



378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorioles.com



Benefits Summary

Prepared for Charlotte Public Schools
July 1, 2022



Client Focused. Solution Driven.

NIS Corporate Headquarters: 250 South Executive Drive, Suite 300, Brookfield, WI 53005-4273

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
- Family Healthcare Center

Feeling Secure

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

Work-Life Balance

- Employee Assistance Program
- Paid Time Off
- Pet Insurance



Contact Information for Benefit Vendors

Health Insurance.....	6
Blue Cross Blue Shield of Michigan 313-225-9000 www.bcbsm.com	
Health Center Information.....	27
Care ATC New Patient Phone Number: 800-993-8244 Existing Patient Phone Number: 517-482-2420 www.careatc.com/patients Download the Care ATC Mobile App	
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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800-672-7723	
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Long Term Disability Insurance.....	48
Reliance Standard Life Insurance Company	
800-353-3986	
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LifeWorks	
866-451-5465	
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Pet Insurance.....	59
Pet Partners	
866-774-1113	
www.petpartners.com	



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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

Forms.....75



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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Health Plan Option 1

Simply Blue PPO HSA \$1,400/\$2,800

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



**Blue Cross
Blue Shield**
of Michigan

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

Charlotte Public Schools
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Simply Blue PPO HSASM ASC
Effective Date: On or after July 2022
Benefits-at-a-glance

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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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Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association. 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.

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 Simply Blue prescription drug coverage 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.	\$1,400 for a one-person contract or \$2,800 for a family contract (two or more members) each benefit year (no 4th quarter carry-over)	\$2,800 for a one-person contract or \$5,600 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.	
Flat-dollar copays Coinsurance amounts (percent copays) Note: Coinsurance amounts apply once the deductible has been met.	None None	None • 20% of approved amount for most covered services
Annual out-of-pocket maximums - applies to deductibles and coinsurance amounts for all covered services - including prescription drugs cost-sharing amounts	\$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), one 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 sterilizations for females	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

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Benefits	In-network	Out-of-network
Contraceptive injections	100% (no deductible or copay/coinsurance)	80% 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) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable. One per member per benefit year	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.
Routine screening colonoscopy	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. One per member per benefit year	80% after out-of-network deductible

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	100% after in-network deductible	80% after out-of-network deductible
Note: Online visits by a vendor are not covered.		

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Benefits	In-network	Out-of-network
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
Postnatal care	100% after in-network deductible	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

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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 Limited to a maximum of 90 days per member, per benefit year	100% after in-network deductible
Hospice care	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)	100% after in-network deductible
Home health care: <ul style="list-style-type: none"> • must be medically necessary • must be provided by a participating home health care agency 	100% after in-network deductible	100% after in-network deductible
Infusion therapy: <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 	100% after in-network deductible	100% 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	100% after in-network deductible	80% after out-of-network deductible
Presurgical consultations	100% after in-network deductible	80% after out-of-network deductible
Voluntary sterilization for males	100% after in-network deductible	80% after out-of-network deductible
Note: For voluntary sterilizations for females, see "Preventive care services."		
Voluntary abortions	Not covered	Not covered

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

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Behavioral Health Services (Mental Health and Substance Use Disorder)

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance treatment	100% after in-network deductible	80% after out-of-network deductible
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 <p>Note: Online visits by a vendor are not covered.</p>	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)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization	100% after in-network deductible	100% 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	100% after in-network deductible	80% after out-of-network deductible
Other covered services, including 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

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Benefits	In-network	Out-of-network
Chiropractic spinal manipulation and osteopathic manipulative therapy Massage therapy is combined with chiro visits. Be sure to see a BCBS participating provider	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 Note: DME items 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. For a list of covered DME items required under PPACA, call BCBSM.	100% after in-network deductible	100% after in-network deductible
Prosthetic and orthotic appliances	100% after in-network deductible	100% after in-network deductible
Private duty nursing care	100% after in-network deductible	100% after in-network deductible
Prescription drugs	Covered by EHIM	Covered by EHIM

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Charlotte Public Schools A1HAV9 000000000000 Hearing Care Coverage Effective Date: On or after July 2022 Benefits-at-a-glance

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Member's responsibility (deductible and copay)

Note: Limited to a benefit maximum of \$3,000 for monaural hearing aids, \$6,000 for binaural hearing aids every 36 months per member for participating providers

Benefits	Participating provider	Nonparticipating provider
Deductible	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 or binaural hearing aid) - one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered

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Benefits	Participating provider	Nonparticipating provider
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 A1HAV8 0000000000000 Simply Blue PPO HSASM ASC Effective Date: On or after July 2022 Benefits-at-a-glance

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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 Simply Blue prescription drug coverage 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 - including prescription drugs cost-sharing amounts	\$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), one 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 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

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Benefits	In-network	Out-of-network
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) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance, if applicable. One per member per benefit year	60% 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.
Routine screening colonoscopy	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. One per member per benefit year	60% after out-of-network deductible

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

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Benefits	In-network	Out-of-network
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	80% after in-network deductible	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.		
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

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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	80% after in-network deductible Limited to a maximum of 90 days per member, per benefit year
Hospice care	80% after in-network deductible	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)
Home health care: <ul style="list-style-type: none"> 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: <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 	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	Not covered	Not covered

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
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

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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
<p>Note: Online visits by a vendor are not covered.</p> <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 behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization	80% after in-network deductible	80% after in-network deductible
<p>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.</p>		
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible
Other covered services, including mental health services, for autism spectrum disorder	80% after in-network deductible	60% after out-of-network deductible

Other covered services

Benefits	In-network	Out-of-network
Outpatient Diabetes Management Program (ODMP)	80% after in-network deductible	60% after out-of-network deductible
<p>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.</p> <p>Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p>		
Allergy testing and therapy	80% after in-network deductible	60% after out-of-network deductible

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Benefits	In-network	Out-of-network
Chiropractic spinal manipulation and osteopathic manipulative therapy Massage therapy is combined with chiro visits. Be sure to see a BCBS participating provider	80% 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	80% 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 Note: DME items 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. For a list of covered DME items required under PPACA, 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	80% after in-network deductible
Prescription drugs	Covered by EHIM	Covered by EHIM

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**Blue Cross
Blue Shield**
of Michigan

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

Charlotte Public Schools

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Hearing Care Coverage

Effective Date: On or after July 2022

Benefits-at-a-glance

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)

Note: Limited to a benefit maximum of \$3,000 for monaural hearing aids, \$6,000 for binaural hearing aids every 36 months per member for participating providers

Benefits	Participating provider	Nonparticipating provider
Deductible	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 or binaural hearing aid) - one every 36 months	100% of approved amount after Simply Blue HSA deductible and coinsurance	Not covered

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Benefits	Participating provider	Nonparticipating provider
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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378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorioles.com

Health Center Information

SET SEG Family Healthcare Center

Who is Eligible and When:

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

Contact Information

SET SEG/ Care ATC
setseg.org/ssfhc-lansing
800-993-8244

Employee Cost

FREE for those enrolled in CPS health insurance.
\$20/month for those not enrolled in CPS health insurance.

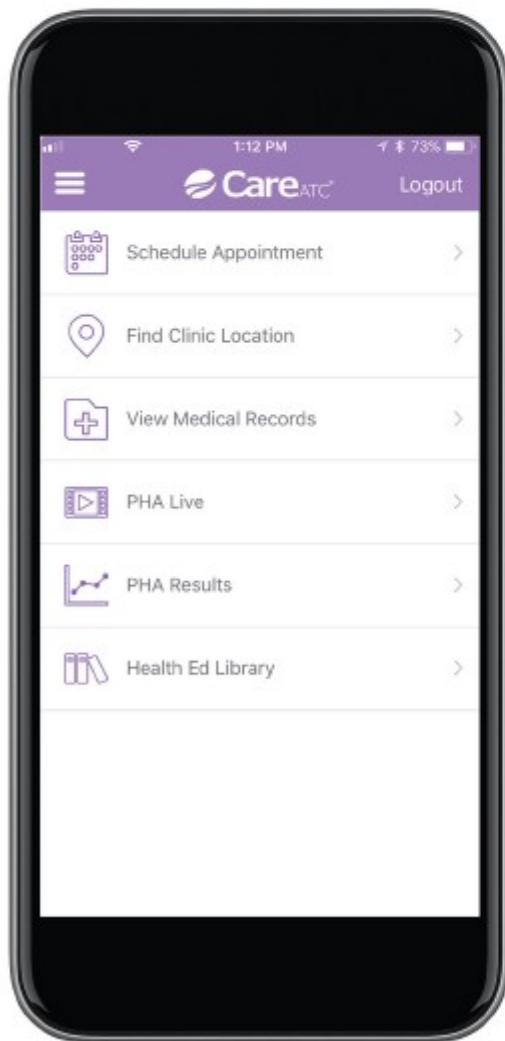
Benefits You Receive

See attached benefits summary.



CareATC Mobile App

Healthcare in the palm of your hand.



Care at your fingertips.

Use the CareATC Mobile App for secure and easy access to your personalized health information and SET SEG Family Healthcare Center resources.

- Refill prescriptions
- View lab and PHA results
- Access health education resources
- View medical records

How do I log in?

Need your username or password? Visit careatc.com/patients or call **800.993.8244** to setup your username and password. Once you have visited the SET SEG Family Healthcare Center, you will be given an access code for easier login.

Available on the App Store® and on Google Play™





Family Healthcare Center

Full-service primary care
FOR THE ENTIRE FAMILY

The SET SEG Family Healthcare Center is dedicated to keeping you healthy and emphasizing strong relationships with patients. You and your family will enjoy 30-minute appointments, allowing enough time to discuss concerns and treat ailments.

TYPES OF CARE

- Family medicine (children ages 2+, adults)
- Annual physicals and sports physicals
- Acute illness (cold, flu, infection, etc.)
- Immunizations
- Lab draws
- Sprains and strains
- Back or neck pain
- Minor injuries (cuts, burns, etc.)
- **LIMITED ON-SITE PHARMACY** - prescriptions dispensed on site

HOW MUCH DOES IT COST?

The cost of your visit depends on two things:

1. The reason for your visit
2. Whether you are on a traditional health plan or an HSA health plan

HEALTH PLAN	COST
Traditional	\$0
Health Savings Account (HSA)	Preventive Visits: \$0 <i>(Example: annual physical or cholesterol screening)</i> Acute Care Visits: \$40 <i>(Example: treating a cold or flu)</i>



“The SET SEG Family Healthcare Center did more for me in 40 minutes than my previous provider was able to do for me in seven years.”

**CHARLOTTE PUBLIC SCHOOLS
EMPLOYEE**

HOW TO PREPARE FOR YOUR FIRST VISIT

- 1. Make a list of your medications.**
 - Prescription drugs
 - Over-the-counter medications (acetaminophen, ibuprofen, aspirin, and cold medications)
 - Vitamins
 - Dietary supplements
- 2. Make a list of questions for the provider.** It is easy to forget questions you planned to ask during your appointment. Writing down your questions is the best way you can help your provider help you.
- 3. Think about your personal health goals.** This isn't the typical six-minute office visit. You have the opportunity to build a personal relationship with the healthcare team and discuss your big picture health goals. What topics would you like to cover?

The SET SEG Family Healthcare Center offers you and your family same-day and next-day appointments as well as little to no wait times.

SCHEDULE YOUR APPOINTMENT TODAY!

1. **New Patient Call: 800-993-8244**
Existing Patient Call: 517-482-2420
2. Visit careatc.com/patients
3. Download the **CareATC Mobile App**



Family
Healthcare
Center

800-993-8244

setseg.org/healthcarecenter



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Charlotte, MI 48813

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www.charlotteorion.com

Prescription Coverage

EHIM

\$10/\$40/80 Prescription

Effective: 07/01/2022

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 physician 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 patient 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 Single \$4,000 Family \$8,000	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. 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.

Charlotte, MI 48813

517-541-5100

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



Pharmacy Benefit Strategists



378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorion.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 2022, the maximum is \$3,650 for single coverage and \$7,300 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

517-541-5100

www.charlotteorion.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





PO Box 610
 Southfield, MI 48037
 248-901-3705

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

Class I Preventive Services – 80%

Routine Oral Examinations	Twice per plan year
Prophylaxis (Cleaning), Periodontal Maintenance	Twice per plan year
Topical Application of Fluoride	Twice per plan year to age 18
Bitewing X-Rays	Twice per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 36 months
All Other X-Rays	

Class II Restorative Services – 80%

Composite and Amalgam fillings**	
Space Maintainers	Up to age 14
Root Canal Therapy	
Periodontal Root Planing	
Periodontal Surgery	
Oral Surgery and Extractions	Medical plan primary for certain procedures
General Anesthesia or IV Sedation	With covered oral surgery or medically necessary
Occlusal Guards	For Bruxism Only
TMJ Appliances and Services	

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	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	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.charlotteorion.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
Contact Lens Fitting:	Retail Less 10%	\$75 Polarized Lenses \$65 Transitions Single Vision Standard \$70 Transitions Multi-Focal Standard
Lenses:	Glass or Plastic	\$15 Standard Scratch Coating
Single Vision	\$35.00	\$12 UV Coating
Bifocal	\$55.00	\$35 Polycarbonate
Trifocal or Lenticular	\$70.00	\$45 Standard Anti-Reflective
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.charlotteorion.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 Reliance Standard 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

Reliance Standard Life Insurance Company

www.reliancestandard.com





378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorion.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 Reliance Standard 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

Reliance Standard Life Insurance Company

www.reliancestandard.com





378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorion.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 \$2,850 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

517-541-5100

www.charlotteorion.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) administered 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.

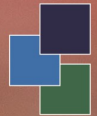
You can contact our FREE Employee Assistance Program toll-free at 866-451-5465, or you can visit the website at www.niseap.com.





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

(over)

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

Claimant Assist Services Are Available:
866.472.2734

*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.

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 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



378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorion.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.





The New Standard in Group Pet Insurance

Underwritten by
Independence American Insurance Company

Employee Benefit Summary

Date: May 16, 2022

Employer Name: Charlotte Public Schools

Plan Options:

Underwritten by Independence American Insurance Company

Accident & Illness Coverage - per covered pet

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 - per covered pet

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 The amount you are responsible for per coverage period per pet before we will pay a claim for covered expense.	\$500	\$500
Coinsurance The reimbursement portion of covered expenses after the deductible is met per pet.	80%	80%
Annual Limit The maximum amount we will reimburse you for all covered expenses during a coverage period.	\$10,000	\$10,000
Minimum Issue Age of Pet at Effective Date	8 Weeks	8 Weeks
Maximum Issue Age of Pet at Effective Date	<i>Not Applicable</i>	No Maximum Age Limit

	Accident Only	Accident & Illness
Expiration Age of Pet	None	None

Benefit Waiting Periods

The time period each pet must wait before coverage is payable. The Benefit Waiting Period starts from the effective date of coverage. Conditions that occur during the Benefit Waiting Period will be excluded from coverage as pre-existing conditions.

Injuries	Waived	Waived
Illnesses	<i>Not Applicable</i>	Waived
Cruciate Ligament (knee) Injury	6 Months	6 Months
Pre-Existing Conditions	Covered after 12 months (look back period is from date of birth)	6 months look back, then covered after 12 months
<p>Prior Coverage Credit</p> <p>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.</p>	<i>Not Applicable</i>	Included

Continuity of Coverage

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.

Additional Benefits (Riders)

<p>Office Exams and Telehealth Consult</p> <p>Provides reimbursement toward covered expenses towards physical examination, including costs/fees for telephone consultation, not wellness or routine related.</p>	Included - Subject to Deductible & Coinsurance	Included - Subject to Deductible & Coinsurance
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Accident Only**Accident & Illness**

<p>Rehabilitation and Physical Therapy</p> <p>Provides reimbursement toward the rehabilitation and physical therapy treatment for a covered condition, such as hydrotherapy and therapeutic massage.</p>	<p>Included - Subject to Deductible & Coinsurance</p>	<p>Included - Subject to Deductible & Coinsurance</p>
<p>Inherited and Congenital Care</p> <p>– Not available for Accident Only</p> <p>Provides reimbursement, after a 30-day Benefit Waiting Period*, toward covered expenses for congenital and inherited conditions, such as hip dysplasia and birth defects.</p>	<p><i>Not Applicable</i></p>	<p>Included Subject to Deductible and Coinsurance, and 30-day Benefit Waiting Period</p>
<p>Alternative and Behavioral Care</p> <p>Provides reimbursement toward holistic and alternative treatment for a covered condition such as Acupuncture, Chiropractic, Homeopathy, Herbal Therapy, Naturopathy, and Vitamins/Supplements (Behavioral Care not available for Accident Only)</p>	<p>Included Subject to Deductible & Coinsurance</p>	<p>Included Subject to Deductible & Coinsurance</p> <p>Behavioral Care subject to \$1,000 Annual Limit and 14-day Benefit Waiting Period</p>
<p>Final Respects</p> <p>Provides reimbursement toward the cremation or burial expenses of your pet due to death or humane euthanasia.</p>	<p>Included \$300 Limit Paid in excess of Annual Limit Not subject to Deductible or Coinsurance</p>	<p>Included \$300 Limit Paid in excess of Annual Limit Not subject to Deductible or Coinsurance</p>

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 – For Accident Only plans, treatment, services, and Supplies resulting from Illness regardless of the cause.
- 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: Bi-Monthly – 24

\$5.34

Accident & Illness – per Covered Pet

Frequency: Bi-Monthly – 24

	Age	Adult Weight in Pounds
Dog	Age 0 - 14+	0 - 90+
		\$26.38
Cat	Age 0 - 14+	
		\$14.75

Employer Group Pet Insurance underwritten by Independence American Insurance Company, located at 485 Madison Avenue New York, New York 10022

Policies and claims administered by PetPartners, Inc., located at 8051 Arco Corporate Drive, Suite 350, Raleigh, NC 27617

For complete benefits, exclusions, and other details, which may vary by state, please refer to Certificate of Insurance form (which may differ by state): Group Pet Insurance Accident & Illness Coverage – IAIC GPI CERT AI 0321 and Group Pet Insurance Accident Coverage – IAIC GPI CERT A 0321



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

www.charlotteorion.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>





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						
		You	Employer		You	Employer
	SAVINGS	2%	1% match	SAVINGS	3%	3% match 4% mandatory
	PHF	2%	2% match	PHF	2%	2% match
	PENSION	6.2%*	6.2%*	PENSION	N/A**	N/A**
	*This rate could change each year. You will contribute half of the cost of the plan. 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.***			**You do not get a pension. 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.***		
	<small>***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.</small>					

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

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.**

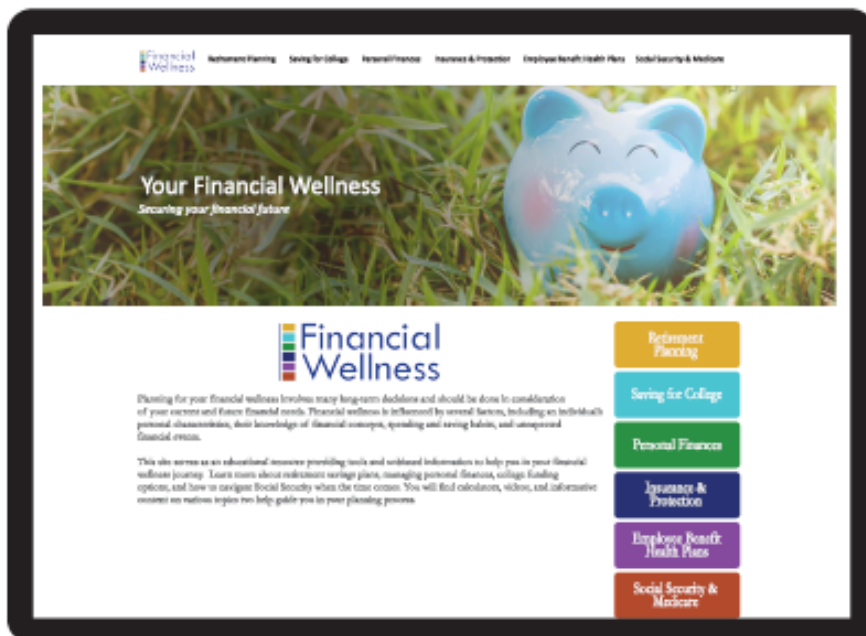
At our core, we are a group of people helping people achieve their retirement planning and wellness goals. We are just like you. We work hard so that one day we, too, can have a secure financial future.

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



378 State St.

Charlotte, MI 48813

517-541-5100

www.charlotteorion.com

Forms

Forms

Attached are the enrollment forms for all coverage types.

- Subscriber Application: Must be completed if electing any employee benefits. Also includes a section to waive health insurance coverage.
- HSA Voluntary Payroll Deduction Form: Must be completed if you want to contribute money to your Health Savings Account held at Independent Bank
- Health Center Enrollment Form: Must be completed if you would like to have the option to use the private SET SEG Family Healthcare Center
- Pet Insurance Election Form: Must be completed if you are electing pet insurance. An enrollment link will be sent to you following open enrollment to finalize the process.



Please read the following information before completing the reverse side of this application.

THE INFORMATION ON THIS FORM AND THE FOLLOWING CONDITIONS ARE PART OF MY CONTRACT WITH NATIONAL INSURANCE SERVICES AND/OR ITS DESIGNATED UNDERWRITING INSURANCE COMPANY(IES).

I am applying for coverage under my group or association contract with National Insurance Services (NIS). Coverage begins on the date determined by NIS and/or its underwriters. When NIS accepts my application I and covered members of my family are bound by the terms of the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my dependents' eligibility for coverage when requested by NIS or the appropriate insurance company(ies) underwriting my coverage(s). Authorization: I appoint my group or association to handle all matters of coverage. They may forward any agreed deductions for coverage from my wages. I am responsible for giving notice to my group or association of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, births, or death of someone covered under the policy. I authorize the appropriate insurance company(ies) underwriting my coverage(s) and/or my physician(s) to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage, and for other purposes necessary to fulfill the underwriter's contractual and statutory obligations.

Release of information: NIS does not require your Social Security number, however, your group or association, Medicare, Medicaid and others do require it. NIS will release information about you only when:

- You authorize it in writing.
- It must be released to process a claim (e.g. to another insurance company). Upon your written request, NIS will tell you when the information was sent.

Underwriting Insurance Companies:

- Health Insurance
- Supplemental Medical Insurance
- Basic Life, Accidental Death and Dismemberment Insurance
- Group Medical Options
- Dental Insurance
- Vision Insurance
- Group Long-Term Disability Insurance

These benefits may be underwritten and/or administered by one or more of several Insurance Companies or Third-Party Administrators, depending on the type of coverage and carrier selected by your employer. Please contact NIS or your employer regarding questions related to what specific coverage and/or carrier your employer has selected.



Voluntary Payroll Deduction Request Health Savings Account

Employee Name: _____

Effective Date: _____

I wish to have \$_____ of my pay withheld each pay period and deposited on my behalf by Charlotte Public Schools into my personal Health Savings Account held at Independent Bank.

My HSA account number is _____.

I understand that this is a voluntary deduction that can be changed by submitting a request to the District in writing. I further understand that it is my responsibility to adhere to federal HSA contribution limits.

Employee Signature: _____ Date: _____

Business Office Only:

Processed By: _____ Date Processed: _____

Employer _____

Account Number _____

Effective Coverage Date

EMPLOYEE INFORMATION

Job Title _____

Name _____

Hire Date _____

Social Security Number _____

Date of Birth _____
Gender Male Female

Street Address _____

City _____ State _____ ZIP _____

Phone _____

Email Address _____

Are you enrolled in the district's health plan? Yes No

Do you have a High Deductible Health Plan (HDHP)? Yes No

REQUIRED SPOUSAL INFORMATION

Name _____

Social Security Number _____

Date of Birth _____
Gender Male Female

Do they have a High Deductible Health Plan (HDHP)? Yes No

SIGNATURE

I understand by signing below, I am enrolling in the benefit(s) selected.

Applicant Signature _____

Date _____

Signed form must be received within 30 days of requested effective date. Upload to www.setseg.org by logging in and selecting "Upload Employee Enrollment Forms" from the Employee Benefit Services menu or email to enrollment@setseg.org.

REQUIRED DEPENDENT INFORMATION

Name _____

Social Security Number _____

Date of Birth _____
Gender Male Female

Do they have a High Deductible Health Plan (HDHP)? Yes No

Name _____

Social Security Number _____

Date of Birth _____
Gender Male Female

Do they have a High Deductible Health Plan (HDHP)? Yes No

Name _____

Social Security Number _____

Date of Birth _____
Gender Male Female

Do they have a High Deductible Health Plan (HDHP)? Yes No

Name _____

Social Security Number _____

Date of Birth _____
Gender Male Female

Do they have a High Deductible Health Plan (HDHP)? Yes No

Voluntary Pet Insurance Election Form

Employee Name: _____

Employee Date of Birth: _____

I am electing to enroll in the voluntary Pet Insurance program through Pet Partners. I understand that the monthly premium will be payroll deducted equally from each bi-monthly paycheck. I will receive a website link following open enrollment to complete my pet's enrollment in the program. I understand that signing this form does not complete the enrollment process.

Employee Signature: _____

Date: _____

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.

