BENEFITS SUMMARY

STOCKBRIDGE COMMUNITY SCHOOLS

Prepared for: Stockbridge Community Schools
Plan Year: 2022-2023

NIS National Insurance Services

OUR EMPLOYEES ARE OUR MOST VALUABLE ASSET.

Stockbridge Community Schools is committed to offering a comprehensive employee benefits program that helps our employees stay healthy, feel secure and maintain a work-life balance.

STAY HEALTHY

- Medical, dental and vision care
- Flexible spending accounts

FEELING SECURE

- Disability insurance
- MPSERS/403(b)/457 plan
- Life and accidental death & dismemberment (AD&D) insurance
- Identity theft program

WORK-LIFE BALANCE

- Employee assistance program

CONTACT INFORMATION FOR BENEFIT VENDORS

HEALTH INSURANCE

WHO IS ELIGIBLE AND WHEN:

Superintendent, Administrators, Supervisors, Admin Office Support, Teachers, Secretaries, Custodians, and 30 hour eligible ACA employees

BENEFITS YOU RECEIVE:

See attached Benefit Summary

EMPLOYEE PAYS:

Refer to your employment contract or bargained agreement

EMPLOYER PAYS:

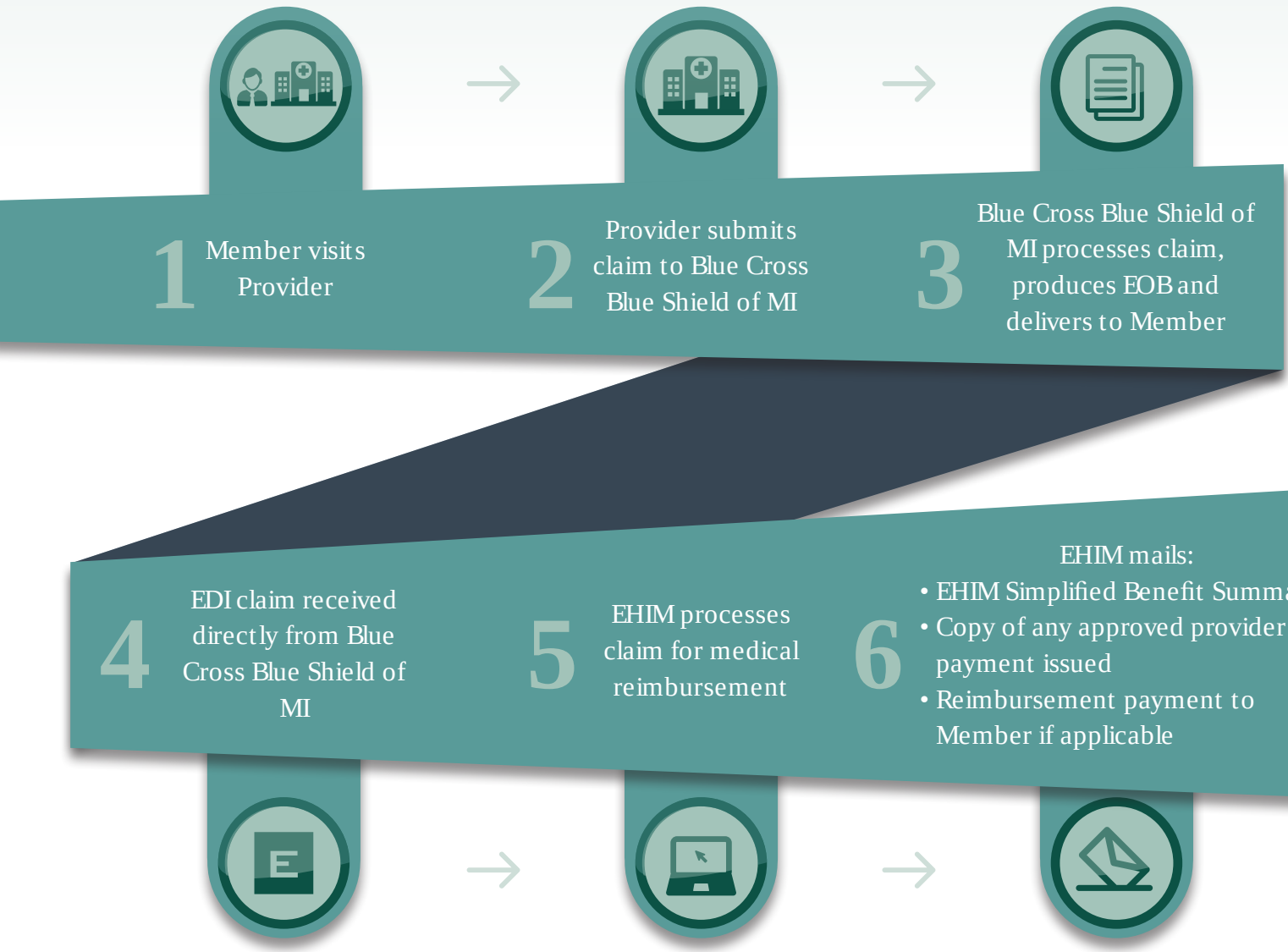
Refer to your employment contract or bargained agreement

Stockbridge Community Schools 10-1-2022 to 9-30-2023		
Medical/Rx - Plan Highlights $100 Deductible HRA - BCBSM/EHIM		
Partial listing of covered services	**In Network**	**Out of Network**
Deductible and Out-of-Pocket		
Annual Deductible	$100 per person $200 per family	$10,000 per person $20,000 per family
Annual medical out-of-pocket maximum	$100 per person $200 per family	$12,700 per person $25,400 per family
Annual Rx out-of-pocket maximum	$800 per person $1,600 per family	Member could pay more due to U&C restrictions
Preventive Healthcare		
Annual physical	you pay nothing	Most preventative services not covered. Mammography and Colonoscopy covered at 40% member cost-share. See benefit summary or contact BCBSM for more details.
Immunizations and Prenatal		
Postnatal, family planning & screenings		
Preventative Care Drugs		
Office Visits		
Illness or injury	$20 Co-pay	you pay 40% after deductible
Physical, occupational therapy, speech therapy		
Chiropractic care		
Mental / Chemical health care		
Retail Clinic		
Emergency Care		
Care at an urgent care clinic or medical center	$40 Co-pay	you pay 40% after deductible
Emergency care at a hospital ER	$250 Co-pay	$250 Co-pay
Inpatient Hospital Care		
Illness or injury	you pay nothing after deductible	you pay 40% after deductible
Mental / Chemical health care		
Outpatient Care		
Scheduled outpatient procedures	you pay nothing after deductible	you pay 40% after deductible
MRI/CT		
Durable Medical Equipment (DME)		
Hearing Aids	$1,684 limit per ear for hearing aid, plus $250 for other services	
DME & prosthetic devices	you pay nothing after deductible	you pay 20% after deductible
Pharmacy Highlights		
Partial listing of covered services		
	Retail Pharmacy	
Generic preferred	$10 copay	$10 copay (member must pay in advance and then submit for reimbursement at usual and customary). Member may not be fully reimbursed based on Usual & Customary.
Brand preferred	$40 copay	$40 copay (member must pay in advance and then submit for reimbursement at usual and customary). Member may not be fully reimbursed based on Usual & Customary.
Non-preferred	$80 copay	$80 copay (member must pay in advance and then submit for reimbursement at usual and customary). Member may not be fully reimbursed based on Usual & Customary.
	Mail Order Pharmacy (up to a 90-day supply)	
Generic preferred	$20 copay	Not covered
Brand preferred	$80 copay	
Non-preferred	$160 copay	

EHIM
Third Party Administration

Special Medical Reimbursement Plan

PROCESS



1. Member visits Provider
2. Provider submits claim to Blue Cross Blue Shield of MI
3. Blue Cross Blue Shield of MI processes claim, produces EOB and delivers to Member
4. EDI claim received directly from Blue Cross Blue Shield of MI
5. EHIM processes claim for medical reimbursement
6. EHIM mails:
   - EHIM Simplified Benefit Summary
   - Copy of any approved provider payment issued
   - Reimbursement payment to Member if applicable

In a rare instance where the provider will not bill BCBS for covered services, get an itemized receipt and submit it to EHIM. EHIM will assist you in filing your claims with BCBS. If you receive a bill before you receive a Simplified Benefit Summary from EHIM please call EHIM for assistance.

QUESTIONS? Contact the EHIM Medical Claims Department.

26711 Northwestern Hwy., #400 Southfield, MI 48033

Telephone: 248-948-9900 | Fax: 248-945-4887

Stockbridge Community Schools
Community Blue PPO Plan
Explanation of Special Medical Reimbursement Benefits

Your Current Benefits

You are enrolled in a Preferred Provider Organization (PPO) Plan with benefits being paid by two parties, Blue Cross Blue Shield of Michigan (BCBSM) and your employer. Your underlying purchased program through Blue Cross includes deductible, coinsurance and flat dollar copayments as well as an out-of-pocket maximum.

Your employer will be sharing in a portion of service that BCBSM applies to your deductible and coinsurance as outlined in the chart below:

IN-NETWORK BENEFITS

SINGLE COVERAGE

Employee responsible for	$100.00
Employer pays the remaining	$4,900.00

Annual Coinsurance	$6,750.00
Employee pays	$0.00
Employer pays entire 20%	$1,350.00
Employee out-of-pocket expense	$100.00

TWO PERSON OR FAMILY COVERAGE

Employee responsible for	$200.00
Employer pays the remaining	$9,800.00

Annual Coinsurance	$13,500.00
Employee pays	$0.00
Employer pays entire 20%	$2,700.00
Employee out-of-pocket expense	$200.00

Fixed Dollar Copayments

(for single, two person, and family coverage)

Fixed Office Visit & Chiropractic Care Copay	$40.00
Employee pays	$20.00
Employer pays	$20.00

Fixed Emergency Room Copay	$250.00
Employee pays	$250.00
Employer pays	$0.00

Urgent Care Copay	$40.00
Employee pays	$40.00
Employer pays	$0.00

OUT-OF-NETWORK BENEFITS

SINGLE COVERAGE

Annual Deductible	$10,000.00
Employee responsible for entire	$10,000.00

Annual Coinsurance	$2,700.00
Employee responsible for entire	$2,700.00
Employee out-of-pocket expense	$12,700.00

TWO PERSON OR FAMILY COVERAGE

Annual Deductible	$20,000.00
Employee responsible for entire	$20,000.00

Annual Coinsurance	$5,400.00
Employee responsible for entire	$5,400.00
Employee out-of-pocket expense	$25,400.00

EHiM

Pharmacy Benefits. *Managed.*

PHARMACY BENEFIT SUMMARY

10/01/2021

STOCKBRIDGE COMMUNITY SCHOOLS

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Your Rx Benefits

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No Changes

Effective: 10/01/2021

We are pleased to announce that there will be NO changes to your existing pharmacy benefit plan for the upcoming year!

You can continue to utilize the current ID card that you have.

Summary of Copayments

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

Customer Service

800-311-3446 • 24/7/365

EHIM's primary mission is to provide our members with the best customer service possible. If you are experiencing a problem ***filling a retail or mail order prescription,*** contact EHIM's Pharmacy Help Desk.

For your convenience, our help desk has a representative available ***24 hours a day, 7 days a week, 365 days a year.***

Our toll free number is ***printed on the front of your ID card*** for easy reference.

EHIM values our clients and we appreciate the opportunity to continue to service our members.

$10	Copayment on any generic medication
$40	Copayment on any Preferred Brand Medication
$80	Copayment on any Non-Preferred Brand Medication
$80	Copayment on any Multi-Source Brand Medication (Brand Name Drugs that are dispensed when an exact generic is available) The *physician* will indicate "DAW" or "Dispense as Written" on the prescription.
$80	Copayment **plus the difference** in cost between the brand & generic on any Multi-Source Brand Prescription (Brand Name Drugs that are dispensed when an exact generic is available) The *patient* indicates the brand to be dispensed. DAW penalty does not count towards the OOP Max
$80	Copayment on all Specialty Medications (Example: Oncology, Multiple Sclerosis, Organ Transplant) Please contact EHIM at **800-311-3446**
$10	Copayment on any medication covered under the EHIM OTC program
Generic $20 Brand $80 NP Brand $160	Standard Copayment for all eligible maintenance medication filled in a three month supply. Brand & Generic eligible maintenance medications can be filled through the Local Retail Pharmacy or through Mail Order in order to obtain them in a 3 month supply.
Single $800 Family $1,600	Out of Pocket Maximum: Once a member/contract spends the maximum in pharmacy copays that member/contract will have a $0 copay on all covered medications for the rest of the plan year. One person in a 2-person/Family contract will be capped at the single amount and the rest of the members under that contract will have to meet the other single max combined. Only medications on the EHB Drug List will accumulate towards the OOP max.
Important Note Regarding Copayments: Any form of patient assistance (e.g. manufacturers' coupons, copay cards, copay assistance program) will NOT be considered as true-out-of-pocket costs for members and will NOT accumulate toward member deductibles and out-of-pocket maximums.	

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Quantity Limits for Certain Medications

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

Alliance Walgreen's + Prime Mail Order

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

Non-Preferred Drug List

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

EHIM Pharmacy Network

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

EHIM Pharmacy Help Desk

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

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Did You Know...?

OTC Medications available for $10 COPAY

How to Use the OTC Program:

1. If you are currently using a prescription Anti-Ulcer or Allergy medication, talk to your physician about using an Over-the-counter (OTC) treatment.
2. If your physician believes an OTC treatment is right for you, ask them to write a prescription for the OTC medication. (OTC must be written on the script)
3. Present that prescription to the pharmacist.
4. The pharmacist will bill the prescription to EHIM.
5. **You will receive the OTC product for a $10 copay!**

You can receive certain Over-the-counter (OTC) medications for a **$10** copay. Your prescription drug program through EHIM provides coverage for certain OTC Anti-Ulcer and Allergy medications. These OTC medications are considered to be therapeutically equivalent to those medications available by prescription only.

To help reduce some of your current out of pocket costs, you may want to consider utilizing a medication available through the OTC program instead of your prescription medication.

Anti-Ulcer (Acid-Reflux) Medications		
If you take: • Dexilant • Nexium		**You are currently paying:** **$80 Copay**
If you change to: • Axid (nizatidine) • Pepcid AC & Complete (famotidine) • Prevacid OTC (lansoprazole) • Prilosec OTC (omeprazole OTC)	• Tagamet (cimetidine) • Zantac (ranitidine) • Zegerid OTC (omeprazole/sodium bicarbonate)	**You would pay:** **$10 Copay**
Allergy Medications		
If you take: • Flonase Nasal Inhaler • Nasacort AQ • Nasonex Nasal Inhaler	• Rhinocort Aqua Nasal Inhaler • Veramyst Nasal Inhaler • Xyzal	**You are currently paying:** **$80 Copay**
If you change to: • Alavert (loratadine) • Alavert-D (loratadine-D) • Allegra (fexofenadine) • Allegra-D (fexofenadine-D) • Benadryl (diphenhydramine) • Claritin (loratadine)	• Claritin-D (loratadine-D) • Nasacort Allergy 24 HR • Rhinocort Allergy Spray • Zyrtec (cetirizine) • Zyrtec-D (cetirizine-D)	**You would pay:** **$10 Copay**

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List of Preventive Care Drugs - Covered for $0.00 copayment

With preventive care services under the Affordable Care Act, several therapeutic classes of medications must have therapies available to members without any member cost-share. In short, the following list of medications are available to members for a $0 copayment. If a member opts to use a medication within these therapy classes and the medication is **NOT** listed below, the member will have a cost-share based on the plan design **(Brand Copay on Alternative)**. However, in the case of the contraceptives, this list is merely a guide and not all-inclusive. Members are encouraged to speak to their providers regarding the treatment that best fits their needs.

Rx Name	Drug Type
Antivirals ($0.00 Copay)	
Truvada (subject to clinical protocols)	Brand
Contraceptives - Oral ($0.00 Copay)	
apri	Generic
aranelle	Generic
aviane	Generic
azurette	Generic
balziva	Generic
camila	Generic
caziant	Generic
cesia	Generic
cryselle-28	Generic
enpresse-28	Generic
errin	Generic
gianvi	Generic
gildess FE 1/20	Generic
gildess FE 1.5/30	Generic
heather	Generic
jolivette	Generic
jolessa	Generic
junel 1/20	Generic
junel FE 1/20	Generic
junel 1.5/30	Generic
junel FE 1.5/30	Generic
kariva	Generic
kelnor 1/30	Generic
leena	Generic
levora	Generic
low-orgestrel	Generic
lutera	Generic
microgestin 1/20	Generic
microgestin 1.5/30	Generic
microgestin FE	Generic
microgestin FE 1.5/30	Generic
mononessa	Generic
necon 0.5/35-28	Generic

Rx Name	Drug Type
Contraceptives - Oral ($0.00 Copay)	
necon 1/35-28	Generic
necon 1/50-28	Generic
necon 10/11-28	Generic
necon 7/7/7	Generic
nora-BE	Generic
norinyl	Generic
nortrel 0.5/35 (28)	Generic
nortrel 1/35 (21)	Generic
nortrel 1/35 (28)	Generic
nortrel 7/7/7	Generic
ocella	Generic
ogestrel	Generic
orsythia	Generic
portia	Generic
quasense	Generic
reclipsen	Generic
solia	Generic
sprintec-28	Generic
sronyx	Generic
tilia FE	Generic
tri-legest FE	Generic
trinessa	Generic
tri-sprintec	Generic
tri-lo-sprintec	Generic
trivora-28	Generic
velivet	Generic
zenchent	Generic
zenchent FE	Generic
zovia 1/35E	Generic
zovia 1/50E	Generic
Contraceptives - Patch ($0.00 Copay)	
Ortho Evra	Brand
Contraceptives - Ring ($0.00 Copay)	
Nuvaring	Brand

For Plans Effective 7/1/2020 or Later

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List of Preventive Care Drugs - Covered for $0.00 copayment

With preventive care services under the Affordable Care Act, several therapeutic classes of medications must have therapies available to members without any member cost-share. In short, the following list of medications are available to members for a $0 copayment. If a member opts to use a medication within these therapy classes and the medication is **NOT** listed below, the member will have a cost-share based on the plan design **(Brand Copay on Alternative)**. However, in the case of the contraceptives, this list is merely a guide and not all-inclusive. Members are encouraged to speak to their providers regarding the treatment that best fits their needs.

Rx Name	Drug Type
Contraceptives - Diaphragm ($0.00 Copay)	
Femcap	Brand
Ortho All Flex	Brand
Ortho-Diaphragm	Brand
Contraceptives - Emergency ($0.00 Copay)	
levonorgestrel, next choice	Generic
Contraceptives - Implantable ($0.00 Copay)	
Paraguard	Brand
Nexplanon	Brand
Contraceptives - Injectable ($0.00 Copay)	
medroxyprogesterone	Generic
Smoking Cessation - Oral ($0.00 Copay)	
bupropion SR 150 (Zyban)	Generic
Chantix Starting Pack	Brand
Chantix Continuing Pack	Brand
Smoking Cessation - Inhaler ($0.00 Copay)	
Nicotrol	Brand
Smoking Cessation - Gum ($0.00 Copay)	
Nicotine Gum	OTC
Smoking Cessation - Lozenge ($0.00 Copay)	
Nicotine Lozenge	OTC
Smoking Cessation - Patch ($0.00 Copay)	
Nicotine Patch	OTC

Rx Name	Drug Type
Statins ($0.00 Copay, Men & Women Age 40-75)	
atorvastatin 10mg, 20mg	Generic
fluvastatin 20mg, 40mg	Generic
fluvastatin ER 80 mg	Generic
lovastatin 10mg, 20mg, 40mg	Generic
pravastatin 10mg, 20mg, 40mg, 80mg	Generic
rosuvastatin 5mg, 10mg	Generic
simvastatin 5mg, 10mg, 20mg, 40mg	Generic
Preventive Medications ($0.00 Copay)	
aspirin 81mg (males 45-79 yrs, females 55-79 yrs)	Generic
folic acid .4mg - .8mg (females 18-45 yrs)	Generic
iron supplement (6mos - 1yr)	Generic
oral fluoride (under 5yrs old)	Generic
vitamin D (65 years or older)	Generic
tamoxifen	Generic
Bowel Prep Agents (Men & Women Age 50-75)	
gavilyte	Generic
gavilyte N/flavor pack	Generic
gavilyte-G	Generic
PEG 3350/electrolytes	Generic
PEG 3350NACL/NA	Generic
bicarbonate/KCL	Generic
trilyte	Generic

For Plans Effective 7/1/2020 or Later

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Commit to Quit

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In an effort to support the wellness of our employees, we are pleased to announce that we are offering a Smoking Cessation program! The smoking cessation benefits will include the following:

Both over the counter (OTC) medications and prescription medications are covered!

SAMPLE OF OVER-THE-COUNTER (OTC) MEDICATIONS INCLUDED:			
• Commit 2mg Lozenges	$0	• Nicotine 21/24 Hr. TD Patch	$0
• Commit 4mg Lozenges	$0	• Nicotine Polacrilex 2mg (Nicotine Gum)	$0
• Nicotine 7/24 Hr. TD Patch	$0	• Nicotine Polacrilex 4mg (Nicotine Gum)	$0
• Nicotine 14/24 Hr. TD Patch	$0		

SAMPLE OF PRESCRIPTION MEDICATIONS INCLUDED:			
• bupropion hcl 150mg SA	$0	• Nicotine Cartridge Inhaler	$0
• Chantix Continuing Pack	$0	• Nicotine Nasal Inhaler	$0
• Chantix Starting Pack	$0		

Talk to your physician about which treatment may be right for you!

How to Use the Smoking Cessation Program:

1. Talk to your doctor about which anti-smoking treatment may be right for you.
2. Obtain a prescription for either the over the counter (OTC) medication or the prescription strength medication.
3. Present that prescription to the pharmacist.
4. Pharmacist will bill the prescription to EHIM.
5. You will receive the medication for a $0.00 copay.

allianceRx Walgreens + PRIME

EHIM Pharmacy Benefits. Managed.

Prescriptions that deliver in every way.

Alliance Rx Walgreens Prime

As a member of EHIM, you are eligible to enroll in Alliance Rx Walgreens Prime, offering you convenient delivery of your ongoing maintenance medications from Walgreens to the location of your choice.

It's easy to register and order prescriptions, just have the following ready:

- **Member ID Number** (Located on ID Card)
- **Group Number**
- **Payment Information**

Select the option that works for you and follow the steps to get started.

	Online	Fax	Mail	Phone
1 REGISTER	Register or Sign In at Walgreens.com/MailService. Follow the prompts to complete enrollment.	Not available	Send completed *Registration and Prescription Order Form* to: Alliance Rx Walgreens Prime P.O. Box 29061 Phoenix, AZ 85038	Call 800-345-1985 and ask to be registered for Walgreens mail service. Please have your insurance information handy.
2 ORDER your first prescription.	Ask your doctor if he or she can prescribe your medications electronically. If he or she is unable, select an alternative option.	Have your doctor complete and fax the Prescriber Fax Form to: 800-332-9581*	Send completed *Registration and Prescription Order Form along with your original prescription* to: Alliance Rx Walgreens Prime P.O. Box 29061 Phoenix, AZ 85038	Call 800-345-1985 and request that Walgreens reach out to your doctor for a new prescription.†
3 REFILL‡	Prescriptions eligible for refills are listed in your member profile at Walgreens.com/MailService.	Not available	Send completed *Preprinted Refill Order Form* enclosed with your last order to: Alliance Rx Walgreens Prime P.O. Box 29061 Phoenix, AZ 85038	Call 800-345-1985 and select "refill a prescription" or ask to speak with a customer service representative.

*By law, prescriber fax forms and e-prescriptions are valid only if sent from a prescriber's office.

†You will need to provide your doctor's contact information as well as the name and dosage of your medication. Walgreens will notify you if your doctor doesn't respond.

‡To automatically receive refills of your medications, select the "Auto Refill" option in your online profile or on the Registration and Prescription Order Form.

§Scripts that cannot be transferred and require a new written prescription include: expired prescriptions, no refills remaining, controlled substances & compound medications.

DENTAL INSURANCE

WHO IS ELIGIBLE AND WHEN:

Superintendent, Administrators, Supervisors, Admin Office Support, Teachers, Secretaries, Custodians

BENEFITS YOU RECEIVE:

See attached Benefit Summary

EMPLOYEE PAYS:

Refer to your employment contract or bargained agreement

EMPLOYER PAYS:

Refer to your employment contract or bargained agreement

ADN ADMINISTRATORS

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

STOCKBRIDGE COMMUNITY SCHOOLS Dental Benefits Plan Group #9898
Administrators

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**Plan year July 1 through June 30**
Annual Maximum	$1000 per eligible individual for covered class I, II and III services.
Lifetime Maximum	$1500 per eligible individual for covered class IV services
Class I Preventive Services – 100%	
Routine Oral Examinations	Twice per plan year
Prophylaxis (Cleaning)	Twice per plan year (includes Periodontal Maintenance)
Topical Application of Fluoride	Twice per plan year to age 19
Space Maintainers	Once per area per lifetime, up to age 14
Bitewing X-Rays	Once per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Class II Restorative Services – 90%	
Composite and Amalgam fillings	Once per tooth surface per 24 months
Onlays and Crowns**	Once per permanent tooth per 60 months
Root Canal Therapy	
Periodontal Maintenance	Twice per plan year following treatment (includes prophylaxes)
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 36 months
Oral Surgery and Extractions	Medical plan primary for certain procedures
General Anesthesia or IV Sedation	Medically necessary and with covered oral surgery
Occlusal Guards	Once per lifetime
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch
Class III Major Services – 90%	
Complete and Partial Removable Dentures	Once per arch per 60 months
Fixed Partial Dentures (Bridges)	Once per area per 60 months
Addition of Teeth to Partial Dentures	
Endosteal Implants	Once per permanent tooth per 60 months
Class IV Orthodontic Services – 90%	
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	Fixed Appliance Therapy, up to age 19

Not Covered

Sealants Eposteal and Transosteal Implants TMJ/TMD Treatment Cosmetic Treatment

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

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

****Note – Quotes of benefits do not constitute a guarantee of payment. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitation. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $200.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

ADN ADMINISTRATORS

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

STOCKBRIDGE COMMUNITY SCHOOLS Dental Benefits Plan Group #9898 Custodians

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**Plan year October 1 through September 30**
Annual Maximum	$800 per eligible individual for covered class I, II and III services.
Lifetime Maximum	$800 per eligible individual for covered class IV services
TMJ Lifetime Maximum	$500 per eligible individual for covered TMJ services
Class I Preventive Services – 80%	
Routine Oral Examinations	Twice per plan year
Prophylaxis (Cleaning)	Twice per plan year
Topical Application of Fluoride	Once per plan year to age 18
Sealants	Once per 24 months; permanent molars to age 14
Bitewing X-Rays	Twice per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 36 months
All Other X-Rays	
Space Maintainers	Once per area per lifetime, up to age 19
Class II Restorative Services – 80%	
Composite and Amalgam fillings**	
Root Canal Therapy	
Periodontal Maintenance	Twice per plan year following treatment
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 24 months
Oral Surgery and Extractions	Medical plan primary for certain procedures
General Anesthesia or IV Sedation	Medically necessary and with covered oral surgery
Occlusal Guards	Once per 24 months
Class III Major Services – 80%	
Inlays, Onlays and Crowns**	Once per permanent tooth per 60 months
Complete and Partial Removable Dentures	Once per arch per 60 months
Fixed Partial Dentures (Bridges)	Once per area per 60 months
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 24 months, per arch
Addition of Teeth to Partial Dentures	
Class IV Orthodontic Services – 50%	
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	Fixed Appliance Therapy, up to age 19
Not Covered	

Implants Cosmetic Treatment

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

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

****Note – Quotes of benefits do not constitute a guarantee of payment. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitation. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $200.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

ADN ADMINISTRATORS

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

STOCKBRIDGE COMMUNITY SCHOOLS Dental Benefits Plan Policy — Group #9898

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**Plan year July 1 through June 30**
Annual Maximum	$1000 per eligible individual for covered class I, II and III services.
Lifetime Maximum	$1500 per eligible individual for covered class IV services
Class I Preventive Services – 100%	
Routine Oral Examinations	Twice per plan year
Prophylaxis (Cleaning)	Twice per plan year (includes Periodontal Maintenance)
Topical Application of Fluoride	Twice per plan year to age 19
Space Maintainers	Once per area per lifetime, up to age 14
Class II Restorative Services – 90%	
Bitewing X-Rays	Once per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Composite and Amalgam fillings	Once per tooth surface per 24 months
Onlays and Crowns**	Once per permanent tooth per 60 months
Root Canal Therapy	
Periodontal Maintenance	Twice per plan year following treatment (includes prophylaxes)
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 36 months
Oral Surgery and Extractions	Medical plan primary for certain procedures
General Anesthesia or IV Sedation	Medically necessary and with covered oral surgery
Occlusal Guards	Once per lifetime
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch
Class III Major Services – 90%	
Complete and Partial Removable Dentures	Once per arch per 60 months
Fixed Partial Dentures (Bridges)	Once per area per 60 months
Addition of Teeth to Partial Dentures	
Endosteal Implants	Once per permanent tooth per 60 months
Class IV Orthodontic Services – 90%	
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	Fixed Appliance Therapy, up to age 19
Not Covered	

Sealants Eposteal and Transosteal Implants TMJ/TMD Treatment Cosmetic Treatment

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

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

****Note – Quotes of benefits do not constitute a guarantee of payment. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitation. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $200.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

ADN ADMINISTRATORS

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

STOCKBRIDGE COMMUNITY SCHOOLS Dental Benefits Plan Group #9898
Teachers and Secretaries

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**Plan year October 1 through September 30**
Annual Maximum	$1000 per eligible individual for covered class I, II and III services.
Lifetime Maximum	$1500 per eligible individual for covered class IV services
Class I Preventive Services – 100%	
Routine Oral Examinations	Twice per plan year
Prophylaxis (Cleaning)	Twice per plan year (includes Periodontal Maintenance)
Topical Application of Fluoride	Twice per plan year to age 19
Space Maintainers	Once per area per lifetime, up to age 14
Class II Restorative Services – 90%	
Bitewing X-Rays	Once per plan year
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Composite and Amalgam fillings	Once per tooth surface per 24 months
Onlays and Crowns**	Once per permanent tooth per 60 months
Root Canal Therapy	
Periodontal Maintenance	Twice per plan year following treatment (includes prophylaxes)
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Once per quadrant per 36 months
Oral Surgery and Extractions	Medical plan primary for certain procedures
General Anesthesia or IV Sedation	Medically necessary and with covered oral surgery
Occlusal Guards	Once per lifetime
Denture Repair and Adjustment	
Denture Reline or Rebase	Once per 36 months, per arch
Class III Major Services – 90%	
Complete and Partial Removable Dentures	Once per arch per 60 months
Fixed Partial Dentures (Bridges)	Once per area per 60 months
Addition of Teeth to Partial Dentures	
Endosteal Implants	Once per permanent tooth per 60 months
Class IV Orthodontic Services – 90%	
Limited and Interceptive Treatment	Removable and Fixed Appliance Therapy, up to age 19
Comprehensive Treatment	Fixed Appliance Therapy, up to age 19
Not Covered	

Sealants Eposteal and Transosteal Implants TMJ/TMD Treatment Cosmetic Treatment

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

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

****Note – Quotes of benefits do not constitute a guarantee of payment. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitation. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $200.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

VISION INSURANCE

WHO IS ELIGIBLE AND WHEN:

Superintendent, Administrators, Supervisors, Admin Office Support, Teachers, Secretaries, Custodians

BENEFITS YOU RECEIVE:

See attached Benefit Summary

EMPLOYEE PAYS:

Refer to your employment contract or bargained agreement

EMPLOYER PAYS:

Refer to your employment contract or bargained agreement

ADN ADMINISTRATORS

STOCKBRIDGE COMMUNITY SCHOOLS - Vision Benefits Plan **Group # 9898**
Administrators and Policy

The Plan-at-a-Glance	**Benefit Year – July 1 through June 30**
Vision Examination	Covered at 100% of Reasonable & Customary (R&C)
Spectacle Lenses (Pair):	
Single Vision	Covered at 100% of R&C
Bifocal	According to Limits & Exclusions
Trifocal	
Lenticular	
Frames	Covered Up to $65
Contact Lenses (Pair)	
Cosmetic/Elective (Includes Vision Exam and Fitting)	Covered Up to $115
Medically Necessary	Covered at 100% of R&C

Extra Lens Features – Tinted, Photochromic (Transition), Polycarbonate, Polarized, Oversize and Blended Lenses, Rimless Drill

Limits & Exclusions

1. Plan participants are limited to one vision examination during a benefit year
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during a benefit year
3. Plan participants may choose between eyeglasses or contact lenses, but not both

No Payments will be made for the following:

1. Non-corrective eyeglass or contact lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Extra charges for any lens treatments and coatings not listed under Extra Lens Features
9. The additional cost of progressive lenses
10. Charges for contact lenses, including the exam, prescription and fitting fee, that exceed the one-time annual plan allowance

Note: For each benefit year, covered charges for contact lenses are in lieu of all other covered charges for each insured person.

ADN ADMINISTRATORS

STOCKBRIDGE COMMUNITY SCHOOLS - Vision Benefits Plan **Group # 9898**
Custodians

The Plan-at-a-Glance	**Benefit Year – October 1 through September 30**
Vision Examination	Covered at 100% of Reasonable & Customary (R&C) Following $5.00 Copay
Spectacle Lenses (Pair):	
Single Vision	Covered at 100% of R&C
Bifocal	Following $7.50 Combined Copay for Lenses and Frames
Trifocal	According to Limits & Exclusions
Lenticular	
Frames	Covered at 100% of R&C Following $7.50 Combined Copay for Frames and Lenses
Contact Lenses (Pair)	Covered Up to $80

Extra Lens Features – Rose Tint 1 and 2

Limits & Exclusions

1. Plan participants are limited to one vision examination during a benefit year
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during a benefit year
3. Plan participants may choose between eyeglasses or contact lenses, but not both

No Payments will be made for the following:

1. Non-corrective eyeglass or contact lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Extra charges for any lens treatments and coatings not listed under Extra Lens Features.
9. The additional cost of progressive lenses
10. Charges for contact lenses, including the prescription and fitting fee, that exceed the one-time annual plan allowance

Note: For each benefit year, covered charges for contact lenses are in lieu of all other covered charges for each insured person.

ADN ADMINISTRATORS

STOCKBRIDGE COMMUNITY SCHOOLS - Vision Benefits Plan **Group # 9898**
Teachers & Secretaries A

The Plan-at-a-Glance	**Benefit Year – October 1 through September 30**
Vision Examination	Covered at 100% of Reasonable & Customary (R&C) Following $6.50 Copay
Spectacle Lenses (Pair):	
Single Vision Bifocal Trifocal Lenticular	Covered at 100% of R&C Following $18 Combined Deductible for Lenses and Frames According to Limits & Exclusions
Frames	Covered Up to $65 Following $18 Combined Deductible for Frames and Lenses
Contact Lenses (Pair)	
Cosmetic/Elective (Includes Vision Exam and Fitting)	Covered Up to $90
Medically Necessary	Covered at 100% of R&C

Extra Lens Features – Tinted, Photochromic (Transition), Polycarbonate, Polarized, Oversize and Blended Lenses, Rimless Drill

Limits & Exclusions

1. Plan participants are limited to one vision examination during a benefit year
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during a benefit year
3. Plan participants may choose between eyeglasses or contact lenses, but not both

No Payments will be made for the following:

1. Non-corrective eyeglass or contact lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Extra charges for any lens treatments and coatings not listed under Extra Lens Features
9. The additional cost of progressive lenses
10. Charges for contact lenses, including the exam, prescription and fitting fee, that exceed the one-time annual plan allowance

Note: For each benefit year, covered charges for contact lenses are in lieu of all other covered charges for each insured person.

ADN ADMINISTRATORS

STOCKBRIDGE COMMUNITY SCHOOLS - Vision Benefits Plan **Group # 9898**
Teachers & Secretaries B

The Plan-at-a-Glance	**Benefit Year – October 1 through September 30**
Vision Examination	Covered at 100% of Reasonable & Customary (R&C)
Spectacle Lenses (Pair):	
Single Vision	Covered at 100% of R&C
Bifocal	According to Limits & Exclusions
Trifocal	
Lenticular	
Frames	Covered Up to $65
Contact Lenses (Pair)	
Cosmetic/Elective (Includes Vision Exam and Fitting)	Covered Up to $115
Medically Necessary	Covered at 100% of R&C

Extra Lens Features – Tinted, Photochromic (Transition), Polycarbonate, Polarized, Oversize and Blended Lenses, Rimless Drill

Limits & Exclusions

1. Plan participants are limited to one vision examination during a benefit year
2. Plan participants are limited to one pair of corrective spectacle lenses and one frame during a benefit year
3. Plan participants may choose between eyeglasses or contact lenses, but not both

No Payments will be made for the following:

1. Non-corrective eyeglass or contact lenses
2. Vision therapy or subnormal vision aids
3. Medical or surgical treatment of the eyes
4. Replacement of lost or broken lenses or frames if benefits applicable to the replacement were previously provided during the benefit year
5. Charges with respect to which benefits are provided under any Workers' Compensation or similar law
6. Vision examination, lenses or frames which would have been furnished without cost in the absence of this insurance or for which an insured person has no legal obligation to pay
7. The cost of frames that exceeds the plan allowance
8. Extra charges for any lens treatments and coatings not listed under Extra Lens Features
9. The additional cost of progressive lenses
10. Charges for contact lenses, including the exam, prescription and fitting fee, that exceed the one-time annual plan allowance

Note: For each benefit year, covered charges for contact lenses are in lieu of all other covered charges for each insured person.

DISABILITY INSURANCE

WHO IS ELIGIBLE AND WHEN:

Classes 01-02, 05: First day of Active Work
Class 03: First day of Active Work if hired during the school year; 9/1 if hired during the summer
Class 04: First day of Active Work if hired from 10/1 through the end of the school year; 10/1 if hired after the end of the school year, but before 10/1
Class 06: First day of Active Work if hired during the school year, September 1 if hired during the summer

BENEFITS YOU RECEIVE:

Class	Class Title and Eligibility (Minimum Hour Requirement)	Maximum Annual Covered Salary / Maximum Monthly Benefit	Benefit	Elimination Period
01	Superintendent (40 hours per week)	$170,000 / $8,500	60%	Modified fill
02	Administrators, Supervisors and Administration Office Support (40 hours per week)	$99,996 / $5,000	60%	Modified fill
03	Teachers (33.75 hours per week)	$50,004 / $2,500	60%	Modified fill
04	Support Staff (40 hours per week)	$50,004 / $2,500	60%	Modified fill
05	Grandfathered Employees working a minimum of 20 hours per week (20 hours per week)	$50,004 / $2,500	60%	Modified fill
06	Part-Time Teacher & Part-Time Administrator (33.75 hours per week)	$99,996 / $5,000	60%	Modified fill

EMPLOYEE PAYS:

10%

EMPLOYER PAYS:

90%

LIFE INSURANCE

WHO IS ELIGIBLE AND WHEN:

Classes 01-02: First day of Active Work if hired during the school year; 9/1 if hired during the summer
Classes 03-04, 06, 09, 11: First Day of Active Work
Classes 07-08: First day of Active Work if hired from 10/1 through the end of the school year; 10/1 if hired after the end of the school year, but before 10/1
Class 10: 60 calendar days after initial hire date
Class 12: First Day of Active Work if hired during the school year, 9/1 if hired during the summer

BENEFITS YOU RECEIVE:

Class	Class Title and Eligibility (Minimum Hour Requirement)	Basic Life and AD&D
01	Teachers with Medical (33.75 hours per week)	$25,000
02	Teachers without Medical (33.75 hours per week)	$35,000
03	Superintendent (40 hours per week)	2 x Annual Salary to a maximum of $200,000
04	Administrators & Department Heads (40 hours per week)	$55,000
06	Administration Office Support (40 hours per week)	$40,000
07	Support Staff with Medical (40 hours per week)	$25,000
08	Support Staff without Medical (40 hours per week)	$35,000
09	Grandfathered Employees working a minimum of 20 hours per week (20 hours per week)	$25,000
10	Custodians (40 hours per week)	$20,000
11	Maintenance Director (40 hours per week)	$35,000
12	Part-Time Teacher & Part-Time Administrator (33.75 hours per week)	$55,000

EMPLOYEE PAYS:

Classes 01-04, 06-09, 11-12: 10%
Class 10: 20%

EMPLOYER PAYS:

Classes 01-04, 06-09, 11-12: 90%
Class 10: 80%

FLEXIBLE SPENDING ACCOUNT

WHO IS ELIGIBLE AND WHEN:

All employees

BENEFITS YOU RECEIVE:

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

HEALTH CARE REIMBURSEMENT FSA

This program lets 's employees pay for certain IRS-approved medical care expenses with a prescription not covered by their insurance plan with pre-tax dollars. The current limit on salary reduction contributions to a health FSA offered under a cafeteria plan is $2,750 and is applicable to both grandfathered and non-grandfathered health FSAs. This limit is indexed for cost-of-living adjustments in subsequent years. Some examples of eligible expenses include:

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

DEPENDENT CARE FSA

The Dependent Care FSA lets 's employees use pre-tax dollars toward qualified dependent care such as caring for children under the age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 (or $2,500 if married and filing separately) per calendar year. Examples include:

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

EMPLOYEE ASSISTANCE PROGRAM

WHO IS ELIGIBLE AND WHEN:

All employees covered under group life insurance plan with Madison National Life

BENEFITS YOU RECEIVE:

The Employee Assistance Program is offered to all employees and immediate family members through Morneau Shepell It is a **completely confidential** counseling program that covers issues such as marital and family concerns, depression, substance abuse, grief and loss, financial entanglements and other personal stressors.

You can contact Morneau Shepell toll-free at 866-451-5465 (EAP), 866-472-2734 (Claimant Assistant), or you can visit their website at www.niseap.com.

EMPLOYEE PAYS:

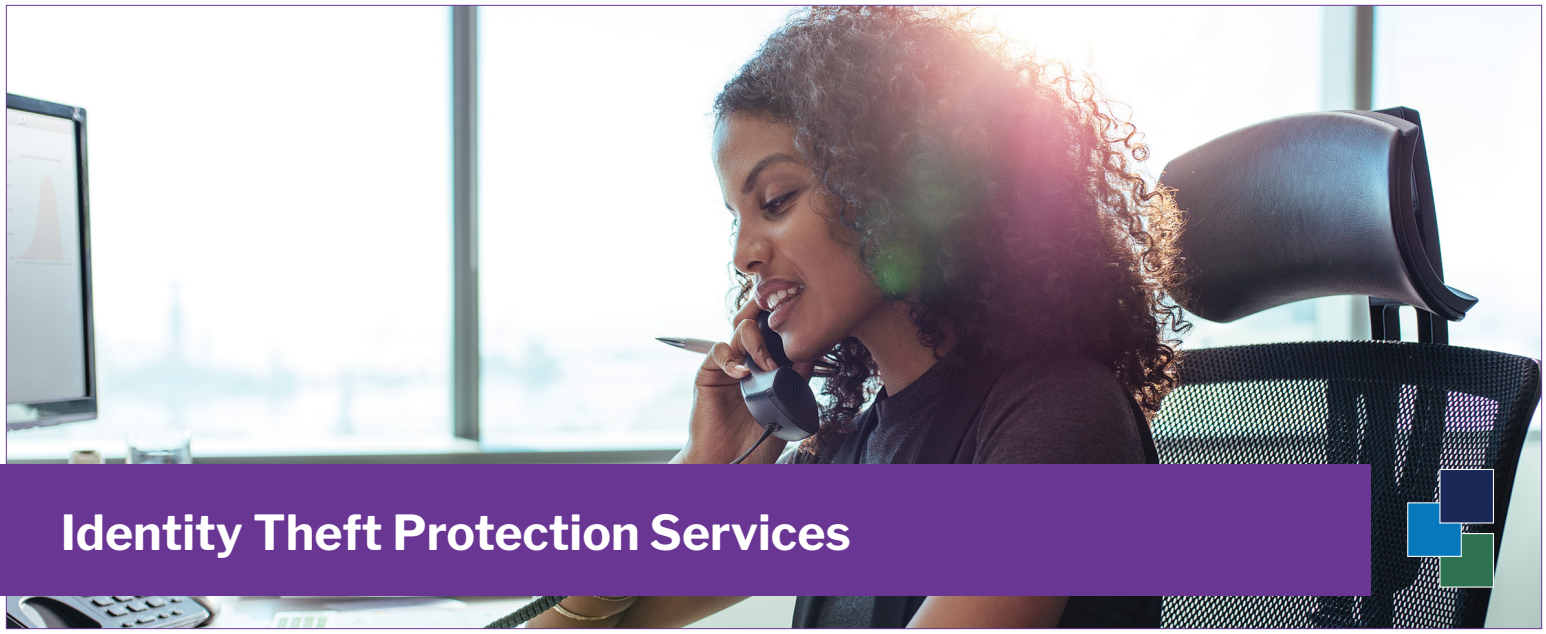
0%

EMPLOYER PAYS:

100%

NIS National Insurance Services

Client Focused. Solution Driven.



Identity Theft Protection Services

There is an identity theft victim every two seconds. If you are a victim, the IDX Identity Theft Recovery specialists will provide concierge-style service every step of the way. Their expertise will offer peace of mind and save valuable time during this stressful process.

Your dedicated recovery specialist will work with you until the identity is restored to pre-fraud status. Support may include:

- Assistance with investigation of the suspected identity theft
- Guidance through the recovery process
- Recovery for all 9 types of identity theft
- Advice from trained professionals in identity protection
- Single point-of-contact if you are a victim
- Assistance with notifying law enforcement or local government agencies
- Limited Power of Attorney to work on the victim's behalf
- Documentation including fraud affidavit
- And much more

IDX™
The Privacy Platform

https://app.idx.us/account-creation/NIS
855.205.6010

"It was great knowing I had someone to help me resolve my identity theft issues and I didn't have to spend hours trying to figure out how to handle it on my own" - IDX member, Needham, MA

Resolution services offered to you by your employer and:

NIS National Insurance Services

Corporate office:
250 South Executive Drive, Suite 300
Brookfield, WI 53005
800.627.3660

Madison National Life Insurance Company
A Member of The IHC Group
PO Box 5008, Madison, WI 53705

Identity theft assistance services are provided by IDX, which is not affiliated with Madison National Life Insurance Company, Inc. Services provided by IDX are not part of Madison National Life's insurance products, and Madison National Life is not responsible for any acts or omissions of IDX in connection with or arising under identify theft assistance services.

Access to IDX program is conditioned upon: (i) your employer remaining a Madison National Life customer; and (iii) the program terms and conditions. This program does not provide credit repair services or any form of legal advice.

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