,000 in \$5,000 increments, not to exceed 50% of Insured coverage, rounded to next lower \$5,000. Child(ren): \$10,000, with elected Insured coverage
Accidental Death and Dismemberment Benefit Amount	Insured: up to Insured Life Benefit Amount Dependent: equal to Dependent Life Benefit Amount
Guarantee Issue	Insured: \$130,000; Spouse: \$25,000; for Insureds age 70 or over: \$20,000; for timely enrollees, these amounts are before age reductions are applied
Benefit Age Reduction	Insured: Benefits reduce to 65% of the Benefit Amount at age 65 and to 50% of the Benefit Amount at age 70. Spouse: Benefits reduce to 65% of the Benefit Amount at age 65.
Dependent Insurance	Unless stated further in the Certificate of Insurance, Spouse insurance ends at age 70 and Child insurance ends at age 26
Annual Enrollment	Late enrollees less than age 70 can enroll up to \$20,000, \$0 if age 70 or older. Current enrollees can increase benefits by \$10,000 without Evidence of Insurability until total elected amount exceeds GI.
Accelerated Death Benefit	Pays a percentage of the Life Benefit Amount in the event of a terminal illness with a life expectancy of 12 months or less
Waiver of Premium Benefit	Applicable if Disabled prior to age 60 following a 6-month elimination period. This benefit ends on, including but not limited to, the Insured's 65th birthday
Rate Guarantee	1 Year
Insurance Portability	Enables Insured Persons who have been continuously covered for 12 months prior to termination, and under age 65, to continue insurance with the required premium payment until the earlier of 5 years, when Insured attains age 65 or the group policy terminates

TERM LIFE INSURANCE

Semimonthly Attained Age Rates

Employee: \$20,000 to \$500,000; \$130,000 GI | Spouse: \$10,000 to \$250,000; \$25,000 GI

Benefit / Age	\$20,000	\$30,000	\$40,000	\$50,000	\$60,000	\$70,000	\$80,000	\$90,000	\$100,000	
< 30	0.60	0.90	1.20	1.50	1.80	2.10	2.40	2.70	3.00	0.06
30-34	0.80	1.20	1.60	2.00	2.40	2.80	3.20	3.60	4.00	0.08
35-39	1.10	1.65	2.20	2.75	3.30	3.85	4.40	4.95	5.50	0.11
40-44	1.30	1.95	2.60	3.25	3.90	4.55	5.20	5.85	6.50	0.13
45-49	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00	0.20
50-54	3.10	4.65	6.20	7.75	9.30	10.85	12.40	13.95	15.50	0.31
55-59	5.80	8.70	11.60	14.50	17.40	20.30	23.20	26.10	29.00	0.58
60-64	8.80	13.20	17.60	22.00	26.40	30.80	35.20	39.60	44.00	0.88
65-69	17.00	25.50	34.00	42.50	51.00	59.50	68.00	76.50	85.00	1.70
70-74	27.60	41.40	55.20	69.00	82.80	96.60	110.40	124.20	138.00	2.76
75+	52.40	78.60	104.80	131.00	157.20	183.40	209.60	235.80	262.00	5.24
AD&D	0.30	0.45	0.60	0.75	0.90	1.05	1.20	1.35	1.50	0.03
Child Life	\$10,000	Life benefit for	\$1.00	Semimonthly	Dependent Child(ren), from 15 days to age 26 are eligible (same premium, regardless of the number of children)					0.20
& AD&D	\$10,000	AD&D benefit for	\$0.25	Semimonthly						0.05

Monthly Rates
per \$1,000 of
Benefit

Specific Details

Guarantee Issue (GI) – the amount of insurance that is available without Evidence of Insurability. Guarantee Issue is applicable to insureds and dependents who apply for insurance within 31 days from the date they satisfy the eligibility requirements.

Annual Enrollment – Up to \$20,000 for late enrollees less than age 70, \$0 if age 70 or above. Current enrollees can increase coverage by \$10,000 during a specified Annual Enrollment Period without Evidence of Insurability (EOI) until the total elected amount exceeds the GI limit.

Accidental Death & Dismemberment – Provides an additional benefit payment in the event of an accidental death or dismemberment, provided the loss occurs within the time period shown in the Certificate of Insurance. Education benefit, Repatriation benefit and Air Bag and Seat Belt benefits included.

LIMITATIONS & EXCLUSIONS

Life Insurance – within the first two years of insurance, no benefit is payable and life insurance premiums will be refunded, if the death is caused or contributed to by suicide or any other intentionally self-inflicted injury or sickness, whether sane or insane. (If the insured person was insured under the prior plan on the date before the Group's effective date with Us, then credit may be given for time he or she was insured under the Prior Plan). The number of years and specific exclusions vary by state.

Dependent Insurance – Election of Spouse or Child insurance coverage is dependent on the purchase of insurance for the Insured.

Accidental Death & Dismemberment – benefits are not payable if the loss is caused or contributed by, including, but not limited to: war or act of war, committing or attempting to commit a felony or being engaged in an illegal occupation, being intoxicated or under the influence of any narcotic (unless administered on the advice of a Physician), physical disease existing at the time of the Accident, and medical negligence.

This Proposal section is for Certificate form number GTL-C-0119.



378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorioles.com

Long Term Care

Explore Trustmark Life Insurance with Long-Term Care Benefit!



Charlotte Public School District employees are eligible to enroll in Trustmark Universal Life/LifeEvents® Insurance with a Long-Term Care benefit. These benefits can help provide you and your family with valuable extra protection should the unexpected occur.

This limited time enrollment offer is available from May 8 – 19, 2023.

Universal Life provides a consistent lifelong benefit, while the Universal LifeEvents® option offers a higher death benefit during your working years, when your needs and responsibilities are the greatest, and a long-term care benefit.

This optional coverage is affordable (see sample rates) and paid directly through a payroll deduction.

Universal Life/LifeEvents sample rates

Sample ranges of weekly rates for employee-only, non-smoker coverage with long-term care benefit. Your exact rate may depend on additional features selected by you and/or by your employer.

Age at purchase	\$25,000 Universal Life policy	\$25,000 Universal LifeEvents policy
30	from \$5.06 - \$6.27	from \$3.49 - \$4.59
40	from \$7.42 - \$9.44	from \$5.05 - \$6.71
50	from \$11.92 - \$15.44	from \$7.84 - \$10.71

Sample ranges of weekly rates for employee-only, non-smoker coverage with long-term care benefit. Your exact rate may depend on additional features selected by you and/or by your employer.

Policy Details

- Guaranteed issue (no health questions are asked) up to \$100,000 for ages 18-64 with long-term care benefit
- Coverage up to \$300,000 by answering a few medical questions
- Coverage is available for spouse, children and grandchildren
- Rates won't change due to age
- Coverage is fully portable (yours if you leave work or retire)

Why Long-Term Care is Important

At any point in your life, you may need qualified long-term care services, which could cost hundreds of dollars per day. Universal LifeEvents® includes an accelerated benefit that can help pay for these services at any age.

Quick takes



40% of people currently receiving LTC are adults 18-64 years old.

Source: How caregiving impacts families, communities and society, Genworth. 2018.



70% of people over 65 will eventually need LTC.

Source: "How Much Care Will You Need?" Longtermcare.gov

The Cost of Long-Term Care

In addition, the best time to plan for care is before you need it, knowing that care services can be costly.

Annual median costs for care services nationwide

In-home Care - Home Health Aide:

\$60,000+

Nursing Home Facility:

\$95,000+

Source: Genworth Cost of Care Survey, 2021

How the Benefits Work

With the Universal LifeEvents® policy, you can collect 4% of the face amount of your policy per month for up to 50 months to help pay for qualified long-term care services. If you collect an accelerated benefit for qualified long-term care services, your full death benefit is still available for your beneficiaries, as much as doubling your benefit.

Learn more and enroll.



Schedule a personal consultation with a licensed benefits counselor. Your one-on-one meeting will take place by phone and will take approximately 10–15 minutes.

**You care.
We listen.**

VIEW PRODUCT DETAILS

Trustmark® and LifeEvents® are registered trademarks of Trustmark Insurance Company. Underwriting conditions may vary and determine eligibility for the offer of insurance. Benefits, definitions, exclusions and limitations, naming conventions and availability may vary by state. The Long-Term Care Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance (except in LA and VA, where the LTC benefit is Long-Term Care Insurance). It begins to pay after 90 days of confinement or services, and to qualify you must meet conditions of eligibility for benefits. Pre-existing condition limitation may apply. Your policy will contain complete details. You should consult a financial advisor to determine if the long-term care benefits and the retirement benefits provided by this policy are right for you.

Products underwritten by Trustmark Insurance Company and Trustmark Life Insurance Company of New York. Rated A (Excellent) for financial strength by AM Best.

400 Field Drive | Lake Forest, IL 60045 | TrustmarkVB.com



Trustmark
benefits beyond benefits

A112-2904-CPS



378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorioles.com

Retirement and Financial Wellness

Retirement and Financial Wellness

Who is Eligible and When:

All employees.

Michigan Retirement Investment Consortium (MRIC)

MRIC (Michigan Retirement Investment Consortium) is a group of public school districts and community colleges across Michigan whose purpose is to provide employees with the opportunity to save for retirement and to ensure financial independence through a supplemental savings plan. Our goal at MRIC is to create the optimal retirement plan experience for all of our participants.

<https://mric.myfinancialwellnesscenter.com/>

TSACG

TSACG is our third party administrator for all employee voluntary retirement savings plans—403(b) and 457(b). A plan participation guide can be found online or on the next page to get you started.

<https://www.tsacg.com/individual/plan-sponsor/michigan/charlotte-public-schools/>

Michigan Office of Retirement Services

All public school employees in Michigan are part of the ORS Public School Employee's Retirement System. The Michigan Office of Retirement Services administers a Defined Benefit plan, two hybrid plans, and a Defined Contribution plan for public school employees. ORS also administers two retiree healthcare plans: the premium subsidy benefit and the Personal Healthcare Fund.

<https://www.michigan.gov/ors/public-school-employees-retirement-system>





**MICHIGAN OFFICE OF
RETIREMENT SERVICES**
Big Plans. Small Steps.



Retirement Plan Election Guide

The Choice Is Yours

Your retirement journey with the Michigan Office of Retirement Services (ORS) begins with an important first step—electing your retirement plan. You have two options: the **Pension Plus 2** plan or the **Defined Contribution** plan.

Visit PickMiPlan.org to learn more about the plans. Then go to miAccount and make your election at Michigan.gov/ORSmiAccount.



Pension Plus 2 Plan

- This pairs pension and savings components.
- Your savings component enrolls you in the State of Michigan 401(k) and 457 plans.
- Your pension component guarantees you a monthly benefit for life after you meet age and service requirements.
- Pension payments are not affected by market fluctuations.
- ORS manages your pension component; you manage your savings component.

This plan may be best for you if:

- You plan on working for 10 years or longer for a Michigan public school to receive a guaranteed benefit.
- You want a guaranteed monthly benefit for life in retirement paired with distributions from your savings component determined by your employee and employer contributions and investment returns.

Defined Contribution Plan

- This is a savings plan only.
- This plan enrolls you in the State of Michigan 401(k) and 457 plans.
- Retirement income will depend on contributions to your savings plan and investment performance. Investment returns aren't guaranteed.
- Retirement income ends when your accounts are depleted. Your total retirement income could be more or less than what the Pension Plus 2 plan provides.
- You manage your savings plan.

This plan may be best for you if:

- You plan on working less than 10 years for a Michigan public school and want your retirement savings to go with you.
- You're comfortable with your retirement income being determined by contributions and investment returns.

Personal Healthcare Fund

With either plan, you're also placed in a Personal Healthcare Fund (PHF). Contributions from you and your employer are deposited into your savings plan. This can be used to pay for health insurance or other expenses when you retire.

REMEMBER YOU HAVE:



COMPARE YOUR OPTIONS

	Pension Plus 2 Plan	Defined Contribution Plan																								
Plan overview	Pension Component with a Savings Component: You get a pension and retirement savings in the State of Michigan 401(k) and 457 Plans.	Savings: You save for retirement in the State of Michigan 401(k) and 457 Plans. You do not get a pension.																								
How long you have to work to qualify for the benefit	Pension Component: You're vested after 10 years of full-time public school employment. If you never vest, you'll receive your contributions toward your pension back, with interest. Savings Component: You always keep 100% of your contributions. After two years, you keep 50% of your employer's contributions; after three years, 75%; and after four years, 100%.	Savings: You always keep 100% of your contributions. After two years, you keep 50% of your employer's contributions; after three years, 75%; and after four years, 100%.																								
Income when you retire	Pension Component: To calculate your annual pension amount, ORS multiplies the average of your five highest consecutive years of earnings by your years of service, times 1.5%. PLUS Savings Component: Retirement income is based on your contributions, your employer's contributions, and investment performance in the State of Michigan 401(k) and 457 Plans.	Savings: Retirement income is based on your contributions, your employer's contributions, and investment performance in the State of Michigan 401(k) and 457 Plans.																								
The money you and your employer contribute	<table> <tr> <th></th><th>You</th><th>Employer</th></tr> <tr> <td>SAVINGS</td><td>2%</td><td>1% match</td></tr> <tr> <td>PHF</td><td>2%</td><td>2% match</td></tr> <tr> <td>PENSION</td><td>6.2%*</td><td>6.2%*</td></tr> </table> <p>*This rate could change each year. You will contribute half of the cost of the plan.</p> <p>For example, Bobby makes \$25,000 per year and works 30 years for a public school. He contributes 6.2% toward his pension and 4% to his savings account. His employer contributes 6.2% toward his pension and 3% toward his savings. His pension income will be \$937.50 per month or \$11,250 per year. Plus, his potential retirement income from his savings will be \$332 per month or \$142,302 total in his savings account.***</p>		You	Employer	SAVINGS	2%	1% match	PHF	2%	2% match	PENSION	6.2%*	6.2%*	<table> <tr> <th></th><th>You</th><th>Employer</th></tr> <tr> <td>SAVINGS</td><td>3%</td><td>3% match 4% mandatory</td></tr> <tr> <td>PHF</td><td>2%</td><td>2% match</td></tr> <tr> <td>PENSION</td><td>N/A**</td><td>N/A**</td></tr> </table> <p>**You do not get a pension.</p> <p>For example, Susan makes \$25,000 per year and works 30 years for a public school. She contributes 5% and her employer contributes 9% to her savings account. Her potential retirement income from her savings account will be \$665 per month or \$284,065 total in her savings account.***</p>		You	Employer	SAVINGS	3%	3% match 4% mandatory	PHF	2%	2% match	PENSION	N/A**	N/A**
	You	Employer																								
SAVINGS	2%	1% match																								
PHF	2%	2% match																								
PENSION	6.2%*	6.2%*																								
	You	Employer																								
SAVINGS	3%	3% match 4% mandatory																								
PHF	2%	2% match																								
PENSION	N/A**	N/A**																								
<p>***These are hypothetical examples for illustrative purposes only and do not represent the performance of an actual investment. It assumes an annual salary of \$25,000, pre-tax contributions, contributing regularly at age 30 until retiring at age 60, 26 pay periods per year, a 6% annual rate of return and reinvestment of earnings. Investments are subject to investment risk including the possible loss of principal. The investment return and principal value of the security will fluctuate so that when redeemed, it may be worth more or less than the original investment. In addition, these figures do not reflect any adjustment for pay raises, inflation, taxes or any fees, expenses or charges of any investment product. Taxes are generally due upon withdrawal of tax-deferred assets.</p>																										

Need more information? Visit PickMiPlan.org or call 800-748-6128.

RD606C Rev. 9/19

Plan Participation Guide

It's your future. Own it.



Plan Participation Guide

What you will find in your Plan Participation Guide

Meet Our Team. 2

Getting Started. 3

- Understanding your Plan
- Why Contribute?
- Online Resources
- Submitting Distributions
- Submitting SRAs

Enrollment. 4

Dear Employee,

Our goal at U.S. OMNI & TSACG Compliance Services is to make your life easier by ensuring your employer's supplemental retirement plan is administered properly and by ensuring that you have the resources you need to take full advantage of the opportunity to participate.

Your employer has placed the administration of their plan(s) in our hands, and this is not a responsibility we take lightly. It is our promise to you that no matter where you are at in life - actively working, nearing retirement, or retired - we will dedicate the time and effort to simplify how you access your account and manage your contributions.

This Plan Participation Guide was developed to provide resource information, but as you dive deeper into the management of your retirement accounts, you may find that you still have questions. Don't worry. We are here to help. Our Customer Service Representatives are available to assist with distribution submission and approval questions as well as salary reduction agreement submission questions. The contact information for our teams can be found later in this document.

Welcome to your benefits plan. We are happy you are here.

Sincerely,
U.S. OMNI & TSACG Compliance Services



Meet U.S. OMNI & TSACG Compliance Services

Making sure you receive the **financial wellness resources you deserve.**

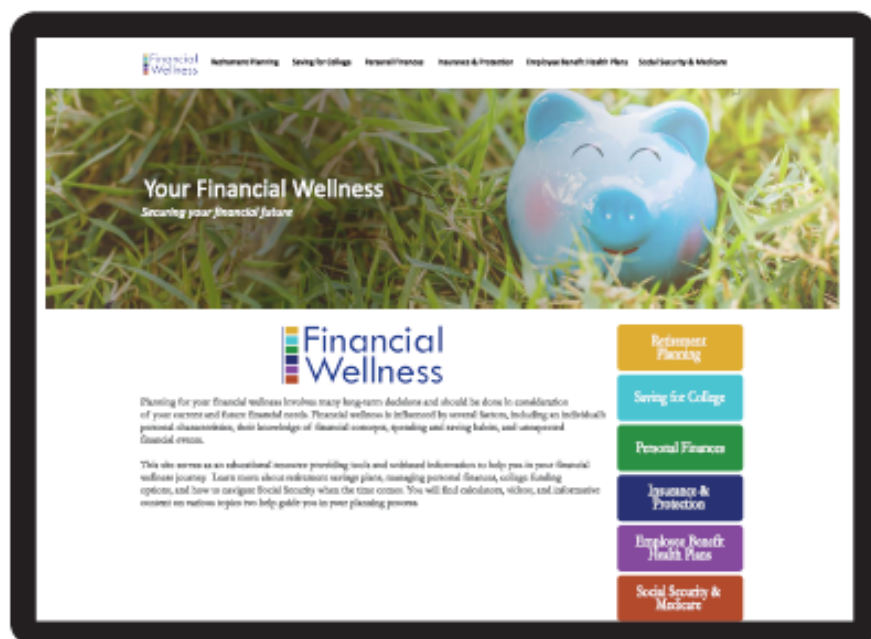
At our core, we are a group of people helping people achieve their retirement planning and wellness goals. We are just like you. We work hard so that one day we, too, can have a secure financial future.

We understand that financial preparedness should be stress-free, so we are here to make sure your plan is administered properly. We take care of the administrative details of your plan, such as remitting contributions, authorizing distribution requests, and answering everyday questions.

Since 1996, we have grown dramatically while remaining focused on what truly matters most: people. Whether it is you, your employer, our employees, or our community, we focus on connecting people with financial wellness solutions that lead to a more fulfilled life.

Many of these solutions can be found in our Financial Wellness Center. The center program contains planning modules that allow you to watch, read, or plan utilizing numerous planning calculators, videos, and educational articles. Center resources can be accessed 24/7.

Financial Wellness Center: <https://usrbpfinancialwellness.com/>



Getting Started

An introduction to your plan.



Understanding Your Plan

A 403(b) or 457(b) plan allows you to save for retirement on a tax-deferred basis. Your contributions are voluntary, and you can choose the amount based on your retirement goals. For more specific information on your employer's plan design, please reference the **Meaningful Notice**, which can be accessed by searching for your employer forms and information at <https://www.tsacg.com/individual/plan-sponsor/>.



Why Wait?

Simply put, waiting could cost you. You might ask: What difference could ten years make? Let's say you wanted to build a \$500,000 nest egg to help bridge the gap of your current retirement savings plan. If you start at age 25, you will need to contribute at least \$1,500 annually to a plan earning 10% in order to meet your goal; however, if you were to wait ten years to start, you will need to contribute at least \$4,400 annually to earn the same amount. The earlier you start, the more potential earnings you can enjoy later in life.



Online Resources

Once enrolled in the plan, you have 24/7 access to a variety of educational tools and plan resources online. Available in the FORMS or INDIVIDUAL sections at <https://www.tsacg.com>, your online access allows you to obtain plan forms, access guides and videos on how to use the website, view the plan's authorized investment providers, and so much more.



Submitting Distributions

Within just a few minutes, distribution requests can be submitted and approved using our Online Distribution System. This online system allows participants and advisors alike to gain immediate approval certification for eligible distributions. Further, all distribution requests may be submitted in this manner -- even those that require supporting documentation. U.S. OMNI & TSACG Compliance Services' Online Distribution System can be found on the homepage at <https://www.tsacg.com>, and is available 24/7. For more information on submitting distributions, please visit our website.



Submitting Salary Reduction Agreements

If this service is being utilized by your employer, you also have the ability to start, change, or stop a deduction at your convenience via our online Salary Reduction Agreement system. This system, which is available 24/7, will provide an immediate confirmation when the request has been submitted. The system also permits your financial advisor/representative to assist you in this process. Your employer's page on <https://www.tsacg.com> houses both a link to the online system and step-by-step instructions.

Enrollment

You have decided to participate in the plan. Now what?

After reviewing your employer's 403(b) or 457(b) plan, you will likely want to take advantage of saving for retirement on a tax-deferred basis. Here are some tips on how to get started.

Pick Your Investment Provider

You will want to review your employer's list of authorized investment providers and determine where you want to invest your money. A complete list of your investment providers is available to you when you visit your employer's page on <https://www.tsacg.com/individual/plan-sponsor/>. Not sure which investment provider to choose? Review company marketing materials, consult with your financial advisor, or ask a trusted colleague or mentor if they work with an advisor or investment provider they would recommend.

Contact Your Chosen Investment Provider

Once you have decided on an investment provider or providers, be sure to contact them and establish an account.

Complete a Salary Reduction Agreement

Next, you simply complete a Salary Reduction Agreement (SRA) via the process defined by your employer. Your employer's page at <https://www.tsacg.com/individual/plan-sponsor/> will either reflect the instructions to submit an SRA via U.S. OMNI & TSACG Compliance Services' online SRA system, and/or house an SRA which can be completed and submitted via the instructions provided by your employer.

What Happens Next?

Once you have submitted your SRA request, your employer will begin deducting your contribution amount from your paycheck and send the funds to your chosen investment provider or providers.



Questions?

(888) 796-3786
Distribution Team: Option 4
SRA Team: Option 5

Customer Service Hours:

Monday through Thursday,
7:00 a.m. to 7:00 p.m. CT

Friday,
7:00 a.m. to 5:00 p.m. CT

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

