



REED CITY SCHOOLS
LEADING THE PACK



EMPLOYEE BENEFITS GUIDE

Reed City Area Public Schools

January 2025 through December 2025

616.600.9397 | www.grandriskadvisors.com

We'll show you the way.



Grand Risk Advisors

We'll show you the way.

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Welcome to the 2025 benefit offering for Reed City Area Public Schools

Your employer has chosen to partner with Grand Risk Advisors to offer benefits to their employees this year. Your employer has chosen a great mix of benefits to offer you this year and we hope that you take advantage of the offering. Our office is available to be of service should you have questions or need to ask questions regarding benefits and what they cover - please feel open to ask all questions. We are more than happy to help. Below you will find your account service team, please contact them whenever necessary. This booklet serves to be a tangible resource to help educate you on the benefits offered to you this year. Please use this as a resource to answer your questions regarding plan details and prices. We appreciate the trust you and your employer have put in our company and look forward to servicing you, your family, and your coworkers this year and for many more in the future.

Sincerely,



Derek A. Lodholtz
President
Grand Risk Advisors



Grand Risk Advisors

We'll show you the way.

Your Customer Service Experience

By Partnering with Grand Risk Advisors your employer has given you more than just insurance benefits, they have given you, and your family, a robust customer service team capable of helping you with any questions or issues you may encounter. Below is an overview of your customer service contacts, please feel free to utilize Grand Risk Advisors whenever you need! Some common topics we can help on are:

- Claim Questions
- Claim Audits
- Plan Dispute Resolution
- Benefit Questions
- ID Card Replacement
- Insurance plan questions
- Provider Assistance
- Prescription Assistance
- More!



Derek A. Lodholtz
Risk Advisor

Phone: 616.600.9724
Email: derek1@grandriskadvisors.com

Contact Derek for quick help on extensive problems such as claims or other escalated service issues. Derek also handles in-depth explanation of the benefits offered and suggestions for your unique situation!



Meagan Tran
Client Executive

Phone: 616.600.9781
Email: meagant@grandriskadvisors.com

Contact Meagan for quick help on extensive problems such as claims or other escalated service issues. Meagan also handles in-depth explanation of the benefits offered and suggestions for your unique situation!



Kailey McKenzie
Account Manager

Phone: 616.600.9816
Email: kaileym@grandriskadvisors.com

Kailey can assist you on all of your questions/concerns! She is a great starting place for any time you have questions and will work with you along the way to a proper answer or resolution!.



Grand Risk Advisors
We'll show you the way.

With a multitude of proficient insurance and financial professionals, we are able to help you with any concerns! Feel free to get ahold of us when you need us!

Phone: 616.600.9397 Web: www.grandriskadvisors.com

Human Resources

Human resources is available to assist you as well! Contact Human Resources with general questions.

When to Enroll In Benefits

Open Enrollment

This Benefits Enrollment Guide provides an overview of the benefits offered to you. If you have any questions about how these benefits may impact you and your family, contact your account manager or Grand Risk Advisors for assistance. To the right you will find important dates regarding when open enrollment starts, ends, and when your elections will be effective.

Starts

11/4/2024

Ends

11/15/2024

Effective

1/1/2025



Enrollment Changes

As long as you remain eligible, your benefit elections will be in place until the next renewal. However, you may make mid-year changes if you have a qualifying event. Examples of qualifying events that allow you to change some of your benefits during the year are:

- | | | |
|------------------|-------------|------------------|
| 1 Marriage | 1 Dependent | 1 Death |
| 1 Divorce | change of | 1 Address change |
| 1 Birth/Adoption | status | |

If you have a qualifying event, you must change your benefits within 30 days of the event. If you do not make a change within 30 days, you must wait until the next open enrollment period.

New Hire Elections

If you are a new hire, you will have to make elections on the benefits offered to you. To the right you will find important deadlines for when you have to have these initial elections completed by as well as when your initial elections become effective. If you have questions as you overview your benefits contact Human Resources or Grand Risk Advisors for assistance.

Starts

Date of Hire

Ends

30 Days after Hire

Effective

1st of Month after Hire

What's New For 2025 ?

- 1 Adjusted Medical Options
- 2 Equitable Life
- 3 Equitable Disability
- 4 Equitable Accident
- 5 Equitable Critical Illness
- 6 Equitable Hospital Indemnity
- 7 AllyHealth Telemedicine



We are going to save you time this enrollment season!

Ease is a robust benefit administration system that serves as your central hub for employee benefits during open enrollment and throughout the year! By utilizing Ease for your benefits we can completely cut out the need to complete paper forms. The enrollment process with Ease can be completed typically within 15 minutes! Ease will compile all of your personal demographic information, as well as that of your dependents. It will use the data you input to show you accurate prices and comparisons of the plans available. Once you choose a benefit it will track and display your per-pay costs! Once you have chosen to enroll or waive in all the benefits being offered to you, then you will be able to sign your forms online and complete the process! Follow the steps below for a smooth enrollment experience! **Keep in mind, every year you will have to log in and complete enrollment!**

- 1 Log in to Ease using your unique login and password. For optimal performance we recommend using Google Chrome or Mozilla Firefox as your internet browser when you use Ease.
 - If you are a new hire, you will receive an email invitation to join Ease for the first time where you will set up a password. Your login will be the email where you received the Ease email.
- 2 Click 'Start Enrollment' to begin the enrollment process
- 3 Verify all your information, and the information of your dependents, is correct
- 4 Follow the prompts on each page to complete your benefit enrollment. Click 'continue' to proceed to the next section.
- 5 Select the 'checkmark' to enroll into a benefit, or select the 'x' to waive a benefit. If you waive a benefit you may be required to provide information as to why.
- 6 If requested, provide emergency contacts, employment documents, Medicare status, missing information, etc.
- 7 Sign forms and complete the enrollment process! Leave us feedback of your experience!

Did you know?

Ease has a mobile application for iOS and Android devices. Download the app today to access your benefit elections, benefit information, and per-pay pricing throughout the year!



PLEASE NOTE: during the Ease enrollment process you will sign multiple forms including forms you may think you do not need to, such as an enrollment or waiver. It is the duty of Grand Risk Advisors to process your enrollment or waiver request according to Ease. If you enroll into a benefit on Ease and sign a waiver, this does not mean you will waive the benefit.

Your Company Login Page Is:
www.rcaps.ease.com

Medical & Prescription Insurance

Below is a snapshot of the Medical insurance options offered to you. Use below to help compare and contrast the benefits of each plan to help aid your decision making process. Please use the chart on the next page to compare and contrast the overall financial aspect of what plan to take, or if your spouse is offered insurance through their employer.

	Medical Option A	Medical Option B	Medical Option C
Company	BCBSM	BCBSM	BCBSM
Plan Name	BCN 1000 0%	BCN HSA 1650 0%	BCN HSA 3300 0%
Network Type	HMO	HMO	HMO
HSA Plan?	No	Yes	Yes
In-Network Cost Sharing*			
Deductible**	\$1,000 / \$2,000	\$1,650 / \$3,300	\$3,300 / \$6,600
Employer Paid Deductible**	N/A / N/A	N/A / N/A	N/A / N/A
Coinsurance**	0%	0%	0%
Coinsurance Maximum**	N/A / N/A	N/A / N/A	N/A / N/A
Out of Pocket Maximum**	\$8,150 / \$16,300	\$4,000 / \$8,000	\$6,900 / \$13,800
Lifetime Maximum	No Limit	No Limit	No Limit
Preventative Care	Covered 100% before Ded.	Covered 100% before Ded.	Covered 100% before Ded.
Copays before Ded?	Before / After Deductible	After Deductible	After Deductible
Office Visit Copay	\$30.00	0% after Deductible	0% after Deductible
Specialist Copay	\$50.00	0% after Deductible	0% after Deductible
Urgent Care Copay	\$60.00	0% after Deductible	0% after Deductible
ER Copay	\$250 after Deductible	0% after Deductible	0% after Deductible
Chiropractor Copay	\$50.00 30 Visits per year	0% after Deductible 30 Visits per year	0% after Deductible 30 Visits per year
Durable Medical Equipment	50% after Deductible	50% after Deductible	50% after Deductible
Prescription Benefits			
Benefits Offered	Before Deductible	After Deductible	After Deductible
Tier 1: Generics	\$10 / \$30	\$4 / \$15 after Ded	\$4 / \$15 after Ded
Tier 2: Preferred Brand	\$60.00	\$40 after Ded	\$40 after Ded
Tier 3: Brand	\$80.00	\$80 after Ded	\$80 after Ded
Tier 4: Preferred Specialty	20% (\$200 max)	20% after Ded	20% after Ded
Tier 5: Specialty	20% (\$300 max)	20% after Ded	20% after Ded
Per-Month Costs			
Single	\$0.00	\$0.00	\$0.00
Double	\$160.45	\$18.09	\$0.00
Family	\$127.80	\$0.00	\$0.00

*For a summary of Out-Of-Network cost sharing (if available) please refer to official plan documents

**For split values the left side represents the value for a single enrollee, the right side represents the value for double or family enrollees



Go online or download the member app to access plan information, claims, extra plan benefits & more!



Plan Selection Assistance

My Health Plan Options			My Spouse's Health Plan Options	
Medical Option A			Medical Option A	
Carrier		1	Carrier	
Cost Per Pay	\$	2	Cost Per Pay	\$
Pay Deductions		3	Pay Deductions	
Total	\$	4	Total	\$
Employer HSA Contributions	\$	5	Employer HSA Contributions	\$
Plan Deductible	\$	6	Plan Deductible	\$
Total Maximum Coinsurance Costs	\$	7	Total Maximum Coinsurance Costs	\$
Prescription Liability	\$	8	Prescription Liability	\$
TOTAL COST FOR THIS PLAN	\$	9	TOTAL COST FOR THIS PLAN	\$
Medical Option B			Medical Option B	
Carrier		1	Carrier	
Cost Per Pay	\$	2	Cost Per Pay	\$
Pay Deductions		3	Pay Deductions	
Total	\$	4	Total	\$
Employer HSA Contributions	\$	5	Employer HSA Contributions	\$
Plan Deductible	\$	6	Plan Deductible	\$
Total Maximum Coinsurance Costs	\$	7	Total Maximum Coinsurance Costs	\$
Prescription Liability	\$	8	Prescription Liability	\$
TOTAL COST FOR THIS PLAN	\$	9	TOTAL COST FOR THIS PLAN	\$
Medical Option C			Medical Option C	
Carrier		1	Carrier	
Cost Per Pay	\$	2	Cost Per Pay	\$
Pay Deductions		3	Pay Deductions	
Total	\$	4	Total	\$
Employer HSA Contributions	\$	5	Employer HSA Contributions	\$
Plan Deductible	\$	6	Plan Deductible	\$
Total Maximum Coinsurance Costs	\$	7	Total Maximum Coinsurance Costs	\$
Prescription Liability	\$	8	Prescription Liability	\$
TOTAL COST FOR THIS PLAN	\$	9	TOTAL COST FOR THIS PLAN	\$

Instructions

- 1 Input the name of your carrier in this box
- 2 Put in the amount the plan will cost you (along with all applicable dependents) per pay period in this box
- 3 Put the amount of pay periods you receive
- 4 Multiple line 2 by line 3 and enter the product in this box
- 5 If you employer contributes annually to your HSA enter the annual amount in this box
- 6 Enter in the annual plan deductible in this box
- 7 Enter in the maximum amount of coinsurance liability under the plan in this box
 - A If there is a coinsurance maximum on the plan use that amount
 - B If there is no coinsurance maximum, subtract the deductible from the maximum out of pocket
- 8 Enter in the maximum amount of prescription liability under the plan in this box
 - A This is figured by subtracting lines 6 and 7 from the maximum out of pocket
- 9 Add lines 4, 5, 7 and 8 together. Subtract line 5 from that amount. This is the maximum liability of that plan.

PLEASE NOTE:

The above is intended to be an easy to use tool for employees/members to compare their plans. Calculations using this sheet are not the advice or recommendation of Grand Risk Advisors. Consult with your Account Manager to ensure an accuracy. Grand Risk Advisors is not responsible for miscalculations as a result of using this sheet.

Your Provider Network



**Blue Care
Network
of Michigan**

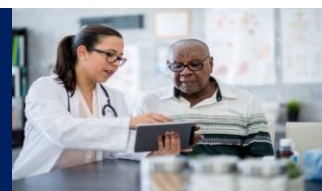
Network Type:	HMO
Primary Care Provider Requirement:	Required

Blue Cross Blue Shield of Michigan has amassed a fantastic provider network for your utilization. By having a PPO plan you do not need to designate a primary care provider for services or referrals, and you can receive services in or out of network (out of network services will generally be more expensive). When receiving from providers in Michigan, you will want to ensure that the provider you are seeing, or will be seeing, is in network. Follow the steps below to check the Blue Cross Blue Shield of Michigan provider directory!

1. Go to www.bcbsm.com
 - a. Scroll to the bottom of the page
 - b. Select 'Find a Doctor or Hospital' under the 'Help and Information' heading
2. If you have a BCBSM Online Account set up select the green 'Get Started' button
 - a. If you do not have account set up you can choose to 'Search without logging in.'
3. Select your Network
 - a. Select 'Employer Group Plans' then select 'PPO Plans'
4. Insert your Home or Work Address or the address where you will be traveling to
5. Insert any specific Doctor or Hospital if necessary to see if they are in the provider network
6. Hit 'Search'



Did you know the BCBSM mobile app will allow for you to search the provider network? Download it today!



IN THE UNITED STATES

- Always carry your member ID card.
- If a PPO member, always use a BlueCard PPO doctor or hospital to ensure the highest level of benefits.
- If a HMO member, call Blue Cross or BCN for precertification or prior authorization, if necessary. Refer to the number on the back of your member ID card.
- When you arrive at the participating doctor's office or hospital, show the provider your ID Card. The provider will identify your benefit level through one of these symbols:



Traditional/
Indemnity
Benefits



PPO
Benefits

AROUND THE WORLD

- Always carry your member ID card.
- Before you travel, contact Blue cross or BCN for coverage details. Coverage may be different outside of the United States.
- If you need medical assistance, call the Service Center for Blue Cross Blue Shield Global Core at 1-800-810-BLUE (2583) or call collect 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization if necessary.

INPATIENT CLAIM

Call the service center if you need inpatient care. In most cases, you should not need to pay upfront for inpatient care except for the out of pocket expenses (noncovered services, deductible, copayment and coinsurance) you normally pay. The hospital should submit the claim on your behalf.

PROFESSIONAL CLAIM

You may need to pay upfront for care received from a doctor and/or hospital. Complete a Blue Cross Blue Shield Global Core International claim form and send it with the bill(s) to the Service Center (address is on the form). You can also submit your claim online or through the Blue Cross Blue Shield Global Core app. The claim form is available at www.bcbsglobalcore.com

Grand Risk Advisors can help you! Contact us with questions or concerns. We are your advocate for great care!



Have fun on your travels! Your health plan is there if you need it!



Preventative Care

Under the Affordable Care Act (ACA) you have access to certain preventative care at no cost sharing when received at an in-network provider. This means you do not have a deductible and you do not have any coinsurance or copays. Below is a brief listing of services offered as preventative. These are broken into three segments: All adults, women, children. Please note this list is not intended to be all inclusive of the services offered under the ACA and is subject to change. For the most detailed information contact your providers office or visit www.healthcare.gov.

FOR ADULTS*

- Routine screenings
- Diet counselling if high risk for chronic disease
- Immunization Vaccines
- Statin Preventive Medication

FOR WOMEN*

- Routine screenings
- Folic Acid when pregnant
- Well-woman visits
- Contraceptive (if plan is not exempt)
- Mammograms
- Immunization Vaccines

FOR CHILDREN*

- Routine screenings
- Vision screenings
- Alcohol/drug assessments
- Well-baby visits
- Immunization Vaccines
- Oral screenings
- Hearing screenings

***Information in these sections sourced from www.healthcare.gov and is accurate as of 09/06/2019. Grand Risk Advisors accept no liability for discrepancies in the above information.**



**Get your checkup!
It's covered at no
cost to you!***

***One annual preventative visit is covered at no cost per person per year**

Understanding The Costs Of Your Care

The cost of your care is important and as history tells us, costs will rise over time. In an effort to control your healthcare costs we want to provide you with the best methods of understanding what care will cost you, then acting in the most effective way of receiving care. Below is an analysis of your plan and what your costs would be in various modes of care delivery. Understanding these differences is key to your healthcare experience and costs.

Location of Care	Symptoms / Conditions	Advantages	Your Cost of Care		
			Medical Option A	Medical Option B	Medical Option C
TeleMedicine	General Medical Questions, Nonemergency treatment questions, etc.	24/7 Access!	No Copay!	No Copay! No Deductible!	No Copay! No Deductible!
Primary Doctor	Sore Throat, Low-grade fever, Earache, Cold & Flu, Allergies, Rashes, Eye Irritation, Sprains & Strains, Etc.	May have extended hours. Ongoing relationship.	\$30.00	0% after Deductible	0% after Deductible
Specialist	More Serious Sore Throat, fever, Earache, Cold & Flu, Allergies, Rashes, Eye Irritation, Sprains & Strains, Etc.	Evening and weekend hours. Walk-In appointments.	\$50.00	0% after Deductible	0% after Deductible
Urgent Care	More Urgent Sore Throat, fever, Earache, Cold & Flu, Allergies, Rashes, Eye Irritation, Sprains & Strains, Etc.	Evening and weekend hours. Walk-In appointments.	\$60.00	0% after Deductible	0% after Deductible
Emergency Room	Life threatening conditions, chest pain, possible broken bones, sudden blurred vision, poisoning, loss of consciousness, etc.	24/7 access. Suitable for emergencies.	\$250 after Deductible	0% after Deductible	0% after Deductible

The Big Picture

We have the same goals as you do: the highest quality of care at the lowest price possible. It may seem that you have limited to no control over the medical plans provided to you, and this is not true! Claims spend is one of the largest pieces that makes up your benefit prices.

How does this affect you? In the short-term, with our strategies you may pay lower costs or even in some cases no cost for the care or prescriptions you receive. Over the long-term, by diverting costs away from your actual insurance program, and reducing claims spend, we can reduce the likelihood of premium increases for everyone.

So, how do you play into this? Be smart about your healthcare choices. This does not mean do not use your healthcare, rather this means analyze the purchase much like you would other purchases you make. We have tools to help you! The next four pages will overview those and provide information on how to use them successfully!

Reducing Healthcare Costs: *TeleMedicine*

Quality care can be delivered without seeing a doctor in person. TeleMedicine allows you access to board-certified doctors at no copay! You can call a doctor, chat with a doctor, or facetime with them to discuss your ailment and the appropriate treatment to make sure you recover! Additionally, the doctor can prescribe you a medication should they feel it an appropriate treatment. You and your family can use TeleMedicine as many times as you want. Best of all, there is no copay for most services when you use the program! Below overviews the program and provides what you can expect when you use it!

Telemedicine	
Company	Ally Health
Plan Name	Telemedicine
Plan Benefits	
General Medical	Included
Prescribe Rx?	Included
Behavioral Health	Not Included
Dermatology	Not Included
Expert Medical Services	Not Included
Back Care	Not Included
In-App Smart Tools	Not Included
Per Month Pricing	
Per Employee	\$0.00 if Enrolled in Medical \$5.55 if Not Enrolled in Medical



Get Started!

**Download
the App
today!**



Why Use TeleMedicine?

Up to 70% of medical visits can be handled telephonically!

Save money! No copays on most services mean you save money each time you use it!

Save Time! No more waiting in for appointments or late night ER visits for children. You can access a licensed doctor 24/7!

Use telemedicine every time before going to the doctor. Chances are they can help you. If they can help you, you save money! If they cannot help you, worst case you will go to the doctor - like you would have originally!

Reducing Healthcare Costs: *Prescription*

Prescription costs are rising and insurance does not always provide the best option for purchasing medications. Insurance companies sometimes are not paying much, if anything towards the costs of your prescriptions, but they are counting this as a claim! There are solutions available that allow access to prescriptions, without use of insurance, for potentially large copay savings! This not only saves you money, but the health plan as well.



Look for Manufacturer Assistance

These programs come directly from the manufacturer of your high cost prescription. Generally, these programs are income based. If you qualify your savings can be huge - even as high as having a \$0 cost for your prescription!

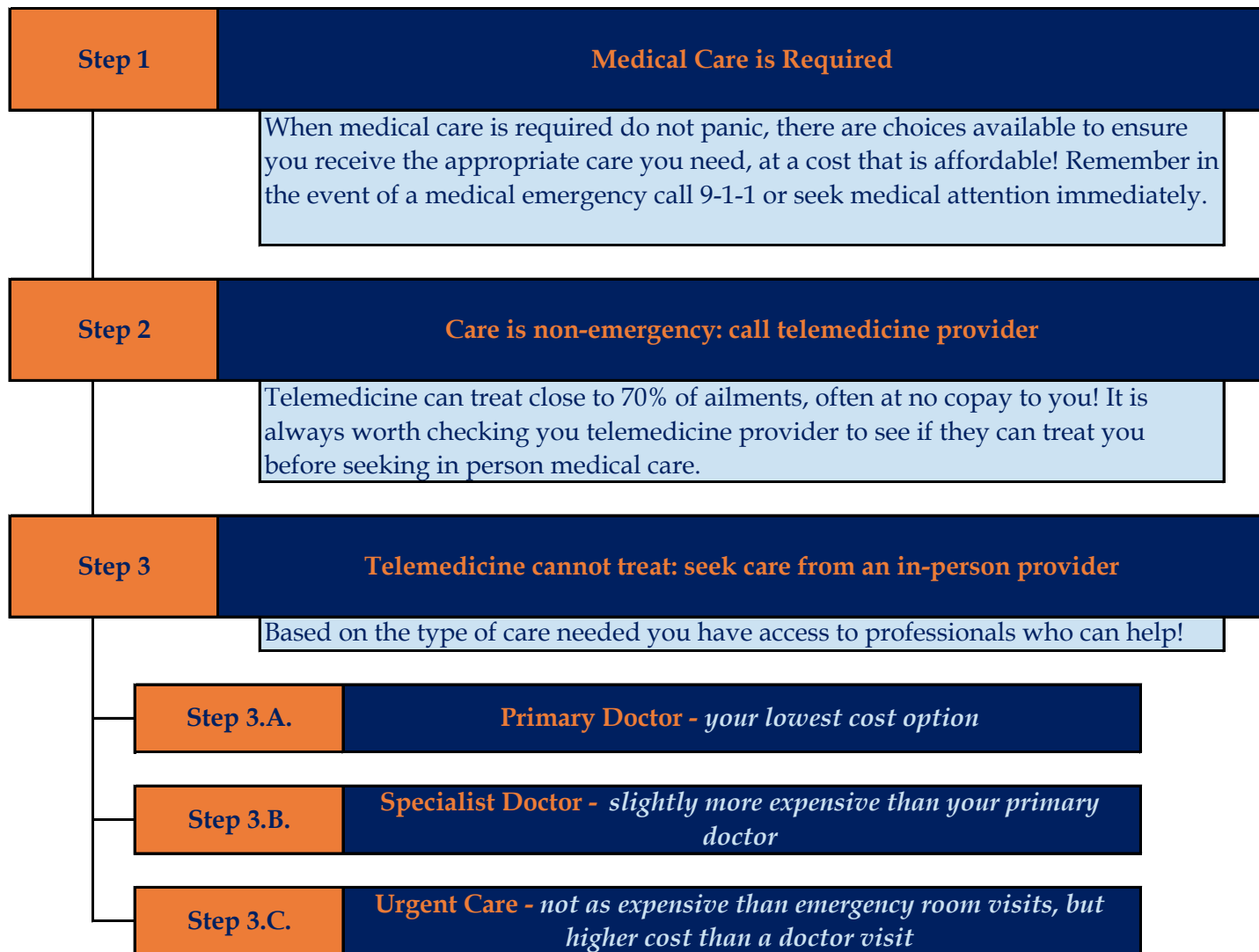
Shop for Generic Prescriptions

Generic prescriptions, when available, are very low cost! Most plans require you to take a generic medication if it is available!



How To Use Your Benefits: *Medical*

Remember, smart purchasing of your healthcare is a key factor to keeping insurance costs manageable. With a group effort we can not only keep prices down for everyone, but we can achieve the same high quality of care you deserve! Below is a basic overview of steps to take for your healthcare needs, by adopting this strategy, where available, you will examine avenues of care that keep your costs minimal!



In the event of a medical emergency call 9-1-1 or seek medical attention immediately

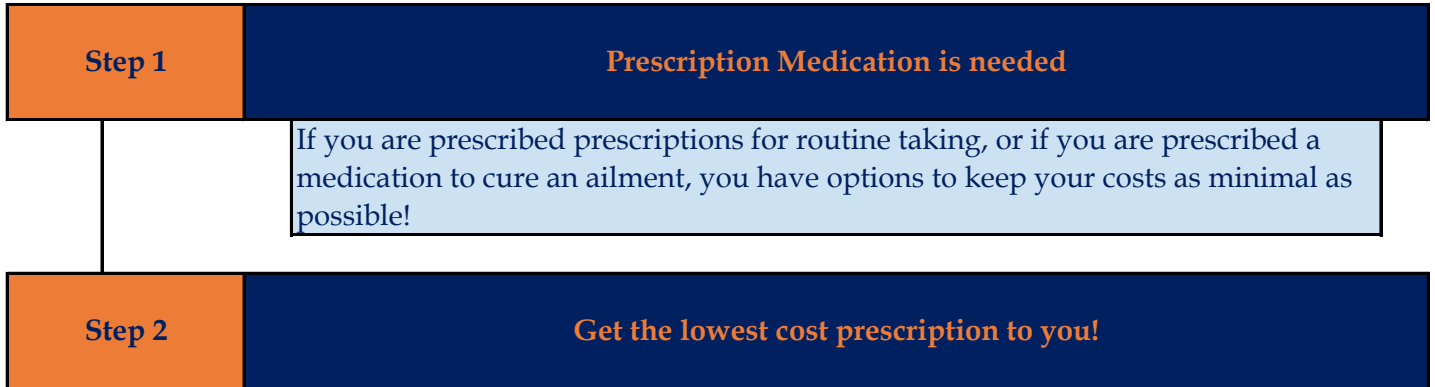
Grand Risk Advisors is not a licensed physician or medical professional, the advice on this page should not be construed as giving medical advice.

By Reducing the costs paid by your insurance company we can keep the cost of insurance affordable over time!*

**This is not a guarantee, costs are calculated based on plan utilization among other factors*

How To Use Your Benefits: *Prescription*

Much like your medical care, you can shop your prescriptions to ensure you receive your medication at the lowest possible cost! Below is a basic overview of steps to take for your prescription needs, by adopting this strategy, where available, you will examine avenues of care that keep your costs minimal!



Due to your prescription insurance, you are not eligible to use non-insurance discount programs

Grand Risk Advisors is not a licensed physician or medical professional, the advice on this page should not be construed as giving medical advice.

By Reducing the costs paid by your insurance company we can keep the cost of insurance affordable over time!*

**This is not a guarantee, costs are calculated based on plan utilization among other factors*

Tax-Advantaged Spending Accounts



Health Savings Account (HSA)

A Health Savings Account (HSA) is a pre-tax savings account established by a participant of a High Deductible Health Plan (HDHP). The funds in this savings account can be used to pay for medical, dental, vision, and prescription expenses including deductibles, coinsurance, copays, and other qualified expenses not covered by the insurance plan. You can contribute to the account at your discretion and funds can be increased, decreased, stopped or started at any time. Your contributions roll over each year and can earn interest for you, based on your account balance you may be able to invest your dollars as well.

Pre-tax Contributions

+

Tax-Free Growth

+

Tax-Free Usage

+

Open Access after Age 65*

=

4 Benefits!

High-Deductible Health Plan (HDHP)

High Deductible

Major Medical

Health Savings Account

YOUR bank account

Portable if you switch

Use even if you can't contribute

TIPS!

Remember that your High Deductible Health Plan offers no coverage (*except preventative*) until the deductible has been met. This is because the plan has been structured so that you will use HSA funds to pay for the deductible.

Remember the tax-advantages of the HSA make your deductible cheaper than it appears. In the 30% tax bracket, for example, each \$1,000 of deductible only costs you \$700 if you utilize your HSA.

Enrollment Tier	2025 Annual HSA Funding Limits	Employer Contribution
Single	\$4,300.00	Detailed online in Ease per Plan
Double & Family	\$8,550.00	Detailed online in Ease per Plan
\$1,000 per year additional contributions may be made by individuals age 55 and older		

Shop for HSA eligible items at www.hsadepot.com

*over the age of 65 HSA funds can be used for any expense with standard tax rules. Contact a tax professional for specifics.

**This does not include the over age 55 \$1,000 catch-up contribution. Contact Grand Risk Advisors if this applies to you.

REMEMBER: Contributions are made pre-tax! Tax documents will be sent to you by your HSA vendor.

IF YOU ENROLL INTO AN HSA PLAN YOU ARE NOT ELIGIBLE FOR THE HEALTH CARE SPENDING PORTION OF THE FSA

Dental Insurance

Below is a snapshot of the Dental option offered to you. You may use the provider of your choice, but your out-of-pocket costs will be lower if you see an in-network provider.

Dental Benefits	
Company	Varipro
Plan Name	RCAPS Dental
Network Type	No Network - See Any Dentist!
In-Network Cost Sharing	
Lifetime Maximum	Unlimited
Annual Maximum	\$1,000 per person
Deductible	\$0 per person
Cleaning/Exam Frequency	Two per year
Preventative Coverage	80%
Prev. Waiting Period	0 months
Basic Coverage	80%
Basic Waiting Period	0 months
Major Coverage	80%
Major Waiting Period	0 months
Ortho Coverage	80%
Ortho Lifetime Maximum	\$1,300 per person
Ortho Waiting Period	0 months
Work In Progress	Covered
Per-Month Costs	
Single	\$0.00
Double	\$0.00
Family	\$0.00

For an official plan summary please contact Grand Risk Advisors.



Go online or download the member app to access plan information, claims, extra plan benefits & more!



Vision Insurance

Below is a snapshot of the Vision option offered to you. You may use the provider of your choice, but your out-of-pocket costs will be lower if you see an in-network provider.

Vision Benefits	
Company	Varipro
Plan Name	RCAPS Vision
Network Type	VSP PPO
In-Network Cost Sharing	
Lifetime Maximum	Unlimited
Deductible	\$0 per person
Exam Copay	\$10
Eye Exam Frequency	Every 12 months
Glasses Lens Copay	\$25
Necessary Contact Copay	\$25
Frames Allowance	\$180
Frames Frequency	Every 12 months
Contacts Allowance	\$180
Contacts Frequency	Every 12 months
Contacts in Lieu of Frames?	Cannot get both
Per-Month Costs	
Single	\$0.00
Double	\$0.00
Family	\$0.00

For an official plan summary please contact Grand Risk Advisors.



Go online or download the member app to access plan information, claims, extra plan benefits & more!



Life Insurance with Accidental Death & Dismemberment

Below is a snapshot of the Life and Accidental Death & Dismemberment Insurance plan offered to you. AD&D comes packaged with your life insurance benefit, so you automatically receive this coverage.

Life & AD&D Benefits	
Company	Equitable
Plan Benefits - <i>Employee Only</i>	
Life Insurance Amount	Detailed online in Ease
Guaranteed Issue Amount	Detailed online in Ease
AD&D Amount	Detailed online in Ease
Age Reduction Schedule	Age 65 Reduces benefits by 35%
	Age 70 Reduces benefits by 50%
Portability Feature	Not Included
Conversion Feature	Included
Per-Pay Costs	
Employee Only	100% Paid for by your employer!



When you designate a beneficiary, they get the proceeds should a claim be made. This can be changed as often as necessary!



What is AD&D Coverage?

Accidental Death & Dismemberment is a coverage included on most employer sponsored life plans. The coverage pays out a benefit amount based on not only accidental death, but also if an employee is dismembered as a result of an accident. Dismemberment is typically paid as a percentage of the AD&D benefit amount, not the whole benefit value. For specifics on your AD&D coverage, reach out to Grand Risk Advisors for more information!

Short-Term Disability Insurance

Below is a snapshot of the Short-Term Disability option offered to you. Short-Term Disability insurance works to prevent loss of income for short periods of time due to illness or injury.

Short-Term Disability Benefits	
Company	Equitable
Plan Benefits	
Benefit Amount (% of salary)	60%
Minimum Benefit	N/A
Maximum Benefit	\$1,200
Benefit Paid	Weekly
Injury Elimination Period	14 Days
Accident Elimination Period	14 Days
Benefit Duration	11 Weeks
Disability Definition	Own occupation
Pre-Existing Conditions	Excluded
Pricing	
Employee Only	Pricing shown online in ease

Long-Term Disability Insurance

Below is a snapshot of the Long-Term Disability option offered to you. Long-Term Disability insurance works to prevent loss of income for long periods of time due to illness or injury.

Long-Term Disability Benefits	
Company	Equitable
Plan Benefits	
Benefit Amount (% of salary)	67%
Minimum Benefit	\$100
Maximum Benefit	\$7,300
Benefit Paid	Monthly
Elimination Period	90 Days
Benefit Duration	Social Security Normal Retirement Age
COBRA Benefit	Not Included
Pre-Existing Conditions	Excluded
Pricing	
Employee Only	100% paid by your employer!

Critical Illness Insurance

Below is a snapshot of the Critical Illness option offered to you. Critical Illness insurance provides a benefit for a list of critical medical conditions should they be contracted.

Critical Illness Benefits	
Company	Equitable
Pre-Existing Conditions	Covered
Ailments (% of Benefit)	See plan summary online or in your folder for specifics per ailment
Plan Benefits - <i>Employee</i>	
Employee Option	Yes
Minimum Benefit	\$5,000
Maximum Benefit	\$20,000
Benefit Increments	\$5,000
Guaranteed Issue	\$20,000
Plan Benefits - <i>Spouse</i>	
Spousal Option	Yes
Minimum Benefit	\$2,500
Maximum Benefit	\$10,000
Benefit Increments	\$2,500
Guaranteed Issue	Cannot exceed 50% of employee election All guaranteed issue
Plan Benefits - <i>Dependents/Children</i>	
Dependent Option	yes
Minimum Benefit	25% of the employee election amount
Maximum Benefit	
Benefit Increments	
Guaranteed Issue	
Pricing	
Employee Only	Pricing shown online in ease

Hospital Recovery Insurance

Below is a snapshot of the Hospital Recovery option offered to you. Hospital Recovery insurance pays a benefit should you become confined in a hospital due to injury/illness/treatment/otherwise.

Hospital Recovery Benefits	
Company	Equitable
Plan Benefits	
Standard Daily Benefit	\$100.00
Maximum Days	365
Standard Admit. Benefit	\$500.00
Maximum Admit.	1
Critical Care Benefit	\$1,000.00
Maximum Days	1
Critical Admit. Benefit	\$200.00
Maximum Critical Admit.	60
Wellness Care	Not included
Pre-Existing Conditions	Covered
Per-Month Costs	
Employee Only	\$8.72
Employee + Spouse	\$7.20
Employee + Child(ren)	\$14.65
Family	\$24.27



Hospital bills can be manageable with hospital recovery insurance! Use this benefit to reduce deductible and coinsurance exposure!



Accident Insurance

Below is a snapshot of the Accident option offered to you. Accident insurance pays a benefit should you incur medical costs due to an accident.

Accident Benefits			
Company	Equitable		
	Plan Benefits		
Individual	Employee	Spouse	Dependent
Accidental Death Benefit	\$20,000.00	\$25,000.00	\$12,500.00
Burns	Up to \$10,000.00	Up to \$10,000.00	Up to \$10,000.00
Lacerations	Up to \$500.00	Up to \$500.00	Up to \$500.00
Dislocation	Up to \$5,000.00	Up to \$5,000.00	Up to \$5,000.00
Fractures	Up to \$6,000.00	Up to \$6,000.00	Up to \$6,000.00
Emergency Room	\$100.00	\$100.00	\$100.00
Per-Month Costs			
Employee Only	\$6.08		
Employee + Spouse	\$11.27		
Employee + Child(ren)	\$13.81		
Family	\$19.01		



Accidental injury might often be the highest cost for those with insurance. Use this benefit to protect against cost exposure!



Hearing Program

Below is a snapshot of the Hearing option offered to you. Hearing insurance pays a benefit should you incur hearing costs for exams for aids. If your program is a discount program please note this is not standard insurance program as you may be used to.

Hearing Benefits	
Company	Amplifon
Program Type	Discount
Program Benefits	
Exam Benefit	Low price guarantee
Aid Benefit	Low price guarantee
Plan Frequencies	
Exam Frequency	As needed
Aid Frequency	As needed
Per-Month Costs	
Single	Included in Vision costs
Double	Included in Vision costs
Family	Included in Vision costs



Hearing loss is prevalent - but no longer unaffordable! The exclusive savings above are built to help you!



Employee Assistance Program (EAP)



Managing work and life can be hard sometimes! You have a resource available to help!



What can an EAP help you with?

Use your EAP - its here for you!

Financial Wellness

Family and relationship matters

Emotional well-being

Substance abuse and addiction

Physical Health

Possibly more!

Call 833.256.5115

Go online at guidanceresources.com

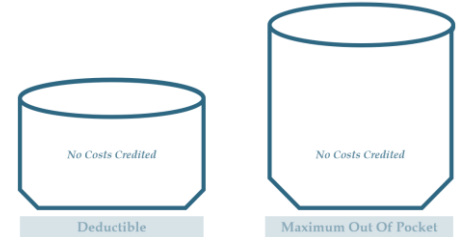


Rest easy, when you need help, you'll have it!

STAGE 1: Deductible

Your deductible is your retained portion of your health insurance risk. Whatever your deductible is, that amount you must pay out before you have medical coverage. In most cases the deductible for a double/family is 2 times the amount of a single. Preventative care is always provided free of charge before deductible. Your deductible resets every year.

In traditional insurance plans your company allows you to access such as doctor visits and prescription before deductible. This is referred to as 'First Dollar Coverage.' You get to use this coverage for its specified copayment before you meet your deductible amount. In HSA Insurance plans you are responsible for your entire deductible without access to First Dollar Coverage.



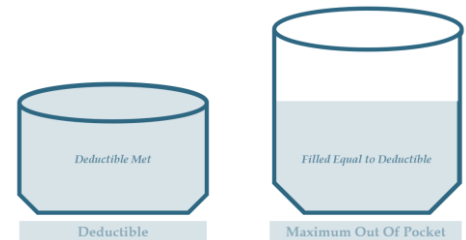
What counts towards your deductible? Services used that are not First Dollar Coverage. Services such as *diagnostic medical care*.

STAGE 2: Coinsurance

After your deductible has been met you enter Stage 2. In stage two the insurance company recognizes that you have now met/exceeded your retained risk and begins to pay out on medical services.

Frequently used services such as office visits and prescriptions are assigned a dollar amount (copayment) that you pay each time you use the service – these function exactly like 'First Dollar Coverage.'

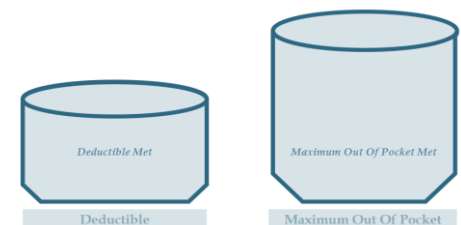
Other services are assigned a percentage (coinsurance) that you must pay when the service is used. Your insurance company covers the excess cost. I.e. if you have 20% coinsurance for a service that costs \$1,000 you would pay \$200 with the insurance company paying the remaining \$800. These can have different values for in and out of network.



All these costs go into your Maximum-Out-Of-Pocket cup.

STAGE 3: Maximum Out Of Pocket

Once you have accrued enough spending to meet your Maximum-Out-Of-Pocket limit the insurance company will begin to pay for covered services at 100% of the cost. Services like chiropractic care that have a visitation limitation on them are no longer covered once this limit is met and are not subject to be covered at 100%. Your Maximum-Out-Of-Pocket resets every year.



Extra Resources: *How HSA's Work*

What is an HSA?

A Health Savings Account is exactly as it sounds: a savings account for your health expenditures. The account is opened either individually or jointly based upon eligibility in your family situation. The most important part of the HSA is the tax deductibility of contributions to the HSA.

Who is eligible for a HSA?

Individuals are deemed eligible for a Health Savings Account when they are enrolled into a High Deductible Health Plan (HDHP). High Deductible Health Plans are health insurance plans that are specifically designed to have high deductible and minimal coverage before that deductible is met. To pay for coverage before the deductible is met they are paired with the ability to enroll into a Health Savings Account.

- Note: Guidelines for a High Deductible Health Plan are typically reassessed every year. It is always best to consult with one of our benefit specialists to gain the most accurate information regarding HSA eligibility.

- Note: If you are enrolled into Medicare then you are not eligible for a HSA.

How to fund your HSA

1. Yourself

- a. Contributions are either deducted on a pre-tax basis from your paycheck if you are eligible through your employer, if you are not eligible via a group-sponsored plan you can deduct deposits on your tax return.

2. your Employer

- a. If you are eligible for an HSA via a group-sponsored plan your employer, at their discretion, can fund all employee's HSA as they choose so long as it is done on a non-discriminatory basis. Employer contributions are expenses to the company.

3. Limitations

- a. There are limitations on how much may be deposited into a HSA in total for one calendar year for individual(single) and joint(family) accounts. These amounts are adjusted annually, it is always best to consult with one of our benefit specialists to gain the most accurate information regarding limitations.

4. Rollover

- a. Every year your deposits rollover! You never lose funds unless you spend them.

How to use your HSA

Your HSA funds are eligible to be used on a tax-free basis for Qualified Medical Expenses. Just swipe the associated debit card for the account and you are all set! For the most accurate, up to date, list contact your benefit specialist today!

Extra Resources: *Ancillary Claims*

If you signed up for Life Insurance, Disability Insurance, Critical Illness, Hospital Recovery or Accident Insurance this will work different than most insurance programs you are used to. Ancillary insurances generally do not have an insurance card to show at the time of claim. And, most ancillary insurance programs all have a little bit different way of filing claims. We are here to help you ensure you maximize your benefit should you need to use them!

Step 1:
*Receive the care
you need*



Care is the most important part! Make sure you obtain the care you need - the claim can wait!

Step 2:
**Contact
Grand Risk
Advisors**



Once you are able, contact us and explain what happened. We will help start the claim!

Step 3:
*Complete
required
documentation*



The claim will likely require information from you and your doctor. We will help explain!

Step 4:
**Return to
Grand Risk
Advisors**



Once the required information has been gathered, contact us again. We will submit the claim for you!

Extra Resources: *How To Find a Provider*

Medical Insurance

1. Go to www.bcbsm.com
 - a. Scroll to the bottom of the page
 - b. Select 'Find a Doctor or Hospital' under the 'Help and Information' heading
2. If you have a BCBSM Online Account set up select the green 'Get Started' button
 - a. If you do not have account set up you can choose to 'Search without logging in.'
3. Select your Network
 - a. Select 'Employer Group Plans' then one of the following options:
 - i. PPO Plans
 - ii. Blue Care Network (HMO)
4. Insert your Home or Work Address or the address where you will be traveling to
5. Insert any specific Doctor or Hospital if necessary to see if they are in the provider network
6. Hit 'Search'

Dental Insurance

1. When you see the Dentist be sure to present them with your new insurance card
 - a. On the card it will have information on where the billing office may send a request for payment
 - b. The card will also prompt the billing office to set up an online account to verify benefits and status of coverage
2. Use your dental plan according to your benefits!
 - a. Rest assured that your plan will be in place!

If your Dentist refuses to bill Varipro:

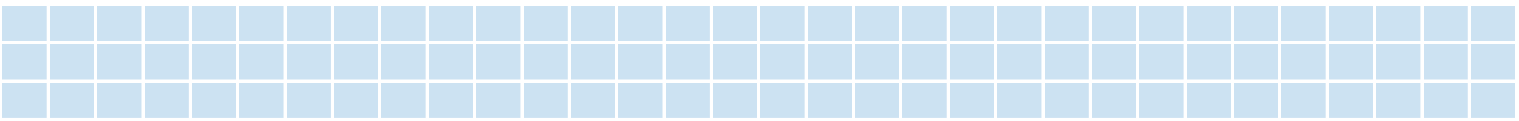
1. Contact Grand Risk Advisors
 - a. We will reach out to the dental office to try and resolve the issue
 - b. If the issue cannot be resolved we will work on reimbursement of claim expenditures according to your plan benefits

Vision Insurance

1. Go to www.vsp.com
2. Select the 'MEMBERS' tab
3. Click on 'FIND A DOCTOR'
4. Enter the Zip Code or City and State in question
5. Hit 'Search'

Hearing Insurance

1. Go to www.amplifonusa.com
1. Click 'Find A Provider'
2. Enter in the zip code of the location/provider in question
3. Click search



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Required Notices

Creditable Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your employer 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. Your employer has determined that the prescription drug coverage offered by your employer 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 employer coverage will not be affected. Include in this a copy of the prescription drug benefit on the group plan.

If you do decide to join a Medicare drug plan and drop your current employer coverage, be aware that you and your dependents 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 your employer 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 or call your employer. **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 your employer changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Date: 10/29/2024
Name of Entity: Reed City Area Public Schools
Contact Person: Rodnie Cook
Address: 225 W Church Ave Reed City Mi 49677
Phone Number: 231.832.2201

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).

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you are declining enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

Michelle's Law Notice

Michelle's Law was signed into law effective January 1, 2010. This law generally allows seriously ill or injured fulltime college students, who are covered under their parent's health insurance plan, to take up to one year of medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility). Under the Patient Protection and Affordable Care Act, group health plans are required to offer coverage to dependent children up to age 26, regardless of student status.

Womens Health and Cancer Rights Act Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact the Plan Administrator.

Newborns & Mothers Health Protection Act Notice

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

Required Notices, continued

Marketplace Coverage Notice

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your employer directly. You may also contact Grand Risk Advisors Financial Group for assistance. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Reed City Area Public Schools		4. Employer Identification Number 38-6003232	
5. Employer Address 225 W Church Ave		6. Employer Phone Number 231.832.2201	
7. City Reed City	8. State Mi	9. Zip Code 49677	
10. Who can we contact about employee health coverage at this job? Rodnie Cook			
11. Phone Number 231.832.2201		12. Email address rcook@reedcityschools.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 - All Employees
 - Some Employees
- with respect to dependents:
 - We offer coverage
 - We do not offer coverage

X

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

¹An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Marketplace Coverage Notice, continued

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Notice Regarding Wellness Program

Your employer sponsored wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which may include a blood test for overall program incentive and effectiveness tracking. You are not required to complete the HRA or to participate in the blood test or other medical examinations. However, employees who choose to participate in the wellness program will receive an incentive indicate the reward/task for the specific specified criteria noted in the program. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive. Additional incentives of up to amounts specified in detail in the program may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting your employer. The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as various program incentives. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and [name of employer] may use aggregate information it collects to design a program based on identified health risks in the workplace, [name of wellness program] will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment. Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are medical professionals, your plan administrator, your plan agent & administrative function companies in order to provide you with services under the wellness program. In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at your

Required Notices, continued

HIPAA Privacy Notice

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

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses & Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Patient Protection Provider Choice Notice

Your employer 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 information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator or issuer. For children, you may designate a pediatrician as the primary care provider. 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 gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator or issuer.

Deductible

A health insurance deductible is the amount of money you pay out of pocket for healthcare services covered under your insurance plan before your plan begins to pay benefits for eligible expenses.

Coinsurance

Coinsurance is the amount, generally expressed as a fixed percentage, an insured must pay against a claim after the deductible is satisfied.

Copayment

A co-pay is a fixed out-of-pocket amount paid by an insured for covered services. It is a standard part of many health insurance plans. Insurance providers often charge co-pays for services such as doctor visits or prescriptions drugs. Co-pays are a specified dollar amount rather than a percentage of the bill, and they usually paid at the time of service.

Maximum Out of Pocket

This number – also called the out-of-pocket limit – is the most a health insurance policyholder will pay each year for covered healthcare expenses.

Coinsurance Maximum

Coinsurance maximum is the total amount of coinsurance that a member is obliged to pay before a health plan begins paying 100% of covered medical expenses per benefit period.

Health Maintenance Organization (HMO)

An HMO limits member coverage to medical care provided through a network of doctors and other healthcare providers who are under contract to the HMO.

Point-Of-Service (POS)

A point-of-service plan is like an HMO. It requires the policyholder to choose an in-network primary care doctor and to get referrals from that doctor if they want the policy to cover a specialist's services. And a point-of-service plan is like a PPO in that it still provides coverage for out-of-network services, but the policyholder will have to pay more than if they used in-network services.

Preferred Provider Organization (PPO)

PPO is a managed-care organization consisting of medical professionals and facilities such as primary and specialty physicians, hospitals, and other healthcare professionals. PPO participants are free to use the services of any provider within their network. Out-of-network care is available, but it costs more for the insured.

Frequency

The frequency at which a service is payable under the plan. Common frequency amounts are once per year or every other year.

Allowance

The maximum amount the plan will pay for that specific service. This is typically tied to services with a frequency limitation and renews when the frequency does.

Guaranteed Issue/Evidence of Insurability

Guaranteed Issue is a term used in insurance to describe a situation where a policy is offered to any eligible applicant without regard to health status. If health information is needed this arrangement is called Evidence of Insurability.

Portability

Portability refers to an employee's option to retain certain benefits when switching employers.

Conversion

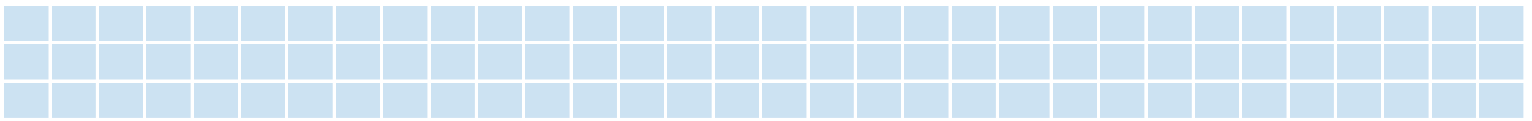
The conversion privilege provision allows an employee that participates in a group plan to convert their group life insurance policy into an individual life insurance policy with little hassle, without having to go through another approval process or a medical exam.

Elimination Period

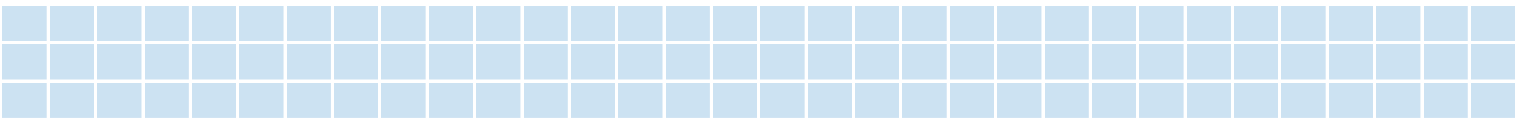
An elimination period is the length of time between when an injury or illness begins and receiving benefit payments from an insurer.

Benefit Duration

The length of time a plan will pay benefit to the insured. This is typically seen under Short & Long-Term Disability insurance plans.



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