CSA CHOICESCHOOLS ASSOCIATES

MICHOICE

Second Home
Child Development Center

2018-2019

Benefit Guide

RIGHT FOR YOU. RIGHT FOR YOUR FAMILY.

See inside for important information about your benefits.

July 1, 2018 - June 30, 2019

WELCOME

Whether you are new to our organization or an existing member of Choice Schools Associates, LLC, MIChoice, LLC or Second Home Child Development Center we are excited that you have made us your employer of choice. This booklet is to help inform you of the benefits available as a full-time active employee.

Eligibility

- Employees working 30 hours per week are eligible for medical, dental, vision and flexible spending benefits.
- Employees must work 35 hours per week to be eligible for all other benefits.
- Benefits are effective on the first of the month following date of hire.
- If the termination date is **between the 1st and 15th of the month**, coverage will terminate on the 15th of the month.
  If the termination date is **between the 16th and the end of the month**, coverage will terminate on the last day of the month.
- **Eligible dependents include children up to the end of the month in which they turn age 26 for medical, dental and vision. Voluntary Life coverage is available for children to age 21, or to age 25 if full-time student.**

Qualified Life Events

Elections you make at this time will remain in effect until the next Open Enrollment period. In addition, if you decline coverage for yourself and/or your dependent(s) when first becoming eligible, you must wait until the next Open Enrollment period to enroll. However, if you experience a qualified life event during the year, you may make changes to your elections at that time.

Qualified life events include:

- **Change in status:** Marriage, divorce, legal separation, annulment or death
- **Change in number of dependents:** Birth, death, divorce, adoption/placement for adoption or dependent reaching limiting age
- **Change in employment status** of employee, dependent or spouse that affects the individual's eligibility
- **Change in employee, spouse or dependent coverage** on spouse's plan during spouse's Open Enrollment period
- **Change in entitlement** to Medicare, Medicaid or State Children's Health Insurance Program (CHIP)* for employee, dependent or spouse
- **Change in eligibility for group health plan premium assistance** under Medicaid or CHIP* for employee, dependent or spouse

It is **your responsibility** to notify Human Resources (HR) within **30 days** of the event. If you fail to do so, you will not be able to enroll or make changes until the next Open Enrollment period. When you, your dependent(s) or your spouse become enrolled as a result of a qualified life event, coverage will be made effective retroactive to the date of the event. For more information please contact HR.

*In such cases you have 60 days to notify HR of the event instead of 30.

Our Benefits Website

Our benefits website is not only for enrolling in benefits, but also for accessing more detailed information, HR-related forms and contact information for carriers. Follow the directions on the Employee Navigator Online Benefit Enrollment page and Employee Enrollment User Guide included toward the back of this guide.

LOOK INSIDE

Medical Coverage: Blue Cross Blue Shield of MI & Blue Care Network

Medical benefits are an important part of your financial security. The impact that an unexpected medical expense may have on the financial well being of a family can be overwhelming. Choice Schools Associates, LLC, MIChoice, LLC and Second Home Child Development Center offer all eligible employees working at least 30 hours per week, and their eligible dependents, a choice of 4 health insurance plans.

If you elect the **Blue Care Network HMO Plan**, you are required to select a participating Primary Care Physician (PCP). You will be able to see a specialist with a referral from your Primary Care Physician.

If you elect one of the **Blue Cross Blue Shield Plans**, you are not required to select a Primary Care Physician (PCP). You will be able to see a specialist without a referral, and may also choose to see providers outside the Blue Cross Network, subject to additional out-of-pocket expenses.

For complete coverage details please refer to the benefit summaries or Summaries of Benefits and Coverage on Employee Navigator.

KEY MEDICAL BENEFITS	BCN HMO Basic Plan	BCBSM PPO Standard Plan	BCBSM PPO Premium Plan	(NEW) BCBSM PPO HDHP HSA Plan*
	In-Network	In-Network Only	In-Network Only	In-Network Only
Deductible (per calendar year)				
Single	$1,500	$250	$0	$1,350
Double / Family	$3,000	$500	$0	$2,700
Coinsurance Maximum (per calendar year)				
Single	$1,500	$1,000	N/A	N/A
Double / Family	$3,000	$2,000	N/A	N/A
Out-of-Pocket Maximum (per calendar year)				
Single	$6,600	$6,350	$6,350	$2,250
Double / Family	$13,200	$12,700	$12,700	$4,500
Covered Services				
Primary Care Physician	$30 copay	$25	$20	20% coinsurance after deductible
Specialist	$40 copay	$25	$20	20% coinsurance after deductible
Routine Preventive Care	covered 100%	covered 100%	covered 100%	covered 100%
Outpatient Diagnostic Lab & X-ray	20% coinsurance after deductible *Advanced Imaging—$150 copay	20% coinsurance after deductible	covered 100%	20% coinsurance after deductible
Emergency Room	$250 copay (copay waived if admitted)	$100 copay (copay waived if admitted or for accidental injury)	$100 copay (copay waived if admitted or for accidental injury)	20% coinsurance after deductible
Urgent Care Facility	$50 copay	$25 copay	$20 copay	20% coinsurance after deductible
Inpatient Hospital Stay	20% coinsurance after deductible	20% coinsurance after deductible	covered 100%	20% coinsurance after deductible
Outpatient Surgery	20% coinsurance after deductible	20% coinsurance after deductible	covered 100%	20% coinsurance after deductible
Retail RX (30-Day Supply)				
Generic	$20 copay	$15 copay	$10 copay	$15 after deductible
Preferred Brand	$60 copay	$50 copay	$40 copay	$50 after deductible
Non-Preferred Brand	$80 copay	$70 or 50% of approved amount, whichever is greater ($100 max.)	$80 copay	$70 or 50% of approved amount after deductible, whichever is greater ($100 max.)
Generic and Preferred Brand Specialty	20% coinsurance ($200 max.)	same as above	same as above	20% of approved amount ($200 max) after deductible
Non-Preferred Brand Specialty	20% coinsurance ($400 max.)	same as above	same as above	25% of approved amount ($300 max) after deductible
Mail Order RX (90-Day Supply) **Specialty Rx—30 day supply only**				
	2x applicable copay	2x applicable copay	2x applicable copay	3x applicable copay minus $10 after deductible (Specialty Rx is same as above)

***Full family deductible must be met before benefits are paid for any one person on the contract.**

HEALTH SAVINGS ACCOUNT

Your HSA can be used for qualified expenses, including those of your spouse and/or tax dependent(s), even if they are not covered by your plan. If you are not enrolled in an HDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified medical expenses.

Lake Michigan Credit Union will issue you a debit card, giving you direct access to your account balance. When you have a qualified medical expense, you can use your debit card to pay. You must have a balance to use your debit card. There are no receipts to submit for reimbursement.

Eligible expenses include doctors' office visits, eye exams, prescription expenses, laser eye surgery and more. IRS Publication 502 provides a complete list of eligible expenses and can be found on www.irs.gov.

Eligibility

You are eligible to open and fund an HSA if:

- You are enrolled in Choice Schools Associates, LLC's HDHP Plan.
- You are not covered by your spouse's non-HSA health plan.
- Your spouse does not have a health care Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

Individually Owned Account

You own and administer your Health Savings Account. You determine how much you'll contribute to the account, when to use the money to pay for qualified medical expenses, and when to reimburse yourself. HSAs allow you to save and roll over money if you do not spend it in the calendar year. The money in this account is portable, even if you change plans or jobs. There are no vesting requirements or forfeiture provisions.

How to Enroll

You must elect the HDHP Plan with Choice Schools Associates, LLC. You will need to complete all HSA enrollment materials and designate the amount to contribute on a pre-tax basis. Once you establish your HSA Account, Choice Schools will transfer your bi-weekly contribution, once bank account information has been provided and verified.

Maximize Your Tax Savings

Contributions to an HSA are tax-free (they can be made through payroll deduction on a pre-tax basis when you open an account with Lake Michigan Credit Union). The money in this account (including interest and investment earnings) grows tax-free. As long as the funds are used to pay for qualified medical expenses, they are spent tax-free.
Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

HSA Funding Limits

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts. For 2018, contributions (which include any employer contribution) are limited to the following:

HSA Funding Limits	
Single	$3,450
Double/Family	$6,900
Catch-Up Contribution (Ages 55+)	$1,000

Employer HSA Annual Contribution*	
Single	$1,320
Double	$1,320
Family	$1,320

***Choice Schools Associates, LLC will contribute $110 monthly.**

HSA contributions in excess of the IRS annual contribution limits ($3,450 for individual coverage and $6,900 for family coverage for 2018) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you can do one of two things:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed from your HSA.
- Leave the excess contributions in your HSA and pay 6% excise tax on excess contributions. Next year you may want to consider contributing less than the annual limit to your HSA to make up for the excess contribution during the previous year.

The Choice Schools Associates, LLC HSA will be established with Lake Michigan Credit Union. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources.

Notes

Teladoc®

Talk to a  anytime

Teladoc® gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone or video consults. It's an affordable alternative to costly urgent care and ER visits when you need care now.

WHEN CAN I USE TELADOC?

Teladoc does not replace your primary care physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

MEET OUR DOCTORS

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 15 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

Talk to a doctor anytime for Free

MyDrConsult.com

1-800-DOC-CONSULT (362-2667)

Mail-Order Prescription: Express Scripts (BCBSM / BCN)

Through the Mail Order Service, you can purchase up to a 90-day supply of most prescription medications and order refills for many of the medications you take on an on-going basis. All medications are delivered to your home. **To obtain a mail-order form, please see your Employee Navigator homepage. Instructions for ordering prescriptions through mail-order:**

Please take a minute to make sure…

- You have included your doctor's signed prescription form and filled out the patient information on the front of the order form for each new prescription.
- You have either filled out the credit card section on the front of this order form or included a check or money order for the required copayment.
- You have written your member ID number on any check or money order.
- You have filled out the Health, Allergy and Medication Questionnaire. This information will help Express Scripts better serve your prescription drug needs.

BCBSM - You can call 1-800-903-8346 anytime to enroll in our automated payment plan, change the credit card on file, check your account balance, or pay by phone using a credit card. Get more information from our website. Visit us at www.bcbsm.com

BCN - You can call 1-800-229-0832 anytime to enroll in our automated payment plan, change the credit card on file, check your account balance, or pay by phone using a credit card. Get more information from our website. Visit us at www.express-scripts.com

Dental Coverage: Delta Dental

Following is a high-level overview of the Dental coverage. For completed coverage details, please refer to the benefit summary in Employee Navigator.

KEY DENTAL BENEFITS	PPO and Premier In-Network
Deductible (per calendar year)	
Per Individual	$0 per member $0 per family
Benefit Maximum (per calendar year; Preventive, Basic and Major Services combined)	
Per Individual	$1,500
Covered Services	
Preventive Services	100%
Basic Services	80%
Major Services	50%
Orthodontia (Children up to age 19)	50%; $1,500 lifetime maximum per child

Vision Coverage: VSP

Following is a high-level overview of the Vision coverage. For completed coverage details, please refer to the benefit summary in Employee Navigator.

Key Vision Benefits	Frequency	In-Network
Exam	Every 12 months	$10 copay
Prescription Glasses	Every 12 months	$25 copay
Lenses Single Vision Lined Bifocal Lined Trifocal Progressive	Every 12 months	(Included in Prescription Glasses) (Included in Prescription Glasses) (Included in Prescription Glasses) $0—$160 Copay
Frames	Every 24 months	(Included in Prescription Glasses) $130 Allowance
Contact Lenses (instead of glasses)	Every 12 months	$130 allowance (Up to $60 exam copay for fitting)

FLEXIBLE SPENDING ACCOUNT

BCN HMO and Blue Cross Standard & Premium Plans only

****Effective 07/01/18 our Flexible Spending Accounts will be administered by Infinisource****

Flexible Spending Account

You can contribute up to $2,650 for qualified medical expenses (deductibles, copays and coinsurance, for example) with pre-tax dollars, which will reduce the amount of your taxable income and increase your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them, so you don't have to wait for reimbursement.

Please note: Over-the-counter (OTC) drugs are not eligible for reimbursement through an FSA without a doctor's prescription.

You can only elect an FSA if you enroll in the BCN HMO or Blue Cross Standard or Premium Plan.

How to Use the Account

You can your FSA debit card at locations such as doctor and dentist offices, pharmacies, and vision service providers. The card cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The swipe transaction will be denied if you attempt to use the card at an ineligible location.

Should you need to submit a receipt, you will receive an email or be mailed a receipt notification from Infinisource. You should always retain a receipt for your records.

General Rules and Restrictions

In exchange for the tax advantages that FSAs offer, the IRS has imposed the following rules and restrictions for both Health Care and Dependent Care FSAs:

- Your expenses must be incurred during the 2018 plan year.
- Your dollars cannot be transferred from one FSA to another.
- You cannot change your FSA election in the middle of the plan year unless you experience a qualifying life event like marriage, divorce or birth of a child.
- If you have remaining funds in your FSA account at the end of the plan year and are still eligible for the FSA, you will be able to roll over $500 from your current plan to the new plan year. Any amount over $500 remaining will be forfeited.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

****Effective 07/01/18 our Flexible Spending Accounts will be administered by Infinisource****

Dependent Care Reimbursement Account

Through the use of a Dependent Care Reimbursement Account (DCRA), you can reduce your tax burden by using pre-tax dollars to pay for eligible child or dependent care expenses. Federal law also allows you to claim a direct credit against federal income taxes for eligible child or dependent care expenses. You may use a DCRA or take a federal tax credit - but not both.

How to Use the Account

The DCRA operates much like a bank account. Deposits are made into your account through pre-tax payroll deductions. Withdrawals from the account are made using a reimbursement form, which is available on Employee Navigator. Reimbursement requests can also be submitted online to Infinisource, along with a copy of your receipt and/or bill and a description of the expense.

General Rules and Restrictions

Dependent care expenses are expenses incurred by you to enable you to work. If you are married, the expenses must be to enable you and your spouse to work, or your spouse to attend school on a full time basis. The expenses must be for the care of your dependent that is under age thirteen and for whom a personal-exemption deduction is allowed for federal income tax purposes; or for the care of your dependent or spouse who is physically or mentally incapable of self-care, or for household services in connection with the care of such a person.

If you are single or married filing a joint return, the maximum amount that can be reimbursed (i.e., deposited) is the lowest of your earned income or your spouse's earned income, or $5,000. If you are married and you file a separate tax return, the maximum amount that can be reimbursed (i.e., deposited) is the lower of 100% of your spouse's income or $2,500. If your spouse is a full-time student or is incapable of self-care, your spouse's earned income is assumed to be not less than $3,000 if you provide care for one person and $6,000 if you provide for two or more people.

Plan Carefully

Since funds going into your account are free from taxes, the IRS imposes some restrictions on the operation of this account. Expenses must be incurred within the year or within the 2 1/2 month grace period following the end of the year. If you have funds remaining in your DCRA account at the end of the period, according to IRS regulations, **you will forfeit this amount**. You will receive a statement from Infinisource before the end of the plan year to help you manage this account.

Know your Eligible and Ineligible Expenses

Maximize the Value of Your Reimbursement Account

INFINISOURCE

Your Health Care Flexible Spending Account (FSA) dollars can be used for a variety of out-of-pocket health care expenses. The following list is based on eligible and ineligible expenses used by federal employees.

Eligible Expenses

Baby/Child to age 13

- ✓ Lactation consultant
- ✓ Lead-based paint removal*
- ✓ Special formula*
- ✓ Tuition: special school/teacher for disability or learning disability*
- ✓ Well baby/well child care

Dental

- ✓ Dental x-rays
- ✓ Dentures and bridges
- ✓ Exams and teeth cleaning
- ✓ Extractions and fillings
- ✓ Oral surgery
- ✓ Orthodontia
- ✓ Periodontal services

Eyes

- ✓ Eye exams
- ✓ Eyeglasses and contact lenses
- ✓ Laser eye surgeries
- ✓ Prescription sunglasses
- ✓ Radial keratotomy

Hearing

- ✓ Hearing Aids and Batteries
- ✓ Hearing exams

Lab Exams/Tests

- ✓ Blood Tests and Metabolism Tests
- ✓ Body Scans
- ✓ Cardiograms
- ✓ Laboratory Fees
- ✓ X-Rays

Medical Equipment/Supplies

- ✓ Air purification equipment*
- ✓ Arches and other orthotic inserts
- ✓ Contraceptive devices
- ✓ Crutches, walkers, wheel chairs
- ✓ Exercise equipment*
- ✓ Hospital beds*
- ✓ Mattresses*
- ✓ Medic alert bracelet or necklace
- ✓ Nebulizers
- ✓ Orthopedic shoes*
- ✓ Oxygen
- ✓ Post-mastectomy clothing
- ✓ Prosthetics
- ✓ Syringes
- ✓ Wigs*

Medical Procedures/Services

- ✓ Acupuncture
- ✓ Alcohol and drug/substance abuse (inpatient treatment and outpatient care)
- ✓ Ambulance
- ✓ Fertility enhancement and treatment
- ✓ Hair loss treatment*
- ✓ Hospital services
- ✓ Immunization
- ✓ In vitro fertilization
- ✓ Personal trainers*
- ✓ Physical examination (not employment-related)
- ✓ Reconstructive surgery (due to a congenital defect, accident or medical treatment.)
- ✓ Service animals
- ✓ Sterilization/sterilization reversal
- ✓ Transplants (including organ donor)
- ✓ Transportation*

Obstetrics

- ✓ Doulas*
- ✓ Lamaze class
- ✓ OB/GYN exams
- ✓ OB/GYN prepaid maternity fees (reimbursable after date of birth)
- ✓ Pre- and post-natal treatments

Practitioners

- ✓ Allergist
- ✓ Chiropractor
- ✓ Christian Science Practitioner
- ✓ Dermatologist
- ✓ Homeopath
- ✓ Naturopath*
- ✓ Optometrist
- ✓ Osteopath
- ✓ Physician
- ✓ Psychiatrist or Psychologist

Therapy

- ✓ Alcohol and Drug Addiction
- ✓ Counseling (must be treating a medical condition)
- ✓ Exercise Programs*
- ✓ Hypnosis*
- ✓ Massage*
- ✓ Occupational
- ✓ Physical
- ✓ Smoking Cessation Programs*
- ✓ Speech
- ✓ Weight Loss Programs*

Medications

- ✓ Insulin
- ✓ Prescription drugs

This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a note of medical necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact Infinisource.

INFINISOURCE

The IRS does not allow the following expenses to be reimbursed under Health Care FSAs, as they are not prescribed by a physician for a specific ailment.

Ineligible Expenses

- Contact lens or eyeglass insurance
- Cosmetic surgery/procedures
- Electrolysis
- Insurance premiums and interest
- Long-term care premiums
- Marriage or career counseling
- Sunscreen (SPF less than 15 needs RX)
- Swimming lessons

Note: This list is not meant to be all-inclusive

Please note: The IRS will not allow OTC medicines or drugs to be purchased with Health Care FSA funds unless accompanied by a prescription.

Eligible Over-the-Counter Items

Note: Product categories are listed in bold face; common examples of products are listed in regular face.

The following is a high level list of over-the-counter (OTC) items that clearly are not medicine or drugs and are eligible for purchase with Health Care FSA dollars. You can use your benefits card for these items

Antiseptics, wound cleaners
Alcohol, peroxide, Epsom salt

Baby electrolytes
Pedialyte, Enfalyte

Denture adhesives, repair and cleansers
PoliGrip, Benzodent, Efferdent

Diabetes testing and aids
Insulin, Ascencia, One Touch, Diabetic Tussin, insulin syringes, glucose products

Diagnostic products
Thermometers, blood pressure monitors, cholesterol testing

Elastics/athletic treatments
ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts

Eye care
Contact lens care

Family planning
Pregnancy and ovulation kits

First aid dressings and supplies
Band Aid, 3M Nexcare, non-sport tapes

Hearing aid/medical batteries

Incontinence products
Attends, Depend, GoodNites for juvenile incontinence

Reading glasses and maintenance accessories

Sunscreen (SPF 15 and over)

For additional information, please contact:

Infinisource
PO Box 488
Coldwater, MI 49036-0488

PH: 866.370.3040
Fax: 800.379.5670
Email: fsa@infinisource.com

Basic Life/AD&D Coverage: The Standard

We help our eligible employees maintain financial security by providing a Basic Life and Accidental Death and Dismemberment (AD&D) benefit.

This benefit is provided at **NO COST** to you.

Basic Life and AD&D	Amount
Employee	**$50,000**

Voluntary Life/AD&D Coverage: The Standard

If you determine you need more than the Employer-paid Basic Life/AD&D coverage, you may purchase additional Life/AD&D insurance on yourself and your spouse, and additional Life insurance on your child-(ren). In order to purchase coverage for your spouse and/or child(ren), you must purchase coverage for yourself. Refer to Employee Navigator or the attached rate grid to calculate your cost.

	Benefit Option	Guarantee Issue*
Employee		
	Increments of $10,000, not to exceed $300,000	**$150,000**
Spouse		
	Increments of $5,000 to a maximum of $150,000, not to exceed 100% of employee elected amount	**$30,000**
Child(ren)		
	Live birth to age 21, or to age 25 if full-time student	**$10,000**

*During your initial eligibility period only, you can receive coverage up to the Guarantee Issue amounts without having to provide Evidence of Insurability (information about your health). Coverage amounts that require Evidence of Insurability will not be effective unless approved by the insurance carrier.

*At each open enrollment period, if you are currently enrolled in coverage under the Guarantee Issue amount, you are eligible to increase your coverage by one $10,000 increment up to the Guarantee Issue amount of $150,000. Currently enrolled spouses are eligible to increase coverage by one $5,000 increment up to the Guarantee Issue amount of $30,000.

*Voluntary Child Life is not subject to Evidence of Insurability.

*Spouse rates & age reductions based on employee's age. See summary in Employee Navigator for full details.

*Your cost will increase as your age increases.

INCOME PROTECTION

Short-Term Disability Coverage: The Standard

The financial consequences of a disability can be disastrous to your financial security and that of your family. We provide **Short-Term Disability** insurance to all eligible employees and **pay the full cost** of this benefit.

Short-Term Disability	Benefit
Benefit Percentage	66.67% of weekly salary
Weekly Benefit Maximum	$500
When Benefits Begin	1st day due to injury 8th day due to illness
Maximum Benefit Duration	90 days
Note: Refer to summary in Employee Navigator for more details and/or limitations.	

Voluntary Long-Term Disability Coverage: The Standard

We also offer eligible employees a Voluntary Long-Term Disability plan. Refer to Employee Navigator or the attached rate grid to calculate your cost.

Voluntary Long-Term Disability	Benefit*
Benefit Percentage	60%
Monthly Benefit Maximum	$5,000
When Benefits Begin	90 days
Maximum Benefit Duration	Later of age 65 or Social Security Normal Retirement Age
Note: Refer to summary in Employee Navigator for more details and/or limitations.	

*Pre-existing condition exclusion applies. You have a pre-existing condition if you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 90 days just prior to your effective date of coverage, and the disability begins in the first 12 months after your effective date of coverage.

*During your initial eligibility period only, you can elect coverage without having to provide Evidence of Insurability (information about your health). Coverage elected at a future open enrollment will require Evidence of Insurability, and will not be effective unless approved by the insurance carrier.

EAP Employee Flyer—Three Face-to-Face

There are times in life when you might need a little help coping or figuring out what to do. Take advantage of the Employee Assistance Program[1] (EAP) which includes WorkLife Services and is available to you and your family in connection with your group insurance from The Standard.‡ It's confidential — information will be released only with your permission or as required by law.

With EAP, assistance is immediate, personal and available when you need it.

Connection to Resources, Support and Guidance

You, your dependents (including children to age 26)[2] and all household members can contact master's-degreed clinicians 24/7 by phone, online, live chat, email and text. There's even a mobile EAP app. Receive referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services.

Your program includes up to three face-to-face assessment and counseling sessions per issue. EAP services can help with:

- Depression, grief, loss and emotional well-being
- Family, marital and other relationship issues
- Life improvement and goal-setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution
- Online will preparation

WorkLife Services

WorkLife Services are included with the Employee Assistance Program. Get help with referrals for important needs like education, adoption, travel, daily living and care for your pet, child or elderly loved one.

Online Resources

Visit **www.eapbda.com** to explore a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

Contact **EAP**

888.293.6948
TDD: 800.327.1833
24 hours a day,
seven days a week

www.eapbda.com
Enter **standard** as the login ID and **eap4u** as the password

NOTE: It's a violation of your company's contract to share this information with individuals who are not eligible for this service.

1 The EAP service is provided through an arrangement with Bensinger, DuPont & Associates (BDA), which is not affiliated with The Standard. BDA is solely responsible for providing and administering the included service. EAP is not an insurance product and is provided to groups of 10–2,499 lives. This service is only available while insured under The Standard's group policy.

2 Children under the age of 12 will not receive individual face-to-face counseling sessions.

‡ The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of 1100 SW Sixth Avenue, Portland, Oregon, in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of 360 Hamilton Avenue, Suite 210, White Plains, New York. Product features and availability vary by state and company, and are solely the responsibility of each subsidiary. Each company is solely responsible for its own financial condition. Standard Insurance Company is licensed to solicit insurance business in all states except New York. The Standard Life Insurance Company of New York is licensed to solicit insurance business in only the state of New York.

Standard Insurance Company

The Standard Life Insurance Company of New York

www.standard.com

Employee Assistance Program-3
17201 (10/15) SI/SNY EE

Life Services Toolkit

Resources and tools to help you and your beneficiary meet life's challenges

Group Life insurance through your employer gives you assurance that your family will receive some financial assistance in the event of a death. But coverage under a Group Life policy from The Standard‡ does more than help protect your family from financial hardship after a loss. We have partnered with Bensinger, DuPont & Associates (BDA) to offer a lineup of additional services that can make a difference now and in the future.

Online tools and services can help you create a will, make advance funeral plans and put your finances in order. After a loss, beneficiaries can consult experts by phone or in person, and obtain other helpful information online.

The Life Services Toolkit is automatically available to those insured under a Group Life insurance policy from The Standard. Recipients of an Accelerated Benefit can access services for 12 months after the date of payment. Life insurance beneficiaries[1] can access services for 12 months after the date of death.

Services to Help You Now

Visit the Life Services Toolkit website for information and tools to help you make important life decisions.

www.standard.com/mytoolkit with the username "assurance"

- **Estate-Planning Assistance:** Online tools, found in the Legal Forms section, walk you through the steps to prepare a will and create other documents, such as living wills, powers of attorney and health care agent forms.
- **Financial Planning:** Consult online services to help you manage debt, calculate mortgage and loan payments, and take care of other financial matters with confidence.
- **Health and Wellness:** Timely articles about nutrition, stress management and wellness help employees and their families lead healthy lives.
- **Identity Theft Prevention:** Check the website for ways to thwart identity thieves and resolve issues if identity theft occurs.
- **Funeral Arrangements:** Use the website to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.

If you are a recipient of an Accelerated Benefit, you may access the services for beneficiaries outlined on the next page.

Standard Insurance Company

The Standard Life Insurance Company of New York

www.standard.com

‡ The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of White Plains, New York.

[1] The Life Services Toolkit is not available to Life insurance beneficiaries who are minors or to non-individual entities such as trusts, estates or charities.

Life Services Toolkit
17526 (10/15) SI/SNY EE FLYER

Services for Your Beneficiary

These supportive services can help your beneficiary cope after a loss:

- **Grief Support:** Clinicians with master's degrees are on call to provide confidential grief sessions by phone or in person. Beneficiaries are eligible for up to six face-to-face sessions and unlimited phone contact.
- **Legal Services:** Beneficiaries can obtain legal assistance from experienced attorneys.
  - They can schedule an initial 30-minute office and a telephone consultation with a network attorney. Beneficiaries who wish to retain a participating attorney after the initial consultation receive a 25 percent rate reduction from the attorney's normal hourly or fixed fee rates.
  - They can obtain an estate-planning package that consists of a simple will, a living will, a health care agent form and a durable power of attorney.
- **Financial Assistance:** Beneficiaries have unlimited phone access to financial counselors who can help with issues such as budgeting strategies, and credit and debt management, including hour-long sessions on topics requiring more in-depth discussion.
- **Support Services:** During an emotional time, beneficiaries can receive help planning a funeral or memorial service. Work-life advisors can guide them to resources to help manage household repairs and chores; find child care and elder care providers; or organize a move or relocation.
- **Online Resources:** Beneficiaries can easily access additional services and features on the Life Services Toolkit website for beneficiaries, including online resources to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements.

For beneficiary services, visit www.standard.com/mytoolkit (User name = support) or call the phone assistance line at 800.378.5742.

Beneficiaries can participate in phone consultations or in-person meetings with trained grief counselors.

Travel Assistance

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you navigate these issues and more at any time of the day or night.

You and your spouse are covered with Travel Assistance[1] — and so are kids through age 25 — with your group insurance from The Standard.‡

Security That Travels with You

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

- Passport, visa, weather and currency exchange information, health hazards advice and inoculation requirements
- Emergency ticket, credit card and passport replacement, funds transfer and missing baggage
- Connection to medical care providers and interpreter services
- 24/7/365 phone access to registered nurses for health and medication information, symptom decision support, and help understanding treatment options
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains[2]
- Connection to a local attorney, consular officer or bail bond services
- Logistical arrangements for ground transportation, housing and/or evacuation in the event of political unrest and social instability; for more complex situations, assists with making arrangements with providers of specialized security services

Contact Travel Assistance

800.527.0218
United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda

+1.410.453.6330
Everywhere else

Assistance@uhcglobal.com

www.standard.com/travel

Global Intelligence Center
www.standard.com/travel
Group #9061
Travel Assistance is available if you travel more than 100 miles from home or in a foreign country.
Contact
800.527.0218: United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda
+1.410.453.6330: Everywhere else
Assistance@uhcglobal.com

UnitedHealthcare Global is not responsible for the availability or results of any medical, legal, or transportation services. You are responsible for obtaining all services not directly provided by UnitedHealthcare Global and for the expenses associated with them. All services must be arranged by UnitedHealthcare Global. No claims for reimbursement will be accepted.

1 Travel Assistance is provided through an arrangement with UnitedHealthcare Global, which is not affiliated with The Standard, and is subject to the terms and conditions, including exclusions and limitations, of the Emergency Travel Assistance Program Employee Description. UnitedHealthcare Global is solely responsible for providing and administering the included service. Travel Assistance is not an insurance product, except in Oregon. UnitedHealthcare Global is the marketing name for FrontierMEDEX, Inc. This service is only available while insured under The Standard's group policy.

2 Must be arranged by UnitedHealthcare Global. Related medical services, medical supplies and a medical escort are covered where applicable and necessary.

‡ The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of 1100 SW Sixth Avenue, Portland, Oregon, in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of 360 Hamilton Avenue, Suite 210, White Plains, New York. Product features and availability vary by state and company, and are solely the responsibility of each subsidiary. Each company is solely responsible for its own financial condition. Standard Insurance Company is licensed to solicit insurance business in all states except New York. The Standard Life Insurance Company of New York is licensed to solicit insurance business in only the state of New York.

Standard Insurance Company

The Standard Life Insurance Company of New York

www.standard.com

Travel Assistance
14684 (8/15) SI/SNY EE

2018-2019 Employee Contributions Rates (Bi-Weekly)

Medical Coverage

Coverage Tier	BCN HMO Basic Plan	BCBSM PPO Standard Plan	BCBSM PPO Premium Plan	(NEW) BCBSM PPO HDHP HSA Plan
	Per Pay Cost	Per Pay Cost	Per Pay Cost	Per Pay Cost
Single	$0.00	$0.00	$45.00	$0.00
Double	$163.14	$338.82	$430.00	$268.02
Family	$265.52	$484.03	$595.46	$382.89

Dental Coverage

Coverage Tier	Delta Dental
	Per Pay Cost
Single	$0.00
Double	$31.19
Family	$31.19

Vision Coverage

Coverage Tier	VSP
	Per Pay Cost
Single	$0.00
Double	$1.65
Family	$5.46

Cash in Lieu

If you have declined medical, dental, vision coverage, and Flex deductions, Choice Schools will provide a credit of $100 toward your Bi-Weekly benefits contribution.
Per Pay Credit
$100.00

Teladoc

Per Pay Cost
$1.18

Voluntary LTD

Premium Factor by age	
<30	$0.001015
30-34	$0.001569
35-39	$0.002631
40-44	$0.004015
45-49	$0.005585
50-54	$0.007200
55-59	$0.009231
60-64	$0.007708
65-69	$0.006092
70-74	$0.005215
75+	$0.005215

Voluntary Long-Term Disability Worksheet		Example: age 36 earning $30,000 annually
List your monthly earnings (Maximum covered payroll is $8,333.33 monthly)	$	$2,500
Multiply by Premium Factor Age:	$	$002631
Your Estimated Bi-Weekly Premium*	$	$6.58

*This is an estimate of premium cost. Actual deductions my vary slightly due to rounding and payroll frequency.

Employee - Life and AD&D Bi-Weekly Cost

AGE	Bi-Weekly Rate per $1,000	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$100,000	$110,000	$120,000	$130,000	$140,000	$150,000
under 25	0.0369	0.37	0.74	1.11	1.48	1.85	2.21	3.69	4.06	4.43	4.80	5.17	5.54
25-29	0.0369	0.37	0.74	1.11	1.48	1.85	2.21	3.69	4.06	4.43	4.80	5.17	5.54
30-34	0.0369	0.37	0.74	1.11	1.48	1.85	2.21	3.69	4.06	4.43	4.80	5.17	5.54
35-39	0.0508	0.51	1.02	1.52	2.03	2.54	3.05	5.08	5.59	6.10	6.60	7.11	7.62
40-44	0.0785	0.79	1.57	2.36	3.14	3.93	4.71	7.85	8.64	9.42	10.21	10.99	11.78
45-49	0.1154	1.15	2.31	3.46	4.62	5.77	6.92	11.54	12.69	13.85	15.00	16.16	17.31
50-54	0.2123	2.12	4.25	6.37	8.49	10.62	12.74	21.23	23.35	25.48	27.60	29.72	31.85
55-59	0.3277	3.28	6.55	9.83	13.11	16.39	19.66	32.77	36.05	39.32	42.60	45.88	49.16
60-64	0.3462	3.46	6.92	10.39	13.85	17.31	20.77	34.62	38.08	41.54	45.01	48.47	51.93
65-69		**$6,500**	**$13,000**	**$19,500**	**$26,000**	**$32,500**	**$39,000**	**$65,000**	**$71,500**	**$78,000**	**$84,500**	**$91,000**	**$97,500**
	0.6323	4.11	8.22	12.33	16.44	20.55	24.66	41.10	45.21	49.32	53.43	57.54	61.65
70-74		**$4,000**	**$8,000**	**$12,000**	**$16,000**	**$20,000**							
	1.3292	$5.32	$10.63	$15.95	$21.27	$26.58	N/A	N/A	N/A	N/A	N/A	N/A	N/A

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Spouse (Age based on employee) - Life and AD&D Bi-Weekly Cost

AGE	Bi-Weekly Rate per $1,000	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
under 25	0.0369	0.18	0.37	0.55	0.74	0.92	1.11
25-29	0.0369	0.18	0.37	0.55	0.74	0.92	1.11
30-34	0.0369	0.18	0.37	0.55	0.74	0.92	1.11
35-39	0.0508	0.25	0.51	0.76	1.02	1.27	1.52
40-44	0.0785	0.39	0.79	1.18	1.57	1.96	2.36
45-49	0.1154	0.58	1.15	1.73	2.31	2.89	3.46
50-54	0.2123	1.06	2.12	3.18	4.25	5.31	6.37
55-59	0.3277	1.64	3.28	4.92	6.55	8.19	9.83
60-64	0.3462	1.73	3.46	5.19	6.92	8.66	10.39
65-69		**$3,250**	**$6,500**	**$9,750**	**$13,000**	**$16,250**	**$19,500**
	0.6323	2.05	4.11	6.16	8.22	10.27	12.33

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Example:
Use this formula to calculate premium for benefit amounts over amounts listed above.

Example	Amount of Insurance	Divided by 1,000	Multiplied by rate	Bi-Weekly Cost
Age 33	$150,000	/ 1,000 = 150	x $0.0369	$5.54
			X	
			X	

Dependent Child(ren) - Life Bi-Weekly Cost

$10,000
0.92

Premium covers all dependent children regardless of the number of children.

HUBLink (Employee Navigator) Online Benefit Enrollment

******2018 Open Enrollment elections will be made utilizing the HUBLink (Employee Navigator) Online Benefit Enrollment portal. Please refer to the log-in information below, and the Employee Enrollment User Guide on the following pages for specific details.******

How to Enroll:

Log into our Employee Benefit Website at: www.employeenavigator.com and click on Login

Returning User: Type in Username and Password. If you have forgotten your password, click on Reset a forgotten password once you have entered your Username. The password reset will be sent to your email address.

New User: Click on Register as a New User. Complete the fields requested to match with the information already loaded in the system.

Use **Choice Sch** as the Company Identifier.

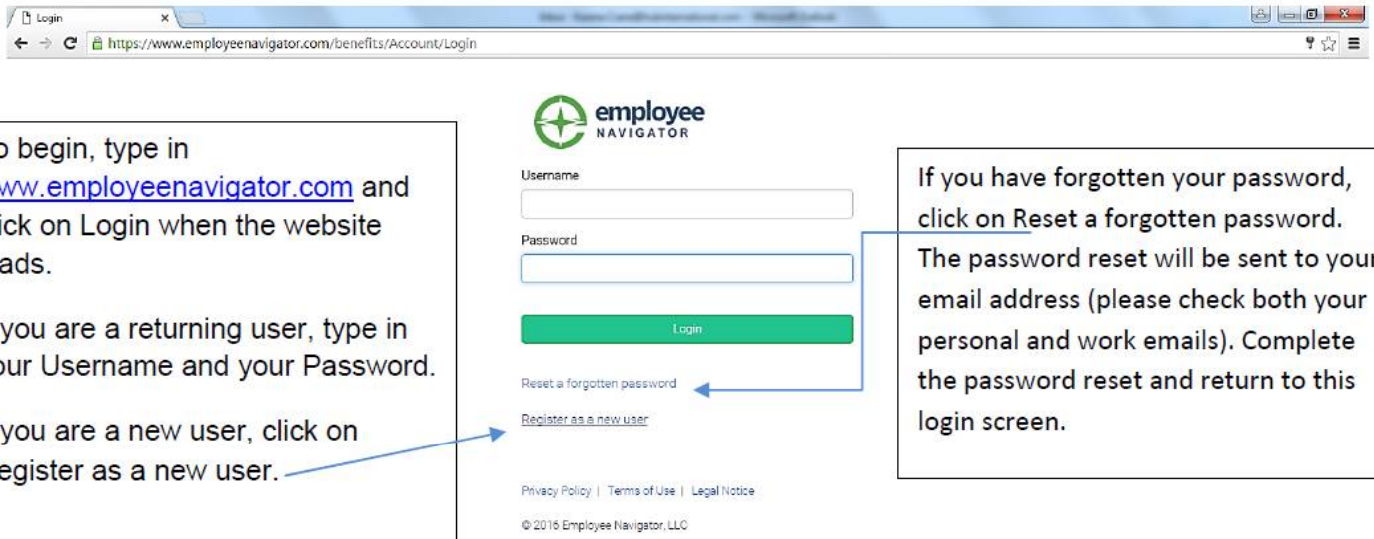
Check to make sure your Personal Information and Dependent Information is correct. Update if necessary.

Be sure to elect or waive each of the coverages.

Review your elections on the Enrollment Summary and click the Agree button to complete your enrollments.

There is a Print icon in the upper right corner of the screen if you wish to print out your benefit summary.

HUBLink (Employee Navigator) Employee Enrollment User Guide

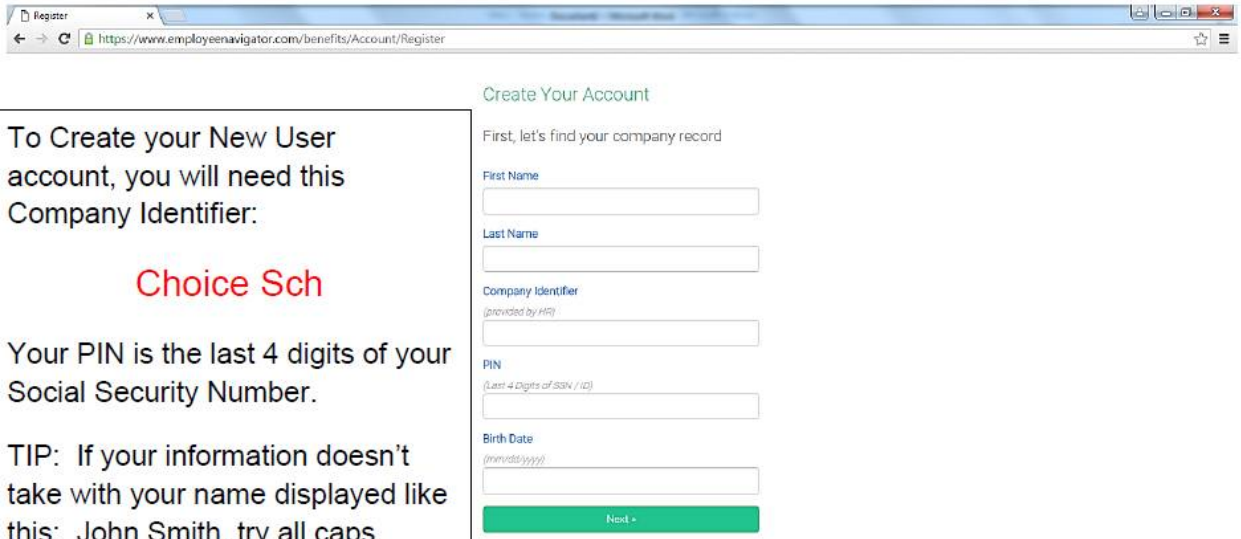


To begin, type in www.employeenavigator.com and click on Login when the website loads.

If you are a returning user, type in your Username and your Password.

If you are a new user, click on Register as a new user.

If you have forgotten your password, click on Reset a forgotten password. The password reset will be sent to your email address (please check both your personal and work emails). Complete the password reset and return to this login screen.



To Create your New User account, you will need this Company Identifier:

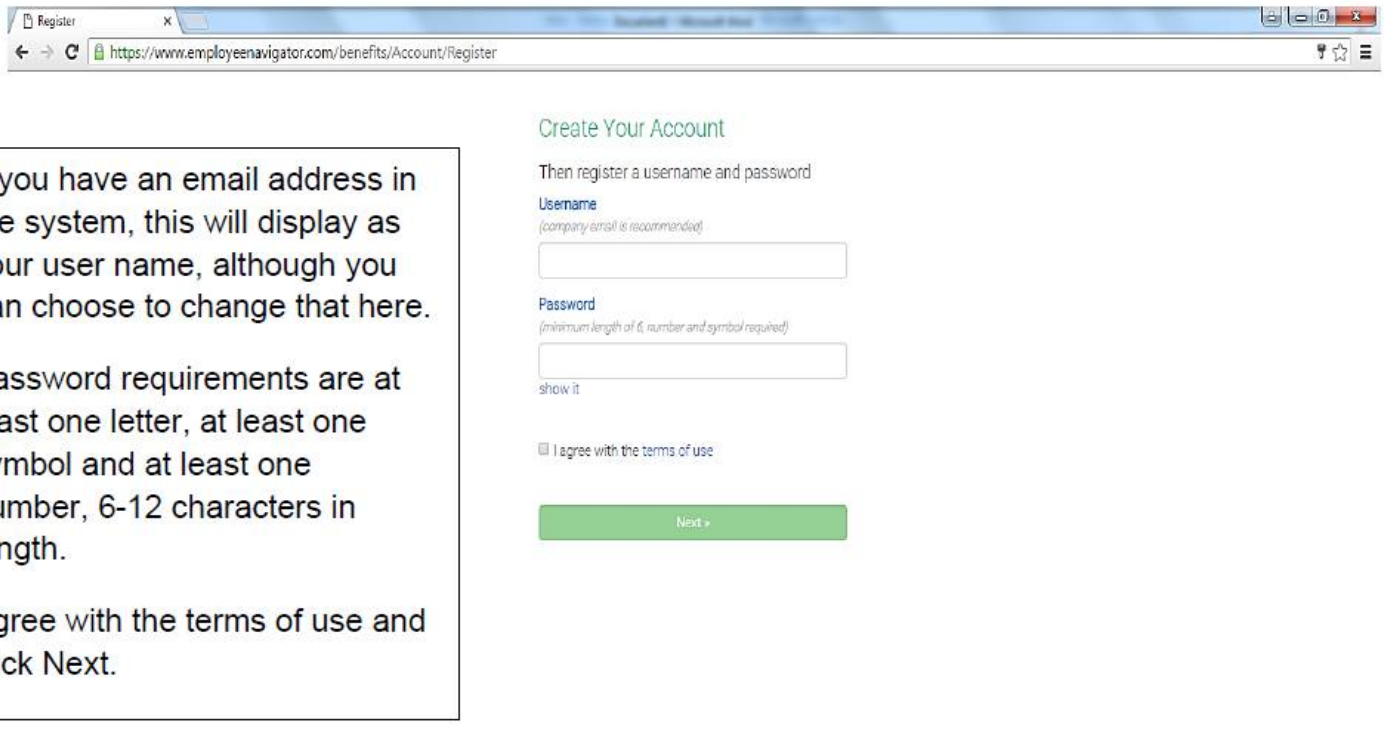
Choice Sch

Your PIN is the last 4 digits of your Social Security Number.

TIP: If your information doesn't take with your name displayed like this: John Smith, try all caps JOHN SMITH.

Click Next

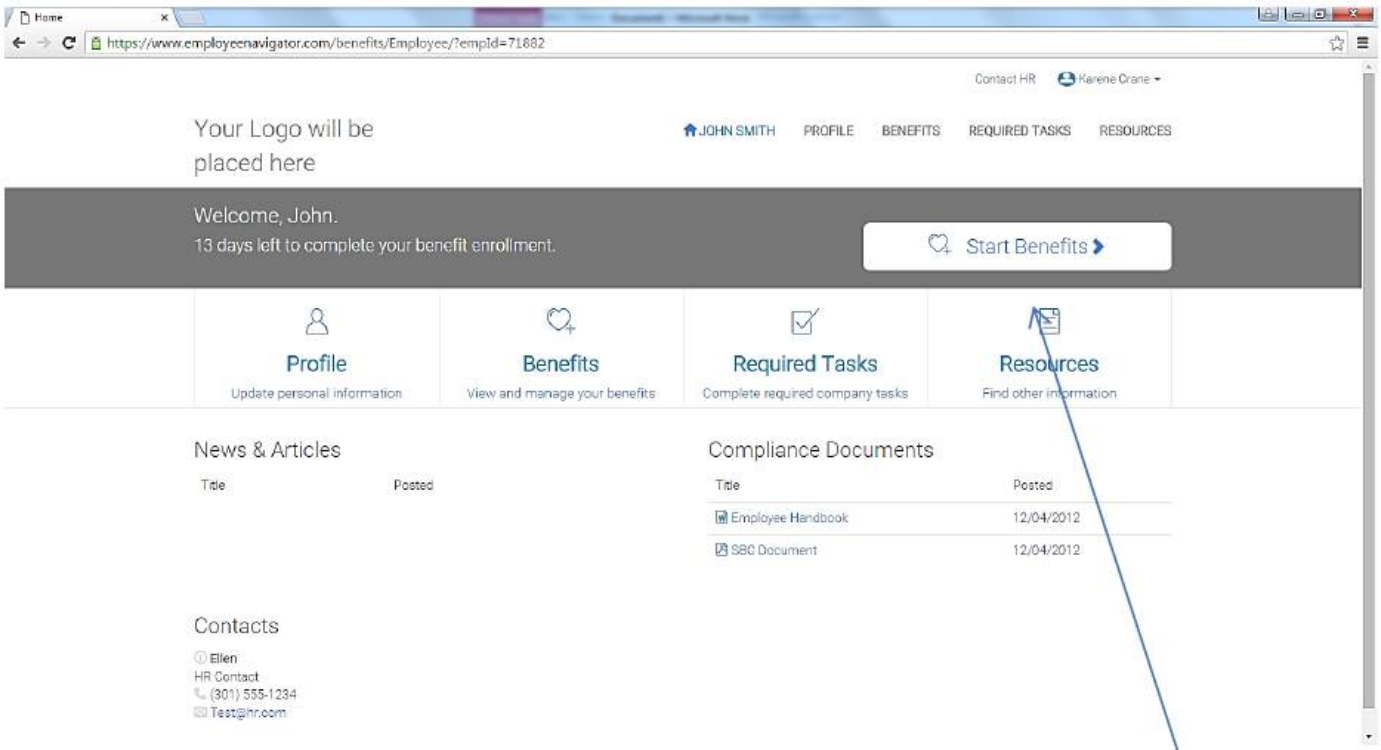
If your information matches the information in the portal, you will be advanced to the next screen.



If you have an email address in the system, this will display as your user name, although you can choose to change that here.

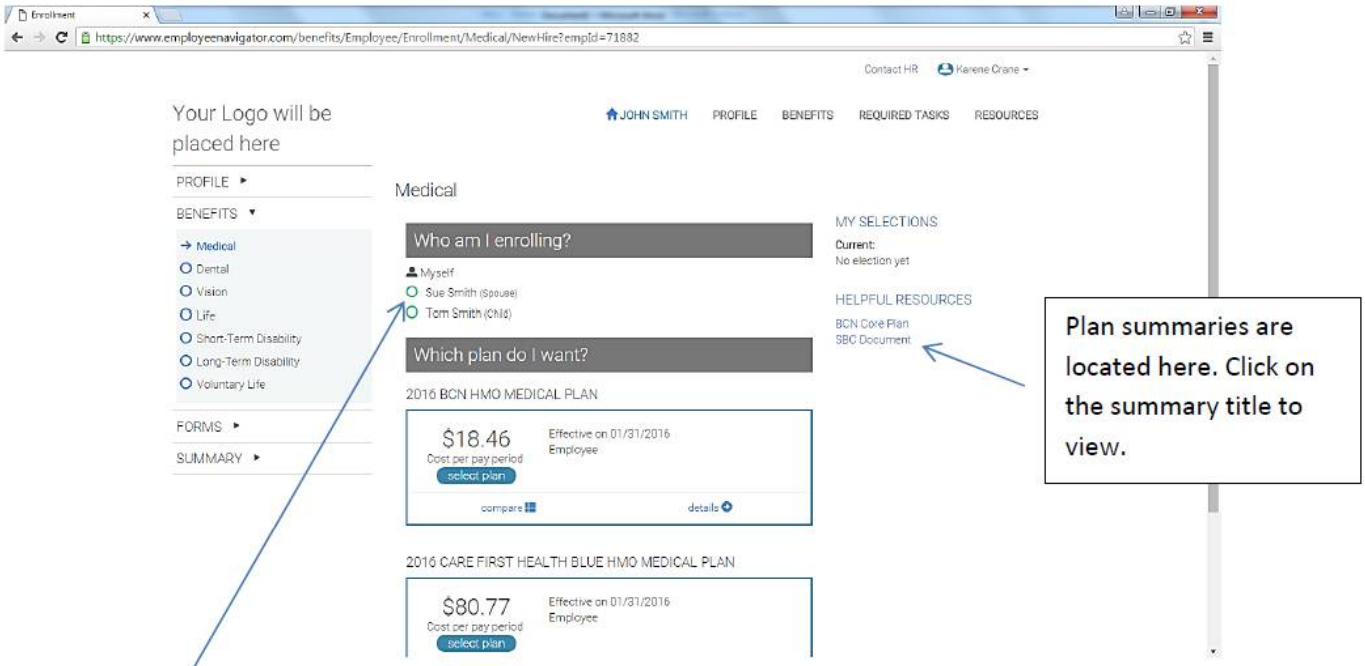
Password requirements are at least one letter, at least one symbol and at least one number, 6-12 characters in length.

Agree with the terms of use and click Next.



This is your Home Page. To start your benefit enrollment, click on the Start Benefits tab.

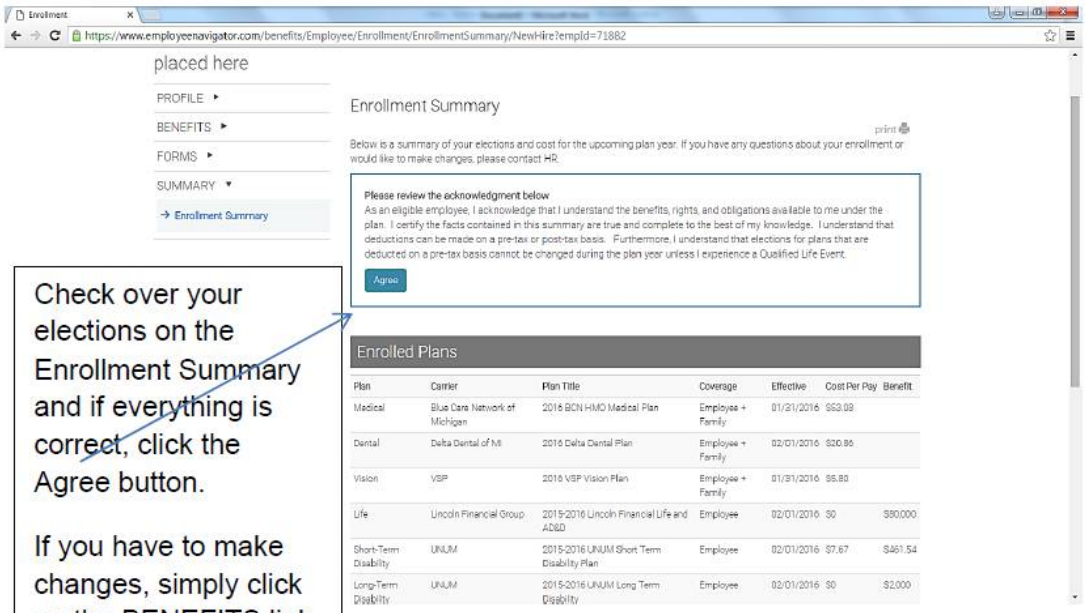
Enrolling in your benefits…



Check to make sure your Personal Information and Dependent Information is correct, Save and Continue.

Displayed here is the Medical Enrollment screen. All of the screens work pretty much the same. Select who you want on the plan – contributions in the Plan boxes will change as you add family members to the Plan. Select the Plan you want to enroll in and Save and Continue. If you wish to decline any benefits, use the 'Don't want this benefit' tab under the 'Save and Continue' tab and choose a reason for your decline.

Continue through all of the benefit offerings until you get your Enrollment Summary.



Benefits Contact Directory

Topic	Contact	Phone Number	Website & Network
General Benefits and/or Enrollment	Sharon Elderkin	(616) 785-8440	sharonelderkin@choiceschools.com
Medical Coverage	Blue Cross Blue Shield of MI Blue Care Network	(877) 790–2583 (800) 662-6667	www.bcbsm.com www.mibcn.com
Health Savings Account	Lake Michigan Credit Union	(616) 234-6335	ira@lmcu.org
Teladoc	Teladoc	(800) 362-2667	www.teladoc.com or www.mydrconsult.com
Dental Coverage	Delta Dental	(800) 482-8915	www.deltadentalmi.com
Vision Coverage	VSP (Vision Service Plan)	(800) 877-7195	www.vsp.com
Flexible Spending Accounts	Infinisource	(866) 370-3040	www.infinisource.com
Basic Life/AD&D **Voluntary Life/AD&D** **Short-Term Disability** **Voluntary Long-Term Disability**	The Standard	(888) 937-4783	www.standard.com

HUB

Michelle Shuart	**(616) 233-0186**	**michelle.shuart@hubinternational.com**
Julia VanLiew	**(616) 233-0184**	**julia.vanliew@hubinternational.com**
Toll Free	**(800) 936-4236**	

Benefits Website

Our benefits website, www.employeenavigator.com, can be accessed anytime you want additional information on our benefits programs.

Human Resources

If you have additional questions, you may also contact Sharon Elderkin in Human Resources at (616) 785-8440 or sharonelderkin@choiceschools.com

Important Note: The material in this benefits brochure is for informational purposes only and is neither an offer of coverage or medical or legal advice. It contains only a partial description of plan or program benefits and does not constitute a contract. Please refer to the Summary Plan Description (SPD) for complete plan details. In case of a conflict between your plan documents and this information, the plan documents will always govern. Annual Notices: ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. The Company will distribute all required notices annually.

Important Notices

Mental Health Parity Act

Per the Mental Health Parity Act, benefits for mental health and substance-use disorder must be treated like benefits for regular medical and surgical care. For example, if there is no limitation on the number of days for inpatient and number of visits for outpatient medical care, then there can be no limitations for mental health and substance-use disorder treatments. As always, treatments must be medically necessary to qualify for coverage. Plan participants should review their plan's certificate of coverage or benefit document for specific information about coverage, limitations and exclusions for mental health care and substance-use disorder treatments.

Summary of Benefits and Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. To help you make an informed choice the company makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about our health coverage in a standard format, to help you compare across options. The SBC also includes a Glossary of Health Coverage and Medical Terms to help you better understand health care terms used in the SBC. You can obtain a copy of the SBC at no cost to you by contacting your Human Resources.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

Our plan complies with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by the patient and her physician. Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information about WHCRA required coverage, you can contact Blue Care Network or Blue Cross Blue Shield of Michigan customer service.

The Newborn Act

Under Federal and state law you have certain rights and protections regarding your Maternity benefits under the Plan.

Under federal law known as the **"Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act)** group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Under Michigan law, if your Plan provides benefits for obstetrical services your benefits will include coverage for postpartum services. Coverage will include benefits for inpatient care and a home visit or visits, which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and Copayments that are no less favorable than for physical Illness generally.

Important Notices

Notice of Patient Protection

If your health plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the health plan designates one for you. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of participating primary care providers, contact Blue Care Network at (800) 662-6667.

You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecology care from a health care professional in our network who specializes in obstetrics or gynecology. However, the health care professional may be required to comply with certain procedures, including obtaining authorization for certain services, following a pre-approved treatment plan, or following certain procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Blue Care Network at (800) 662-6667.

Michelle's Law

Michelle's Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status. Under the law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. Further, if any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

Notice of Privacy Practices Available

The U.S. Department of Health and Human Services has issued regulations as part of the Health Insurance Portability and Accountability Act of 1996. These regulations known as the Standards for Privacy of Individually Identifiable Health Information were effective April 14, 2003 (or April 14, 2004 for small health plans) and control how your medical information may be used and disclosed and how you can access this information. Please be advised that your health benefits plan maintains a current Notice of Privacy Practices to inform you of the policies that is has established to comply with the Standards for Privacy. This Notice describes the responsibilities of the plan and any third party assisting in the administration of claims regarding the use and disclosure of your protected health information, and your rights concerning the same. This Notice is available to you upon request by contacting your company's Privacy Official or Human Resources Director.

NOTICE OF PRIVACY POLICY AND PRACTICES
FOR EMPLOYEE BENEFIT PLAN FOR CHOICE SCHOOLS ASSOCIATES, LLC ("THE PLAN")

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PURPOSE OF THIS NOTICE
The Plan respects the privacy of the personal information supplied by its plan participants and understands the importance of keeping this information confidential and secure. This Notice describes how the Plan protects the confidentiality of the personal information it receives. These practices apply to current and former participants in the Plan.

TYPES OF PERSONAL INFORMATION THE PLAN COLLECTS
The Plan collects a variety of personal information to assist the Plan Sponsor in administering a participant's health coverage. Some of this information is provided by participants on enrollment forms, surveys and correspondence (such as address, social security number, and dependent information). The Plan also receives personal information (such as eligibility and claims information) through transactions and communication with the Plan Sponsor and participants, affiliates, employers, insurance agents, insurers and health care providers. The Plan retains this information after a participant's coverage under the self-funded group health plan ends. The Plan limits the collection of personal information to that which is necessary to administer the Plan and meet regulatory requirements.

HOW THE PLAN PROTECTS PERSONAL INFORMATION
The Plan treats personal information securely and confidentially. The Plan limits access to personal information to only those persons who need to know that information to provide products or services to the Plan Sponsor and/or participants. These persons are trained on the importance of safeguarding this information and must be named on the Confidentiality Agreement established by the Plan in accordance with procedures and applicable law. The Plan applies strict physical, electronic, and procedural security standards to protect personal information and to maintain internal procedures to promote the integrity and accuracy of that information.

DISCLOSURE OF PERSONAL INFORMATION
The Plan may share any of the personal information it collects (as described above) as permitted by law. The Plan may also disclose this information to nonaffiliated entities or individuals as permitted or required by law. Non□affiliates with whom we may disclose information as permitted by law include our third party administrator, attorneys, accountants and auditors, the Plan Sponsor's authorized representatives, a participant's authorized representative, health care providers, Preferred Provider Organizations, and law enforcement or regulatory authorities. The Plan does not disclose personal information about any participant to any other third party without a participant's request, consent or authorization. The Plan participant may, at any time, revoke his/her consent or authorization to release personal information.

INDIVIDUAL RIGHTS TO ACCESS AND CORRECT INFORMATION
The Plan has procedures for a participant to access proper, reasonable and specific personal information, and will make this information available to the participant upon proper, reasonable and specific written request and consent. If you would like a copy of your personal information or believe your information is not accurate, please send your request in writing to:

Director of Payroll & Benefits
Employee Benefit Plan for Choice Schools Associates, LLC
5251 Clyde Park Avenue SW, Wyoming, MI 49509

FURTHER INFORMATION
The Plan may amend its privacy policy from time to time in accordance with applicable law. The Plan will advise participants of its privacy and practices at least once every three years. Additionally, the notice of privacy and practices will be available to participants upon written request at no cost to the participant.

HITECH ACT
Effective September 23, 2009, the Health Information Technology for Economic and Clinical Health Act (HITECH Act) went into effect. The HITECH Act is the HIPAA Privacy and Security provision of the American Recovery and Reinvestment Act of 2009 (ARRA). Under the HITECH Act, employer sponsored health plans and other HIPAA covered entities (e.g. health care providers) must notify affected individuals, HHS, and sometimes the media when unsecured PHI is breached. As an employee of Choice Schools Associates, LLC, we have addressed HIPAA confidentiality requirements in this HIPAA policy. Choice Schools Associates, LLC will comply with the HITECH Act as an employer, committing to the following additional duties:

- In the unlikely event that Choice Schools Associates, LLC discovers a breach of unsecured PHI, Choice Schools Associates, LLC will notify the PHI contact of each affected client without unreasonable delay after discovery of the breach. In no case will this delay exceed sixty (60) days. Breaches are treated as discovered on the first day on which such breach is known to the company or, by exercising reasonable diligence, should have been known to the company.
- The HITECH Act requires covered entities (e.g. employers sponsoring health plans) to make additional disclosures. These include notifications to individuals, HHS, and/or prominent media outlets. A breach is defined as "the acquisition, access use, or disclosure of PHI in a manner not permitted under HIPAA which compromises the security or privacy of the PHI."
- Unsecured PHI is defined as any PHI "that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specific by the Secretary (i.e. encryption or destruction)."
- In addition, Choice Schools Associates, LLC agrees to comply with the Security safeguards and documentation requirements in the HIPAA Regulations.
- Choice Schools Associates, LLC agrees to refrain from directly or indirectly receiving remuneration in exchange for any PHI of an individual unless such exchange is specifically allowed by HIPAA.
- Choice Schools Associates, LLC agrees to comply with the marketing limitations identified in the HITECH Act.
- Any required accounting of PHI disclosures by Choice Schools Associates, LLC shall comply with the HITECH Act.

Important Notice from Choice Schools Associates, LLC About Your Prescription Drug Coverage and Medicare

(Applies to all offered medical plans)

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Choice Schools Associates, LLC has determined that the prescription drug coverage offered by the Employee Benefit Plan for Choice Schools Associates, LLC is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your current Choice Schools Associates, LLC coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Choice Schools Associates, LLC coverage, be aware that you and your dependents or will not be able to get this coverage back.

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

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

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Choice Schools Associates, LLC changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov.

Call your State Health Insurance Assistance Program and for personalized help

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

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

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

Date: July 1, 2018

Name of Entity/Sender: Choice Schools Associates, LLC

Contact--Position/Office: Sharon Elderkin—Director of Payroll & Benefits

Address: 5251 Clyde Park Ave SW, Wyoming, MI 49509

Phone Number: 616-785-8440