



FLEXIBLE COMPENSATION BOOKLET

**ST. CLAIR COUNTY
EMPLOYEES**



**BENEFIT PLAN YEAR
01/01/2020 - 12/31/2020**

**2020 Flexible Benefit Menu
Community Blue Plan**

BENEFIT	CORE	OPTION I	OPTION II
Medical – BCBS	PPO/Community Blue Plan 8 Preventative Services \$20 Office Visit Co-pay \$20 Chiropractic Visit Co-Pay \$15/30/45 Rx Co-pay \$500 Individual Deductible * \$1000 Family Deductible * 80/20% Co-insurance * \$2500/\$5000 (Ind/Family) Co-Insurance Maximum (Plus Deductible) * \$6350/\$12700 (Ind/Family) * Out-of-Pocket Max Inc Deduct, Co-pays * In-Network Services Includes Vision & Hearing Benefits <u>COST</u> Single \$1174.44/26 = \$44.03/pay 2-Person \$2818.70/26 = \$105.68/pay Family \$3523.37/26 = \$132.09/pay	OPT OUT Complete and Return Declination of Health Insurance Form on Page 10. <i>Please refer to your Labor Agreement to determine eligibility.</i> <u>CASH REBATE</u> Single \$ 650/yr Two Person \$1100/yr Family \$1350/yr	N/A
Dental - DELTA	Class I (Preventative) 100% Class I (Other) 50% Class II & III 50% Annual Maximum \$1000 Class IV (Orthodontic) 50% Lifetime Maximum (Ortho) \$1500	OPT OUT <i>Please refer to your Labor Agreement to determine eligibility.</i> \$200 to a Flexible Reimbursement Account	OPT OUT <i>Please refer to your Labor Agreement to determine eligibility.</i> \$150 Cash Rebate
Long Term Disability	66 2/3% to \$4,000, up to a maximum of 5 (five) years	Employee may purchase 70% to \$6000, to maximum benefit period	
Life Insurance	Current Labor Agreement Benefit Level	Employee may purchase an additional 1x Core amount	Employee may purchase an additional 2x Core amount
Uninsured Health Care Reimbursement Account	Pretax dollar payroll deductions to a maximum of \$2,750 Uninsured Health Care expenses.		
Dependent Care Reimbursement Account	Pretax dollar payroll deductions to a maximum of \$5,000 Dependent Care expenses.		

THE ABOVE TABLE SHOULD BE READ ACROSS NOT VERTICALLY. SELECT ONE OPTION FROM EACH BENEFIT CATEGORY.

Additional Voluntary Benefits Including AFLAC, Pet Insurance, Legal/IDShield, Medtipster

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ADMINISTRATOR –

St Clair County will administer the entire Flexible Compensation Program. St. Clair County has retained Maestro Health to administer the Reimbursement Accounts. Representatives will be available to answer any questions that you may have either prior to or during enrollment. They will also be responsible for handling the plan on an ongoing basis. For assistance call: 1-888-488-5054. You can also contact them via email at questions@maestrohealth.com.

Introduction

It is inconceivable to think that a single person, a family with children and a couple approaching retirement would all want the same benefits. That is why the Administration and Employee representatives of St. Clair County, Michigan gathered together to create the **St. Clair County Flexible Compensation Plan**.

Flexible Compensation is based on the concept that you are the best judge of your benefit needs. Therefore, the program provides you with a Core of essential coverage and then gives you the option of either electing additional coverage, less coverage or opting out of coverage altogether. Should you decide to take less comprehensive coverage or no coverage at all, you may be eligible to receive a designated amount of cash. **That cash can either be reinvested elsewhere in the menu or added to your earnings and received over your normal pay schedule.**

Flexible Compensation also provides you with an array of benefit alternatives previously unavailable and gives you the opportunity to pay for those benefits before the government takes out any taxes. By shifting current out-of-pocket expenses and paying them through the Flexible Compensation Plan pretax, you not only take care of your necessary responsibilities, but you give yourself a **pay raise** at the same time. In turn, your pay raise can be used to enhance Core benefits or purchase other benefits that were previously unaffordable. (See example on next page.)

The opportunity to choose is accompanied by the responsibility of understanding your choices. This booklet provides information about Flexible Compensation and the options that are available to you.

In addition, you will find worksheets to help determine your benefit needs. It is essential that you complete the worksheets prior to enrollment, since these are intended to assist you in making the proper benefit selections. Enrollment can only be held **once** each year so make sure that you are prepared.

PLAN OVERVIEW

St. Clair County's Flexible Compensation Program is made up of two components:
The Core Program and Employee Options.

The Core Program - includes all the current levels of coverage provided by the County:

- Medical Coverage for you and your eligible dependents up to the age of 26
- Dental Coverage for you and your eligible dependents
- Term Life Insurance
- Long Term Disability Insurance (**Only if included in your Labor Agreement**)

Employee Options - allow you to modify the Core Program, as you wish.

Included among your Employee Options are a number of different alternatives:
(Please refer to your **Labor Agreement to determine eligibility of these options**)

- No Medical Coverage in exchange for cash
- No Dental Coverage in exchange for Reimbursement Account
- No Dental Coverage in exchange for cash
- Additional Long Term Disability Insurance
- Additional Term Life Insurance
- An Employee Reimbursement Account for Uninsured Health Care and/or Dependent Care Expenses
- Additional Voluntary Benefits

The following example (assuming Single taxpayer) illustrates how the payment of after-tax expenses on a pretax basis creates a pay raise for the employee.

	<u>With Account</u>	<u>Without Account</u>
Annual Gross Salary	24,000	24,000
Dependent Care	1,800	0
Health Care Expenses	<u>700</u>	<u>0</u>
Taxable Income	21,500	24,000
Federal Tax (18.5% blended)	3,978	4,440
FICA (7.65%)	1,645	1,836
State Tax (3.9%)	<u>839</u>	<u>936</u>
(Total taxes = 30.05%)		
After-Tax Income	15,038	16,788
After-Tax Dependent Care	0	1,800
After-Tax Health Care	<u>0</u>	<u>700</u>
Spendable Income	\$15,038	\$14,288
NET PAY RAISE	<u>750.00</u>	

NOTE: A portion of your pay raise should be used to address the possible disadvantage of pretax funding. (See the section entitled "How to Avoid Potential Disadvantages").

Liability Worksheet

Before you can decide which benefits to choose, it is necessary to evaluate your own personal financial responsibilities. Fill in the blanks below as accurately as possible. Once you have completed this section, you will be able to determine your benefit needs.

MONTHLY EXPENSES	MONTHLY PAYMENT	OUTSTANDING LIABILITY
Mortgages/Rent	\$ _____	_____
NOTE: If your homeowners insurance and taxes are included with your mortgage payment, then include here and skip those items as annual expenses.		
Second Mortgage	\$ _____	_____
Car Payment	\$ _____	_____
Car Expense (gas/repairs)	\$ _____	_____
Utilities: Electric \$ _____ + Gas \$ _____ + Phone \$ _____ + Water/Sewage \$ _____ + Cable \$ _____ + Other \$ _____	= _____	
Food/Sundries	\$ _____	
Installment Loans	\$ _____	_____
Credit Cards	\$ _____	_____
Entertainment (theater, movies, sporting events, restaurants)	\$ _____	
Miscellaneous (special occasions, money for children, etc.)	\$ _____	
Monthly Total:	\$ _____	
	x12	
Annual (monthly) Subtotal:	\$ _____	*

* Note: Carry this number to the bottom marked Annual (monthly) Subtotal.

ANNUAL EXPENSES	ANNUAL PAYMENT	
Taxes (primary residence, secondary residence, other property)	\$ _____	
Vacation(s)	\$ _____	
Insurance(s): Life \$ _____ + Auto \$ _____ + Homeowners \$ _____ + Health \$ _____ + Cancer \$ _____ + Disability \$ _____ + Other \$ _____	= _____	
Miscellaneous (tuition, political, religious donations)	\$ _____	
Annual Subtotal	\$ _____	
Annual (monthly) Subtotal +	\$ _____	*
TOTAL YEARLY EXPENSES	\$ _____	\$ _____
		TOTAL OUTSTANDING \$LIABILITIES

Term Life Coverage

Term Life coverage provides a source of funds to assist you in meeting financial responsibilities in the event of your death. It may be used to ensure the repayment of a loan or mortgage for yourself or your family. It can cover your children's college tuition or provide a source of income for your dependents.

CORE

The Core Term Life coverage benefit amount is based upon your Labor Agreement. Please refer to your Labor Agreement for details.

EMPLOYEE OPTIONS

OPTION I
Additional 1 x Core Amount
(No AD&D)

OPTION II
Additional 2 x Core Amount
(No AD&D)

If you wish, you may add to your Core coverage by purchasing additional Term Life coverage. You will be required to provide evidence of insurability. This form can be obtained from the Human Resource Department. Coverage is effective upon written approval from the carrier. The first \$50,000 of coverage can be paid for with pretax dollars. With amounts in excess of \$50,000, the Internal Revenue Service requires taxation on a portion of your premium. The cost to provide this coverage is reflected on the rate sheet, page 5.

Optional Term Life Coverage

<u>AGE</u>	<u>Cost per thousand per month</u>
0 - 34	\$.13
35 - 39	\$.17
40 - 44	\$.23
45 - 49	\$.33
50 - 54	\$.51
55 - 59	\$.80
60 - 64	\$1.28
65 - 69	\$2.42
70 - 74	\$3.96
75 - 79	\$6.82

To calculate the cost of additional term life insurance:

1) Find your age and corresponding monthly cost per thousand

$$2) \frac{\text{Cost per thousand}}{\text{Cost per thousand}} \times \frac{\text{Life ins. amt (omit 000)}}{\text{Life ins. amt (omit 000)}} = \frac{\text{Monthly Cost}}{\text{Monthly Cost}}$$

$$3) \frac{\text{Monthly Cost}}{\text{Monthly Cost}} \times \frac{12 \text{ months}}{12 \text{ months}} = \frac{\text{Annual Cost}}{\text{Annual Cost}}$$

$$4) \frac{\text{Annual Cost}}{\text{Annual Cost}} \div \frac{26}{\text{No. of pays}} = \frac{\text{Cost per pay}}{\text{Cost per pay}}$$

EXAMPLE:

- 38 years old (.17 per thousand)
- Base Life Insurance \$30,000
- would like to purchase additional one (1) x base
- 26 pays per year

$$2) \frac{.17}{\text{Cost per thousand}} \times \frac{30}{\text{Life ins. amt (omit 000)}} = \frac{5.10}{\text{Monthly Cost}}$$

$$3) \frac{5.10}{\text{Monthly Cost}} \times \frac{12 \text{ months}}{12 \text{ months}} = \frac{61.20}{\text{Annual Cost}}$$

$$4) \frac{61.20}{\text{Annual Cost}} \div \frac{26}{\text{No. of pays}} = \frac{2.35}{\text{Cost per pay}}$$

Long-Term Disability Coverage

(Consult your current Labor Agreement for availability and coverage level.)

Long-Term Disability (LTD) benefits provide income if you are unable to work for a prolonged period due to illness or injury.

CORE

The payments, which begin **180 days** after the onset of your disability, replace **66 2/3%** of your base monthly salary. The minimum benefit is the greater of **\$100** or **10%** of your gross income. The maximum benefit is **\$4,000** per month.

Disability benefits are available if you are disabled from your own occupation for the first 2 years and from any occupation (taking into consideration education and experience) for a maximum of 5 years.

LTD benefits are coordinated with other benefits such as Social Security, Workers Compensation, Employers Retirement Plan, any other Group Insurance Plan.

Coverage is effective on the date of completion of three (3) months of active employment.

Percent of Monthly Salary	66 2/3%	
Maximum Monthly Benefit	\$4,000	
Maximum Benefit Period:	<u>Age at Disability</u>	
	Less than age 65	Up to 5 Years
	65 – 68	To age 70 but not less than 1 year
	69 and Over	1 Year

EMPLOYEE OPTIONS

If you wish to protect more of your income, you may elect to purchase additional Long-Term Disability coverage. This increases the percentage of your monthly income that would be replaced in the event of a disability.

Percent of Monthly Salary	70%	
Maximum Monthly Benefit	\$6,000	
Maximum Benefit Period:	<u>Age at Disability</u>	
	Less than age 60	To age 65 but not less than 60 months
	60	60 months
	61	48 months
	62	42 months
	63	30 months
	65	24 months
	66	21 months
	67	18 months
	68	15 months
	69 and over	12 months

The cost to purchase this coverage is reflected on the rate sheet, page 7.

Optional Long-Term Disability Coverage

<u>AGE</u>	<u>Monthly Rate (per \$100 of Benefit)</u>
0 - 24	\$.13
25 - 29	\$.15
30 - 34	\$.24
35 - 39	\$.32
40 - 44	\$.43
45 - 49	\$.59
50 - 54	\$.86
55 - 59	\$.82
60 - 64	\$.28
65 - 69	\$.28
70 +	\$.28

To calculate the cost of additional Long Term Disability Insurance:

$$(1) \text{ \$ } \frac{\text{Annual Salary}}{\text{rate}/100} \times \text{rate}/100 = \text{ \$ } \text{Annual Cost}$$

$$(2) \text{ \$ } \frac{\text{Annual Cost}}{\# \text{ of Pays}} / \frac{26}{\# \text{ of Pays}} = \text{ \$ } \text{Cost Per Pay}$$

EXAMPLE:

- Age 35
- Annual Salary \$45,000
- Would like to purchase additional long-term disability benefits
- 26 pays per year

$$(1) \text{ \$ } \frac{45,000}{\text{rate}/100} \times \frac{.0032}{\text{rate}/100} = \text{ \$ } \frac{144.00}{\text{Annual Cost}}$$

$$(2) \text{ \$ } \frac{144.00}{\text{Annual Cost}} / \frac{26}{\# \text{ of Pays}} = \text{ \$ } \frac{5.54}{\text{Cost Per Pay}}$$

Dental Coverage

The schedule below provides a comparison and explanation of all dental options available. Each eligible employee must elect one option only. Should you elect a coverage with a cash rebate, that rebate will be returned in equal installments over the annual Flexible Compensation Plan Year pay schedule. You may spend your rebated dollars on other coverage elsewhere in the menu.

		CORE	OPTION I	OPTION II
DEDUCTIBLE	Up front payment by employee.	0	-	-
COINSURANCE	CLASS I: Diagnostic, preventative and minor emergency procedures to relieve pain	100%	-	-
	CLASS I: Radiographs, emergency palliative, restorative, oral surgery, endodontic and periodontic.	50%	-	-
	CLASS II & III: Bridges and partial and complete dentures.	50%	-	-
	CLASS IV: Orthodontic services for treatment and procedures required for the correction of malposed teeth. No age limit. Please refer to your Labor Agreement for benefit level.	50%	-	-
ANNUAL MAXIMUM	Each member is entitled to maximum benefits of this amount every contract year.	\$1,000	-	-
ORTHODONTIC LIFETIME	Each member has a lifetime maximum of this amount available for orthodontic services. Please refer to your Labor Agreement for benefit level.	\$1,500	-	-
CASH REBATE-REIMBURSEMENT ACCOUNT	Cash may be deposited into a Flexible Reimbursement Account.	0	\$200	0
CASH REBATE	Cash may be received in your paycheck.	0	0	\$150

- *Employees and retirees of the County, that have a spouse working for or retired from the County or County agency, may or may not be eligible to participate in the Opt Out plan option. Please refer to your Labor Agreement to determine eligibility.*

Medical Coverage - At A Glance

The schedule below provides a "comparison-at-a-glance" of all medical options. Please refer to the Benefits-At-A-Glance available in Human Resources or online for detailed explanations of coverage and your current Labor Agreement before making your selection. Each employee must elect one option only. Should you elect coverage with a cash rebate, that rebate will be returned in equal installments over the Flexible Compensation Plan Year pay schedule. You may spend your rebated dollars on other coverage elsewhere in the menu. Employees who wish to opt out of coverage must sign the declination of health insurance form on page 10. Dependent coverage is available with any option for spouses and eligible dependents up to the end of the month in which they turn age 26.

BENEFIT	CORE	OPTION I
CARRIER:	Blue Cross/Blue Shield PPO Community Blue Plan 8	Opt Out - No Coverage
DEDUCTIBLE *	\$500/\$1000	-
CO-PAYMENT *	80% Plan Pays 20% You Pay	-
CO-INSURANCE MAX * <i>(Does not include Deductible)</i>	\$2500/\$5000	-
OUT-OF-POCKET MAX * <i>(Includes Co-pays/Deductibles)</i>	\$6350/\$12700	
DRUG PLAN	\$15/\$30/\$45 Copay	-
CASH REBATE (Annual) *Refer to your CBA	None	Single \$ 650 Two Person \$1,100 Family \$1,350
EMPLOYEE COST (Annual)	Single \$ 1144.83 Two Person \$ 2747.57 Family \$ 3434.46	N/A

* In-Network Services

- *Employees and retirees of the County, that have a spouse working for or retired from the County or County agency, may or may not be eligible to participate in the Opt Out plan option. Please refer to your Labor Agreement to determine eligibility.*

Opt Out

DECLINATION OF HEALTH INSURANCE

I, _____, hereby elect to decline my health insurance coverage offered through the County of St. Clair, Michigan. I elect to receive \$_____ annually (distributed equally throughout the plan year payroll schedule) in lieu of this health insurance benefit. I understand that if the health insurance provided by _____ should terminate I may have the right to re-elect coverage through St. Clair County.

Please be advised of the following consequences regarding your decision to waive coverage:

- You should be aware of the individual responsibility requirement under the Affordable Care Act. If you refuse the offer of the Employer's health coverage and do not obtain the required coverage on your own, you will be subject to a penalty.
- You cannot enroll in the Employer's health plan until the next open enrollment. However, if you are covered under another plan, but that coverage is lost, you can enroll in your Employer's health plan immediately. You must request enrollment within 30 days of losing the other coverage.
- If you gain a new dependent through birth, adoption or marriage, you may enroll yourself, the new dependent, and the entire family at that time, but you must do so within 30 days of gaining the new dependent. If you miss the 30-day enrollment deadline, you must wait until open enrollment.

I acknowledge that the Employer has offered me affordable minimum essential coverage, as defined under the Affordable Care Act, for the period from January 1, 2020 to December 31, 2020. I further acknowledge that I have minimum essential coverage through another source. I have read the above and I understand the consequences of my waiver of coverage.

(Employee's Signature)

Date_____

(Print Name)

**Employees and retirees of the County, that have a spouse working for or retired from the County or County agency, may or may not be eligible to participate in the Opt Out plan option. Please refer to your Labor Agreement to determine eligibility.*

Please return this form, along with proof of other insurance to Human Resources.

Employee Reimbursement Account

One of the most attractive features of the Flexible Compensation Program is your Employee Reimbursement Account. It enables you to pay a portion of your uninsured Health Care and Dependent Care expenses with pretax dollars. This can save you a considerable amount in taxes.

The Employee Reimbursement Account has two parts: one for uninsured Health Care expenses and one for Dependent Care expenses. Just before the beginning of each plan year, you will have the opportunity to elect to fund your Reimbursement Account for the coming year. The amount that you select will be deducted from your gross salary through automatic payroll deductions. Then, during the plan year, you may submit claims to the Administrator to reimburse yourself for Dependent Care expenses and/or Health Care expenses incurred during the plan year but not reimbursed by your insurance plans. Please note, expenses must be incurred during the applicable plan year. For purposes of these Plans, an expense is considered "incurred" when the service is rendered.

NOTES ABOUT YOUR ACCOUNT

During the year, you should keep receipts for all qualified expenses. To receive reimbursements, you may complete a reimbursement form through the online portal or through an app on your mobile device. You may also request a paper form be sent to you via email to submit through mail or fax if you choose. You may submit claims anytime and reimbursement checks are run on a daily basis. Turnaround time for claim processing is 2 business days plus mail delivery time. You may choose to do direct deposit with funds being in your account within 4 business days. There will be one final check run 90 days after the plan year end.

You will receive a debit card attached to your Flexible Spending Account. The benefit of the debit card is it allows you to pay for your expenses with your debit card at the point of service without having to pay out-of-pocket and then wait for the reimbursement. Please understand that the card does not necessarily make a Flex account completely paperless, you will still need to submit receipts for certain expenses. However, expenses such as office copays and prescription copays will not require any additional paperwork.

For assistance with your Flexible Spending Account, call Maestro Health at 1-888-488-5054. You can also contact them via email at questions@maestrohealth.com.

PLEASE KEEP THESE IMPORTANT CONSIDERATIONS IN MIND:

1. **The Internal Revenue Service (IRS) requires that any money left in your account at the end of the plan year must be forfeited.** This means you should allocate only as much to the Account as you feel certain you will incur in reimbursable expenses during the year. All expenses incurred during a plan year must be submitted for reimbursement and postmarked by March 31st of the following year. Otherwise, any money left in the Account will be forfeited. **Note: St. Clair County has opted to allow employees an additional 2 ½ month to incur claims after the plan year ends.**

In the unlikely event of a forfeiture, there may still be substantial tax savings to the employee. For example, assume an employee contributes \$2,400 to the plan, but only incurs \$2,000 of expenses. The \$2,000 of expenses are reimbursed tax free and the unused \$400, in this case, would be forfeited. An employee in the 30% tax bracket (combined Federal, State, FICA) saves \$720 in taxes on the \$2,400 set aside ($\$2,400 \times 30\% = 720$). If you subtract the \$400 loss attributable to the forfeiture from the \$720 tax savings, the employee still comes out \$320 ahead.

2. If you elect to participate, the amount you designate will be withheld automatically from your paycheck in equal installments. The minimum contribution to the Account is \$5 per month.
3. The annual re-enrollment period is the only time you may change your selections unless you have a change in "family status". Qualifying "status changes" for benefits provided under this plan are subject to approval of your employer, must be on account of a particular event, and satisfy any specific consistency rules that may apply to the particular benefit. Please reference your summary plan description for a detailed list of qualified "status changes". Examples include:

- **Change in your legal marital status, on account of marriage, divorce, death of your spouse, legal separation or annulment;**
- **Change in the number of your dependents, due to birth, adoption, placement for adoption, or death of a dependent;**
- **Change in employment status for you, your spouse, or a dependent;**
- **Change because your dependent satisfies (or ceases to satisfy) the eligibility requirements;**
- **Significant cost increases in a qualifying benefit (other than Uninsured Health Care accounts);**
- **A change in coverage in a spouse's or dependent's Section 125 Plan;**
- **A leave under the Family Medical Leave Act;**

It is very important for you to understand that you must notify the Human Resources Department within 30 days of a "status change" in order to be allowed to select different benefit options. This includes adding dependent coverage. If you have a status change, the new coverage becomes effective as of the date you notify the Human Resources Department of the change or, if administratively possible, the date of the status change. It will always be to your best advantage to notify the Human Resources Department as soon as possible.

4. Although you have only one Reimbursement Account, the Uninsured Health Care portion and Dependent Care portion are entirely separate. Only Health Care expenses may be reimbursed from the Health Care portion; only Dependent Care expenses may be reimbursed from the Dependent Care portion. Once a given portion is used up for the year, no more expenses may be reimbursed for that year. You cannot transfer funds from one portion of the Account to the other.
5. The Dependent Care portion of the Account cannot reimburse you for more money than has been deposited into it by the date you make a claim. Remember, your contributions are deducted each pay, so funds build up gradually in your Dependent Care Reimbursement Account. If you do submit a claim for more than the amount in your Account at that time, any excess will be held for reimbursement until sufficient funds have accumulated.
6. If you should terminate employment during the plan year, you will have 90 days to file for reimbursable expenses incurred during the period in which you were an eligible participant of the plan. In addition, you may have COBRA rights to continue your Flexible Spending Plan if you leave employment.
7. Keep in mind that the funds you contribute to your Reimbursement Account are deducted before taxes are withheld, so you have not paid any taxes on them. Therefore, any items submitted through your Employee Reimbursement Account cannot be used as either a tax credit or deduction.

How To Avoid Potential Disadvantages Should You Fund Your Employee Reimbursement Account

Since contributions to your Employee Reimbursement Accounts are treated as a reduction in income, there will be a slight reduction in Worker's Compensation and Social Security disability, survivorship and retirement benefits. This potential disadvantage is easily overcome, if the employee invests part of their tax savings into either a Deferred Compensation or a cash value life insurance policy. **This reduction in income does not affect your county retirement benefit.** Please note, your retirement contribution is computed on your pay before deductions.

Typically, for every \$100 reduction in income for Social Security purposes, at age 40, an employee only has to invest \$5.00 out of \$22.00 in tax savings to have more benefits at retirement than the Social Security system would provide.

The amount of tax savings that have to be reinvested to make up for the lost Social Security benefit goes up the longer the employee is in the plan.

Uninsured Health Care Expenses

You may contribute up to \$2,750 of your earned income per calendar year to the Health Care portion of the Account to reimburse yourself for expenses incurred by you or an eligible dependent. Common examples include:

- Plan deductibles and co-pays.
 - Medical, Dental and Vision expenses not reimbursed by your plan.
- Please note, an eligible expense must be a medically necessary expense incurred for diagnosis, cure, treatment, mitigation, or prevention of disease, or for the purpose of affecting any bodily function or structure.

The following is a *representative* list of Health Care expenses allowable under the Internal Revenue Code:

Eligible FSA/HSA Healthcare Expenses

Please note that this list is not intended to be comprehensive tax advice.
For more detailed information, please consult IRS Publication 501 or see your tax advisor.

- Acupuncture
- Alcoholism treatment
- Allergy shots and testing
- Ambulance (ground or air)
- Artificial limbs
- Blind services and equipment
- Car controls for handicapped*
- Chiropractor services
- Coinsurance and deductibles
- Contact lenses
- Crutches, wheelchairs, walkers
- Deaf services – hearing aid/batteries, hearing aid animal & care, lip reading expenses, modified telephone, etc.
- Dental treatment
- Dentures
- Diagnostic tests
- Doctor's fees
- Drug addiction treatment & facilities
- Drugs (prescription)
- Eye examinations and eyeglasses
- Home health and/or hospice care
- Hospital services
- Insulin
- Laboratory fees
- LASIK eye surgery
- Medical alert (bracelet, necklace)
- Medical monitoring and testing devices*
- Nursing services
- Obstetrical expenses
- Occlusal guards
- Operations and surgeries (legal)
- Optometrists
- Orthodontia
- Orthopedic services
- Osteopaths
- Oxygen/oxygen equipment
- Physical exams (except for employment-related physicals)
- Physical therapy
- Psychiatric care, psychologists, psychotherapists
- Radial keratotomy
- Schools (special, relief, or handicapped)
- Sexual dysfunction treatment
- Smoking cessation
- Surgical fees
- Television or telephone for the hearing impaired
- Therapy treatments*
- Transportation (essentially and primarily for medical care; limits apply)
- Vaccinations
- Vitamins (prescription only)*
- Weight loss programs*
- X-rays

*if prescribed for a particular ailment or medical condition; provider letter required

Important Change Regarding Over-the Counter (OTC) Medications

Starting January 1, 2011, OTC medications will require a doctor's prescription to be eligible for FSA/HSA reimbursement.

As a result, OTC medications cannot be purchased using the *mySourceCard*® after 12/31/10 unless dispensed by a pharmacy the same as a standard prescription. If a manual claim is submitted for purchase of an OTC medication after 12/31/10, a prescription receipt must be included with the claim in order to receive reimbursement.

Non-medicated OTC products (gauze pads, diabetes test strips, saline solution, etc.) are not affected by this change in the law. You can continue to receive FSA/HSA reimbursement for such items after 12/31/10 in the same manner you do now.

Eligible FSA/HSA OTC Medications and Products

ELIGIBLE NOW, BUT WILL REQUIRE PRESCRIPTION TO REMAIN ELIGIBLE AFTER 12/31/10:

- Acne medications & treatments
- Allergy & sinus, cold, flu & cough remedies (antihistamines, decongestants, cough syrups, cough drops, nasal sprays, medicated rubs, etc.)
- Antacids & acid controllers (tablets, liquids, capsules)
- Antibiotic & antiseptic sprays, creams & ointments
- Anti-diarrheals
- Anti-fungals
- Anti-gas & stomach remedies
- Anti-itch & insect bite remedies
- Anti-parasitics
- Digestive aids
- Baby care (diaper rash ointments, teething gel, rehydration fluids, etc.)
- Contraceptives (condoms, gels, foams, suppositories, etc.)
- Eczema & psoriasis remedies
- Eye drops, ear drops, nasal sprays
- First aid kits
- Hemorrhoidal preparations
- Hydrogen peroxide, rubbing alcohol
- Laxatives
- Medicated bandaids & dressings
- Motion sickness remedies
- Nicotine medications (smoking cessation aids)
- Pain relievers (aspirin, ibuprofen, acetaminophen, naproxen, etc.)
- Sleep aids & sedatives
- Wart removal remedies, corn patches

ELIGIBLE NOW AND WILL REMAIN ELIGIBLE AFTER 12/31/10 WITH NO PRESCRIPTION REQUIRED:

- Braces & supports
- Contact lens solution
- Diabetic testing supplies & equipment
- Durable medical equipment (power chairs, walkers, wheelchairs, CPAP equipment & supplies, etc.)
- Home diagnostic (pregnancy tests, ovulation kits, thermometers, blood pressure monitors, etc.)
- Non-medicated bandaids, rolled bandages & dressings
- Reading glasses

All OTC items listed are examples.

Note: Currently, in order to receive a tax deduction for medical expenses on your tax return; expenses must exceed 7.5% of your adjusted gross income. Therefore, your Uninsured Health Care expense account provides you with the only opportunity to receive full credit for ALL medical expenses incurred regardless of income.

Estimating Health Care Expenses For You and Your Family

(You should refer to the sections entitled "Medical/Dental Options" to help you accurately estimate your expenses.)

	Previous Year (Actual)	This Year (Expected)
Medical plan deductibles	\$ _____	\$ _____
Medical plan coinsurance (the percentage that your plan does not pay)	\$ _____	\$ _____
Dental or orthodontic expenses that are not covered by your plan	\$ _____	\$ _____
Vision care expenses	\$ _____	\$ _____
Hearing aids	\$ _____	\$ _____
Medicine or drugs prescribed by a doctor but not covered by your plan	\$ _____	\$ _____
Other qualified expenses not paid by your plan	\$ _____	\$ _____
YOUR TOTAL HEALTH CARE EXPENSES:	\$ _____	\$ _____

Dependent Care Expenses

The Employee Reimbursement Account can be used to pay for Dependent Care expenses that enable you and your spouse to work or to search actively for work.

Reimbursement Limitations:

A married employee may only be reimbursed for Dependent Care expenses up to the lesser of:

- a. \$5,000 (\$2,500 if married filing a separate return); or
- b. 50% of the employee's compensation; or
- c. the earned income of the employee's spouse.

Therefore, a married employee whose spouse does not work is generally not entitled to Dependent Care assistance reimbursement. However, if the employee's spouse is a full-time student or incapable of caring for himself or herself then the employee will be allowed a limited benefit under the plan. The allowable limit of reimbursement for each month the spouse is a full-time student is \$200 if the employee has one dependent or \$400 if the employee has two or more. If the employee's spouse is incapacitated, the allowable limit is \$200 per month if the employee has one or more additional dependents.

An unmarried employee may be reimbursed for all Dependent Care expenses up to the lesser of:

- a. \$5,000; or
- b. 50% of the employee's compensation

For the purpose of Dependent Care expenses, a dependent includes anyone you claim as a dependent on your income tax return and who is:

Age 12 or younger, or

Physically or mentally incapable of caring for himself or herself (for example, a disabled spouse or an elderly parent). A person other than your spouse must rely on you for more than one-half of his or her support to qualify as a dependent.

Eligible Dependent Care expenses include:

Payments made for services provided in your home (babysitters, for example). These services cannot be provided by someone you claim as a dependent or someone who is a relative residing with you. Provider does not have to be licensed; however they would need to claim money received as income for tax purposes.

Payment made for dependent child care services outside your home. If you use the services of a dependent care center that provides care for at least six people (other than residents), the center must be in compliance with the state and local laws.

Payments made for care outside your home for a dependent (other than a child), if the dependent spends at least eight hours a day in your home. (For example, 24-hour nursing home care for a dependent parent would not qualify).

If you utilize a Dependent Care Reimbursement Account, you must furnish the name, address and tax identification (social security number or corporate tax ID) number for the provider of dependent care services to the FSA Plan Administrator. Please complete the Mandatory Statement for Dependent Care on an annual basis.

FLEXIBLE SPENDING ACCOUNTS



A Flexible Spending Account, or FSA, is an employee benefit that allows you to conveniently save and pay for you and your family's healthcare expenses. The income you choose to contribute to your FSA becomes tax exempt, giving you extra cash to help pay for upcoming healthcare or dependent care costs, as well as the inevitable unexpected expenses.

Healthcare FSA.

Used for certain qualified out-of-pocket expenses not covered by your health plan.

- Out-of-pocket deductible
- Office visit copays
- Out-of-pocket dental
- Orthodontia
- Vision and hearing
- Prescriptions

Here's why you should enroll.

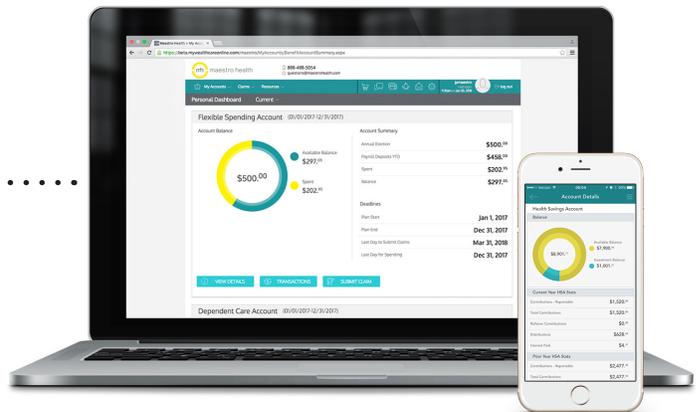
- Fast, daily claim reimbursement
- Online claim filing & account access
- mSAVE™ mobile app for Apple & Android
- mSAVE debit card

Here's how much you can save.

Savings will be determined based on your federal and state tax rates. On average, people save between 20 – 35% on money contributed to an FSA.

What happens if I don't use all my FSA money this year?

Your employer allows up to \$500 of unused rollover dollars from your FSA into the next plan year.



..... Visit msave.maestrohealth.com

Registration ID: Select "Card Number" and enter the 16-digit number on your mSAVE debit card.

Plan Year Start:

Plan Year End:

Annual Election Max:

Questions? Let us help.

888.488.5054 | questions@maestrohealth.com | maestrohealth.com



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of the Blue Cross and Blue Shield Association

COUNTY OF ST CLAIR
00683001
0070062610000 - 06570
Effective Date: 01/01/2017

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

Preauthorization for Select Services - Services listed in this BAAG are covered when provided in accordance with Certificate requirements and, when required, are preauthorized or approved by BCBSM except in an emergency.

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

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

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

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

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

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

Eligibility Information

Members	Eligibility Criteria
Dependents	<ul style="list-style-type: none"> Subscriber's legal spouse Dependent children: related to you by birth, marriage, legal adoption or legal guardianship; eligible for coverage through the last day of the month the dependent turns age 26
Sponsored dependents	<ul style="list-style-type: none"> Dependents of the subscriber related by blood, marriage or legal adoption, over age 19 and not eligible as a dependent under the provisions of the subscriber's contract, provided the dependent meets all eligibility requirements. The subscriber is responsible for paying the cost of this coverage.

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

Benefits	In-network	Out-of-network
Deductible	<p>\$500 for one member, \$1,000 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over)</p> <p>Note: Deductible may be waived for covered services performed in an in-network physician's office and for covered mental health and substance use disorder services that are equivalent to an office visit and performed in an in-network physician's office.</p>	<p>\$1,000 for one member, \$2,000 for the family (when two or more members are covered under your contract) each calendar year (no 4th quarter carry-over)</p> <p>Note: Out-of-network deductible amounts also count toward the in-network deductible.</p>
Flat-dollar copays	<ul style="list-style-type: none"> \$20 copay for office visits and office consultations \$20 copay for online visits \$20 copay for chiropractic and osteopathic manipulative therapy \$50 copay for emergency room visits \$20 copay for urgent care visits 	<ul style="list-style-type: none"> \$50 copay for emergency room visits
Coinsurance amounts (percent copays)	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 20% of approved amount for mental health care and substance use disorder treatment 20% of approved amount for most other covered services (coinsurance waived for covered services performed in an in-network physician's office) <p>Note: Coinsurance amounts apply once the deductible has been met.</p>	<ul style="list-style-type: none"> 50% of approved amount for private duty nursing care 40% of approved amount for mental health care and substance use disorder treatment 40% of approved amount for most other covered services
Annual coinsurance maximums - applies to coinsurance amounts for all covered services - but does not apply to deductibles, flat-dollar copays, private duty nursing care coinsurance amounts and prescription drug cost-sharing amounts	<p>\$2,500 for one member, \$5,000 for the family (when two or more members are covered under your contract) each calendar year</p>	<p>\$3,000 for one member, \$6,000 for the family (when two or more members are covered under your contract) each calendar year</p> <p>Note: Out-of-network coinsurance amounts also count toward the in-network coinsurance maximum.</p>

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Benefits	In-network	Out-of-network
Annual out-of-pocket maximums - applies to deductibles, flat dollar copays and coinsurance amounts for all covered services - including cost-sharing amounts for prescription drugs, if applicable	\$6,350 for one member, \$12,700 for the family (when two or more members are covered under your contract) each calendar year	\$12,700 for one member, \$25,400 for the family (when two or more members are covered under your contract) each calendar year Note: Out-of-network cost-sharing amounts also count toward the in-network out-of-pocket maximum.
Lifetime dollar maximum	None	

Preventive care services

Benefits	In-network	Out-of-network
Health maintenance exam - includes chest x-ray, EKG, cholesterol screening and other select lab procedures	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity	Not covered
Gynecological exam	100% (no deductible or copay/coinsurance), one per member per calendar year Note: Additional well-women visits may be allowed based on medical necessity.	Not covered
Pap smear screening - laboratory and pathology services	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Voluntary sterilization for females	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Prescription contraceptive devices - includes insertion and removal of an intrauterine device by a licensed physician	100% (no deductible or copay/coinsurance)	100% after out-of-network deductible
Contraceptive injections	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Well-baby and child care visits	100% (no deductible or copay/coinsurance) <ul style="list-style-type: none"> • 8 visits, birth through 12 months • 6 visits, 13 months through 23 months • 6 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit 	Not covered
Adult and childhood preventive services and immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% (no deductible or copay/coinsurance)	Not covered
Fecal occult blood screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Flexible sigmoidoscopy exam	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered

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Benefits	In-network	Out-of-network
Prostate specific antigen (PSA) screening	100% (no deductible or copay/coinsurance), one per member per calendar year	Not covered
Routine mammogram and related reading	100% (no deductible or copay/coinsurance) Note: Subsequent medically necessary mammograms performed during the same calendar year are subject to your deductible and coinsurance. One per member per calendar year	60% after out-of-network deductible Note: Out-of-network readings and interpretations are payable only when the screening mammogram itself is performed by an in-network provider.
Colonoscopy - routine or medically necessary	100% (no deductible or copay/coinsurance) for the first billed colonoscopy Note: Subsequent colonoscopies performed during the same calendar year are subject to your deductible and coinsurance. One per member per calendar year	60% after out-of-network deductible

Physician office services

Benefits	In-network	Out-of-network
Office visits - must be medically necessary	\$20 copay per office visit	60% after out-of-network deductible
Online visits - by physician must be medically necessary Note: Online visits by a vendor are not covered.	\$20 copay per online visit	60% after out-of-network deductible
Outpatient and home medical care visits - must be medically necessary	80% after in-network deductible	60% after out-of-network deductible
Office consultations - must be medically necessary	\$20 copay per office consultation	60% after out-of-network deductible
Urgent care visits - must be medically necessary	\$20 copay per urgent care visit	60% after out-of-network deductible

Emergency medical care

Benefits	In-network	Out-of-network
Hospital emergency room	\$50 copay per visit (copay waived if admitted or for an accidental injury)	\$50 copay per visit (copay waived if admitted or for an accidental injury)
Ambulance services - must be medically necessary	80% after in-network deductible	80% after in-network deductible

Diagnostic services

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

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Maternity services provided by a physician or certified nurse midwife

Benefits	In-network	Out-of-network
Prenatal care visits	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Postnatal care visit	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Delivery and nursery care	80% after in-network deductible	60% after out-of-network deductible

Hospital care

Benefits	In-network	Out-of-network
Semiprivate room, inpatient physician care, general nursing care, hospital services and supplies	80% after in-network deductible	60% after out-of-network deductible
Unlimited days		
Note: Nonemergency services must be rendered in a participating hospital.		
Inpatient consultations	80% after in-network deductible	60% after out-of-network deductible
Chemotherapy	80% after in-network deductible	60% after out-of-network deductible

Alternatives to hospital care

Benefits	In-network	Out-of-network
Skilled nursing care - must be in a participating skilled nursing facility	80% after in-network deductible	80% after in-network deductible
Limited to a maximum of 120 days per member per calendar year.		
Hospice care	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance)
Up to 28 pre-hospice counseling visits before electing hospice services; when elected, four 90-day periods - provided through a participating hospice program only ; limited to dollar maximum that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions into individual case management)		
Home health care: <ul style="list-style-type: none"> • must be medically necessary • must be provided by a participating home health care agency 	80% after in-network deductible	80% after in-network deductible
Infusion therapy: <ul style="list-style-type: none"> • must be medically necessary • must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • may use drugs that require preauthorization - consult with your doctor 	80% after in-network deductible	80% after in-network deductible

Surgical services

Benefits	In-network	Out-of-network
Surgery - includes related surgical services and medically necessary facility services by a participating ambulatory surgery facility	80% after in-network deductible	60% after out-of-network deductible
Presurgical consultations	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Voluntary sterilization for males	80% after in-network deductible	60% after out-of-network deductible
Note: For voluntary sterilizations for females, see " Preventive care services. "		
Voluntary abortions	80% after in-network deductible	60% after out-of-network deductible

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Human organ transplants

Benefits	In-network	Out-of-network
Specified human organ transplants - must be in a designated facility and coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% (no deductible or copay/coinsurance)	100% (no deductible or copay/coinsurance) - in designated facilities only
Bone marrow transplants - must be coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	80% after in-network deductible	60% after out-of-network deductible
Specified oncology clinical trials	80% after in-network deductible	60% after out-of-network deductible
Note: BCBSM covers clinical trials in compliance with PPACA.		
Kidney, cornea and skin transplants	80% after in-network deductible	60% after out-of-network deductible

Mental health care and substance use disorder treatment

Note: Some mental health and substance use disorder services are considered by BCBSM to be comparable to an office visit. When a mental health or substance use disorder service is considered by BCBSM to be comparable to an office visit, we will process the claim under your office visit benefit.

Note: BCBSM will cover mental health services performed - MD, DO, Fully Licensed Psychologists and Clinical Licensed Master's Social Workers (CLMSWs), Limited Licensed Psychologists (LLPs), Licensed Professional Counselor, Social Workers who have the following social work degrees/certifications: MMSW, MSSW.

Benefits	In-network	Out-of-network
Inpatient mental health care and inpatient substance use disorder treatment	80% after in-network deductible	60% after out-of-network deductible
		Unlimited days
Residential psychiatric treatment facility: <ul style="list-style-type: none"> covered mental health services must be performed in a residential psychiatric treatment facility treatment must be preauthorized subject to medical criteria 	80% after in-network deductible	60% after out-of-network deductible
Outpatient mental health care: <ul style="list-style-type: none"> Facility and clinic 	80% after in-network deductible	80% after in-network deductible in participating facilities only
<ul style="list-style-type: none"> Physician's office 	80% after in-network deductible	60% after out-of-network deductible
Outpatient substance use disorder treatment - in approved facilities only	80% after in-network deductible	60% after out-of-network deductible (in-network cost-sharing will apply if there is no PPO network)

Autism spectrum disorders, diagnoses and treatment

Benefits	In-network	Out-of-network
Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst - is covered through age 18, subject to preauthorization	Not covered	Not covered
Note: Diagnosis of an autism spectrum disorder and a treatment recommendation for ABA services must be obtained by a BCBSM approved autism evaluation center (AAEC) prior to seeking ABA treatment.		
Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Not covered	Not covered
Other covered services, including mental health services, for autism spectrum disorder	Not covered	Not covered

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Other covered services

Benefits	In-network	Out-of-network
<p>Outpatient Diabetes Management Program (ODMP)</p> <p>Note: Screening services required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider.</p> <p>Note: When you purchase your diabetic supplies via mail order you will lower your out-of-pocket costs.</p>	<ul style="list-style-type: none"> 80% after in-network deductible for diabetes medical supplies 100% (no deductible or copay/coinsurance) for diabetes self-management training 	60% after out-of-network deductible
Allergy testing and therapy	100% (no deductible or copay/coinsurance)	60% after out-of-network deductible
Chiropractic spinal manipulation and osteopathic manipulative therapy	\$20 copay per visit	60% after out-of-network deductible
	Limited to a combined 24-visit maximum per member per calendar year	
Outpatient physical, speech and occupational therapy - provided for rehabilitation	80% after in-network deductible	60% after out-of-network deductible
		Note: Services at nonparticipating outpatient physical therapy facilities are not covered.
	Limited to a combined 60-visit maximum per member per calendar year	
<p>Durable medical equipment</p> <p>Note: DME items required under the provisions of PPACA are covered at 100% of approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of covered DME items required under PPACA, call BCBSM.</p>	80% after in-network deductible	80% after in-network deductible
Prosthetic and orthotic appliances	80% after in-network deductible	80% after in-network deductible
Private duty nursing care	50% after in-network deductible	50% after in-network deductible

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BCBSM Preferred RX Program

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

Specialty Pharmaceutical Drugs - The mail order pharmacy for **specialty drugs** is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel® and Humira®) are used to treat complex conditions such as rheumatoid arthritis, multiple sclerosis and cancer. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many in-network retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Express Scripts. (Express Scripts is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com/pharmacy. If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a "specialty pharmaceutical" whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply. BCBSM reserves the right to limit the quantity of select specialty drugs to no more than a 15-day supply for each fill. Your copay/coinsurance will be reduced by one-half for each fill once applicable deductibles have been met.

Select Controlled Substance Drugs - BCBSM will limit the initial fill of select controlled substances to a 15-day supply. The member will be responsible for only one-half of their cost-sharing requirement typically imposed on a 30-day fill. Subsequent fills of the same medication will be eligible to be filled as prescribed, subject to the applicable cost-sharing requirement. Select controlled substances affected by this prescription drug requirement are available online at bcbsm.com/pharmacy.

Member's responsibility (copays and coinsurance amounts)

Note: Your prescription drug copays and coinsurance amounts, including mail order copay and coinsurance amounts, are subject to the **same** annual out-of-pocket maximum required under your medical coverage. The following prescription drug expenses will not apply to your annual out-of-pocket maximum.

- any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand name drug
- the 25% member liability for covered drugs obtained from an out-of-network pharmacy

Note: If your prescription is filled by any type of in-network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list, you do not need to pay the difference in cost between the maximum allowable cost and the BCBSM approved amount for the brand name drug. You pay only your applicable copay.

Benefits		90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
Tier 1 - Generic drugs	1 to 30-day period	You pay \$15 copay	You pay \$15 copay	You pay \$15 copay	You pay \$15 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$15 copay	No coverage	No coverage
	84 to 90-day period	You pay \$15 copay	You pay \$15 copay	No coverage	No coverage
Tier 2 - Preferred brand-name drugs	1 to 30-day period	You pay \$30 copay	You pay \$30 copay	You pay \$30 copay	You pay \$30 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$30 copay	No coverage	No coverage
	84 to 90-day period	You pay \$30 copay	You pay \$30 copay	No coverage	No coverage
Tier 3 - Nonpreferred brand-name drugs	1 to 30-day period	You pay \$45 copay	You pay \$45 copay	You pay \$45 copay	You pay \$45 copay plus an additional 25% of BCBSM approved amount for the drug
	31 to 83-day period	No coverage	You pay \$45 copay	No coverage	No coverage
	84 to 90-day period	You pay \$45 copay	You pay \$45 copay	No coverage	No coverage

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* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Covered services				
Benefits	90-day retail network pharmacy	* In-network mail order provider	In-network pharmacy (not part of the 90-day retail network)	Out-of-network pharmacy
FDA-approved drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Prescribed over-the-counter drugs - when covered by BCBSM Note: Contact BCBSM Customer Service or the plan's Human Resource Department for list of covered over-the-counter drugs	100% of approved amount less plan copay	100% of approved amount less plan copay	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
FDA-approved generic and select brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved brand-name prescription preventive drugs, supplements and vitamins as required by PPACA	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the Patient Protection and Affordable Care Act	100% of approved amount	Not covered	100% of approved amount	75% of approved amount
FDA-approved generic and select brand name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount	100% of approved amount	100% of approved amount	75% of approved amount
Other FDA-approved brand name prescription contraceptive medication (non-self-administered drugs are not covered)	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	100% of approved amount less plan copay/coinsurance	75% of approved amount less plan copay/coinsurance
Disposable needles and syringes - when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay/coinsurance.	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	100% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug	75% of approved amount less plan copay/coinsurance for the insulin or other covered injectable legend drug
Diabetic test strips and lancets	100% of approved amount less Tier 2 copay	100% of approved amount less Tier 2 copay	100% of approved amount less Tier 2 copay	Not covered

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

* BCBSM will not pay for drugs obtained from out-of-network mail order providers, including Internet providers.

Features of your prescription drug plan

Custom Drug List	<p>A continually updated list of FDA-approved medications that represent each therapeutic class. The drugs on the list are chosen by the BCBSM Pharmacy and Therapeutics Committee for their effectiveness, safety, uniqueness and cost efficiency. The goal of the drug list is to provide members with the greatest therapeutic value at the lowest possible cost.</p> <ul style="list-style-type: none"> ● Tier 1 (generic) - Tier 1 includes generic drugs made with the same active ingredients, available in the same strengths and dosage forms, and administered in the same way as equivalent brand-name drugs. They also require the lowest copay/coinsurance, making them the most cost-effective option for the treatment. ● Tier 2 (preferred brand) - Tier 2 includes brand-name drugs from the Custom Drug List. Preferred brand name drugs are also safe and effective, but require a higher copay/coinsurance. ● Tier 3 (nonpreferred brand) - Tier 3 contains brand-name drugs not included in Tier 2. These drugs may not have a proven record for safety or as high of a clinical value as Tier 1 or Tier 2 drugs. Members pay the highest copay/coinsurance for these drugs.
Drug interchange and generic copay/ coinsurance waiver	<p>BCBSM's drug interchange and generic copay/ coinsurance waiver programs encourage physicians to prescribe a less-costly generic equivalent.</p> <p>If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay/ coinsurance. In select cases BCBSM may waive the initial copay/ coinsurance after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>
Mandatory maximum allowable cost drugs	<p>If your prescription is filled by any type of network pharmacy, and the pharmacist fills it with a brand-name drug for which a generic equivalent is available, you MUST pay the difference in cost between the BCBSM approved amount for the brand-name drug dispensed and the maximum allowable cost for the generic drug plus your applicable copay regardless of whether you or your physician requests the brand name drug. Exception: If your physician requests and receives authorization for a nonformulary brand-name drug with a generic equivalent from BCBSM and writes "Dispense as Written" or "DAW" on the prescription order, You pay only your applicable copay. Note: This MAC difference will not be applied toward your annual in-network deductible, nor your annual coinsurance/copay maximum.</p>
Over-the-counter drugs	<p>Excludes benefits for certain over-the-counter drugs.</p>
Dosage and quantity of drugs	<p>Your prescription drug coverage has eliminated authorization requirements for select prescription drugs, and dosages and quantities of drugs.</p>

Vision Coverage

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

Essential Vision benefits are provided by Heritage Total Services. Heritage Vision Plans is an independent company providing vision benefit services for Blues members. To find a Heritage Total Services network provider, call **1-800-252-2053** or visit Heritage Vision Plans online at heritagevisionplans.com.

Note: Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both.

Member's responsibility (copays)

Benefits	Network doctor	Non-network provider
Eye exam	\$5 copay	\$5 copay applies to charge
Prescription glasses (lenses and/or frames)	Combined \$7.50 copay	Member responsible for difference between approved amount and provider's charge, after \$7.50 copay
Medically necessary contact lenses	\$7.50 copay	Member responsible for difference between approved amount and provider's charge, after \$7.50 copay

Note: No copay is required for prescribed contact lenses that are not medically necessary.

Eye exam

Benefits	Network doctor	Non-network provider
Complete eye exam by an ophthalmologist or optometrist. The exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	\$5 copay	Reimbursement up to \$46 less \$5 copay (member responsible for any difference)

One eye exam in any period of 24 **consecutive** months

Lenses and frames

Benefits	Network doctor	Non-network provider
Standard lenses (must not exceed 60 mm in diameter) prescribed and dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary.	\$7.50 copay (one copay applies to both lenses and frames)	Reimbursement up to approved amount based on lens type less \$7.50 copay (member responsible for any difference)
Note: Preferred pricing discounts on noncovered lens options and upgrades, and on an additional prescription eyeglass or sunglass (second pair) purchase when obtained from a network provider.	One pair of lenses, with or without frames, in any period of 24 consecutive months	
Standard frames	\$100 allowance that is applied toward frames (member responsible for any cost exceeding the allowance)	
	One frame in any period of 24 consecutive months when services are rendered by a Heritage network provider.	

Contact lenses

Benefits	Network doctor	Non-network provider
Medically necessary contact lenses (requires prior authorization approval from Heritage and must meet criteria of medically necessary)	\$7.50 copay	Reimbursement up to approved amount less \$7.50 copay (member responsible for any difference)
	Contact lenses are covered up to allowance every 24 consecutive months	

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

Benefits	Network doctor	Non-network provider
Elective contact lenses that improve vision (prescribed, but do not meet criteria of medically necessary)	\$100 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	\$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
Contact lenses are covered up to allowance every 24 consecutive months		

Hearing Care Coverage

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

Member's responsibility (deductible and copay)

Benefits	Participating provider	Nonparticipating provider
Deductible	None	Not applicable
Copay	None	Not applicable

Covered services

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

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

Benefits	Participating provider	Nonparticipating provider
Audiometric exam - one every 36 months	100% of approved amount	Not covered
Hearing aid evaluation- one every 36 months	100% of approved amount	Not covered
Ordering and fitting the hearing aid (a monaural or binaural hearing aid) - one every 36 months	100% of approved amount	Not covered
Hearing aid conformity test- one every 36 months	100% of approved amount	Not covered

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

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



Blue Cross Online VisitsSM

Medical and behavioral health

Convenient online care for body and mind

It's as simple as using your smartphone, tablet or computer anywhere in the U.S. to meet with:

- A doctor for minor illnesses such as a cold, flu or sore throat when their primary care doctor isn't available.
- A behavioral health professional or psychiatrist to help work through different challenges such as anxiety or grief.

For the whole family

Family members on your plan can also use online visits. Just add children younger than 18 to your account. Your spouse, and children 18 and over, should create their own accounts.



What's included in online visits

Medical care

Use it when you're traveling or at home with a sick child. Or when your primary care doctor isn't available.

Visits last about 10 minutes although the doctor will spend as much time as needed. You can see a doctor on demand or by appointment 24 hours a day, seven days a week.

Behavioral health care

Online visits give you more choices for behavioral health care. Talk to therapists and psychiatrists about life's challenges from the comfort of home.

Therapy visits

Therapists such as psychologists, licensed clinical social workers, marriage and family therapists and professional counselors use talk therapy.

Therapy is available to adults and children age 10 and older by appointment from 7 a.m. to 11 p.m. Visits typically last 45 minutes.

Psychiatry visits

Psychiatrists can make diagnoses and prescribe and manage medications.

Psychiatry is available to adults age 18 and over and visits are by appointment only. Extended hours during evenings and on weekends may be available. The initial visit usually lasts 45 minutes with 15 minute follow-up visits.

Prescriptions

Doctors may write prescriptions, if appropriate. They don't write prescriptions for controlled substances.

How does it work?

Fast and convenient

Sign up now

Mobile – Download the BCBSM Online VisitsSM app

Web – Visit bcbsmonlinevisits.com

Phone – Call 1-844-606-1608

Add your Blue Cross or Blue Care Network health care plan information.



See a doctor or therapist

1. Launch the online visits app or website, and log in to your account.
2. Choose a service: *Medical*, *Therapy* or *Psychiatry*.
3. Pick a doctor or begin a scheduled visit and enter your payment information.
4. Meet with the doctor or therapist online.
5. Get a prescription, if appropriate, sent to a local pharmacy.
6. Send a visit summary to your primary care doctor or other health care provider at the end of your online visit.

Choose a doctor or therapist who's right for you

There are hundreds of doctors and therapists to choose from. They're all specially trained in online visits. You can read their profiles to learn more about them such as languages they speak and other experience.

Doctors have an average of 15 years practicing medicine and are U.S. board-certified. They have experience in areas such as pediatrics, family medicine and emergency care. Psychiatrists are board-certified in psychiatry or neurology.

The masters- and doctoral-level therapists are licensed and credentialed in the state where you're having a visit.

For questions about your online visits account or an online visit, call 1-844-606-1608, 24 hours a day, seven days a week.

Remember to coordinate all care through your primary care doctor. Blue Cross Online VisitsSM uses the American Well[®] technology platform and provider network, and is powered by American Well[®]. American Well[®] is an independent company that provides online visits for Blue Cross and BCN members.

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.



Visit St. Clair County's medtipster employee access portal
at www.scc.medtipster.com and
learn how to get your generic medications for free.

Simple step-by-step instructions walk you through the
process of printing your very own medtipster ID card. This
ID card will make it easier than ever to utilize your
prescription benefit to its full potential.

So logon today and get Rxconnected!



October 1, 2010

Dear Valued Medtipster Member:

St. Clair County and Medtipster, are excited to inform you of an amazing opportunity to save on your prescription drug costs. "Save" may not truly be the appropriate word. How about "FREE"? On October 1, 2010, you will be eligible to obtain and print your very own Medtipster ID card. This ID card will allow you to obtain thousands of generic prescription drugs for FREE at participating neighborhood pharmacies.

Getting started is as simple as 1, 2 and 3.

Step 1: Visit www.scc.medtipster.com. Click the "employee access" tab on the website to register and follow our simple step-by-step instructions to print your Medtipster ID card.

Step 2: Search for your generic medication on www.scc.medtipster.com. A Medtipster  logo indicates that your generic medication is FREE.

Step 3: Print your Medtipster ID card online and take it to one of the pharmacies indicated on the site (along with prescription from your physician) and it's yours – FREE.

You may wish to call your prescribing physician to verify that one of the drugs listed on Medtipster is an option for you. Savings is important, but the goal of Medtipster is to ensure safe, medically sound and cost-effective drug therapy for you and your family.

If you have any questions, please call Medtipster at the toll-free number printed on your member identification card or email us at: contact@medtipster.com.

We look forward to serving you, and making quality prescription drugs affordable for you.

Sincerely,

Your Medtipster team



**Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 3636-0099, 1000
St. Clair County**

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –

	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Sealants – to prevent decay of permanent teeth	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Periodontal Maintenance – cleanings following periodontal therapy	100%	100%	100%
Basic Services			
Radiographs – X-rays	50%	50%	50%
Minor Restorative Services – fillings and crown repair	50%	50%	50%
Endodontic Services – root canals	50%	50%	50%
Periodontic Services – to treat gum disease	50%	50%	50%
Oral Surgery Services – extractions and dental surgery	50%	50%	50%
Major Restorative Services – crowns	50%	50%	50%
Other Basic Services – misc. services	50%	50%	50%
Relines and Repairs – to bridges, implants, and dentures	50%	50%	50%
Major Services			
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit –	No Age Limit	No Age Limit	No Age Limit

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are Covered Services with no limitations.
- Space maintainers are payable once per area per lifetime for people up to age 16.

- Bitewing X-rays are payable twice per calendar year. Full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Sealants are payable once per tooth per five-year period for the occlusal surface of first and second permanent molars up to age 14. The surface must be free from decay and restorations.
- Composite resin (white) restorations are Covered Services on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Implants and implant related services are payable once per tooth in any five-year period.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – \$1,000 per person total per Benefit Year on all services except orthodontics. \$1,500 per person total per lifetime on orthodontic services.

Deductible – None.

Waiting Period – Employees who are eligible for dental benefits are covered 30 days from date of hire.

Eligible People – All full-time employees of the county working at least 37.5 hours per week who choose the dental plan (1000) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees (0099). The Contractor pays the full cost of this plan.

Also eligible are your legal spouse and your children to the end of the month in which they turn 26, including your children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled and your domestic partner as defined by the contractor. You and your eligible dependents must enroll for a minimum of 12 months. If coverage is terminated after 12 months, you may not re-enroll prior to the open enrollment that occurs at least 12 months from the date of termination. Your dependents may only enroll if you are enrolled (except under COBRA) and must be enrolled in the same plan as you. Plan changes are only allowed during open enrollment periods, except that an election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

If you and your spouse are both eligible for coverage under this Contract, you may be enrolled together on one application or separately on individual applications, but not both. Your dependent children may only be enrolled on one application. Delta Dental will not coordinate benefits if you and your spouse are both covered under this Contract.

Benefits will cease on the date of termination.



County of St. Clair

Life and Disability insurance from The Hartford can help you protect the financial future of your loved ones. Your coverage includes valuable services that can help you and your family.

FUNERAL CONCIERGE SERVICES¹

Helps provide peace of mind when it's needed most.

The Hartford's Funeral Concierge offers a suite of online tools and live support to help guide you through key decisions. It allows for pre-planning, documentation of wishes, and even offers cost comparisons of funeral-related expenses. After a loss, this service includes family advocacy and professional negotiation of funeral prices with local providers – often resulting in significant savings.

For more information, call: **1-866-854-5429**

Visit: www.everestfuneral.com/hartford

Use code: **HFEVLC**

BENEFICIARY ASSIST®COUNSELING SERVICES²

Getting through a loss is hard. Getting support shouldn't be.

The Hartford offers you Beneficiary Assist counseling that can help you or your beneficiaries (named in your policy) cope with emotional, financial and legal issues that arise after a loss. Includes unlimited phone contact with a counselor, attorney or financial planner and five face-to-face sessions for up to a year from the date a claim is filed.

For more information, call: **1-800-411-7239**

ESTATEGUIDANCE®WILL SERVICES^{2,3}

Create a simple will from the convenience of your home.

Whether your assets are few or many, it's important to have a will. Through The Hartford you have access to EstateGuidance®It helps you protect your family's future by creating a will online – backed by online support from licensed attorneys.

Visit: www.estateguidance.com

Use code: **WILLHLF**

continued

Travel Assistance

Call toll-free: **1-800-243-6108**

From other locations,

call collect: **202-828-5885**

Fax: **202-331-1528**

What to have ready:

- Your employer's name
- Your phone number
- Nature of the problem
- Your policy number
- Your Travel Assist ID number:
GLD-09012

Ability Assist® & HealthChampion™

Call toll-free:

**1-800-96-HELPS
(1-800-964-3577)**

 (Snap photo with any mobile device to capture information above)

TRAVEL ASSISTANCE WITH ID THEFT PROTECTION⁴

Even the best planned trips can be full of surprises.

Travel Assistance with ID Theft Protection includes pre-trip information to help you feel more secure while traveling. It can also help you access professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less. ID Theft services are available to you and your family at home or when traveling.

In case of a serious medical emergency while traveling, please obtain emergency medical services first (contact the local “911”), and then contact Travel Assistance to alert them.

ABILITY ASSIST® COUNSELING SERVICES WITH HEALTHCHAMPION™ HEALTH CARE SUPPORT^{2,5}

Disability can be a challenge. Getting support doesn't have to be.

Ability Assist Counseling Services offers 24/7 access to master's- and Ph.D.- level clinicians. Includes three face-to-face visits per occurrence per year for emotional concerns and unlimited phone consultations for financial, legal and work-life concerns.

If your company provides disability coverage for less than 5,000 people, Ability Assist is available to you at any time if you're covered by Disability, Voluntary or Leave Management services with The Hartford. If your company provides disability coverage for more than 5,000 people, you'll have access to this service once you have an approved claim. See your benefits manager for details.

HealthChampion offers support if you've become disabled or are diagnosed with a critical illness. You'll receive guidance on care options, helpful resources and help with timely and fair resolution of issues.

Visit TheHartford.com/employeebenefits



¹The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company, Home Office is Hartford, CT. All benefits are subject to the terms and conditions of the policy. Policy underwritten by the issuing company listed above. Detail exclusions, limitations, reduction of benefits and terms under which the policy may be continued in force or discontinued. ©2018 The Hartford

Life Form Series includes GED-1000, GED-1100, or state equivalent. Disability Form Series includes GED-1000, GED-1200, or state equivalent.

²Some services may not be available in all states. For more information, visit www.TheHartford.com/employee-benefits/value-added-services

¹Funeral Concierge Services are provided through Everest Funeral Package, LLC (Everest). Everest and the Everest logo are service marks of Everest Funeral Package, LLC. Everest is not affiliated with The Hartford and is not a provider of insurance services. Everest and its affiliates have no affiliation with Everest Re Group, Ltd., Everest Re Insurance Company or any of their affiliates. The Hartford is not responsible and assumes no liability for the services provided by Everest Funeral Package, LLC as described in these materials and reserves the right to discontinue any of these services at any time.

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³The Estate Guidance® website is secured with a GoDaddy.com Web Server Certificate. Transactions on this site are protected with up to 256-bit Secure Sockets Layer encryption. Printing of a simple will is available at an additional cost to you.

⁴Travel Assistance and ID Theft Protection are provided by General Global Assistance, Inc. General is not affiliated with The Hartford and is not a provider of insurance services.

⁵HealthChampion® specialists are available during business hours only. Inquiries outside this time frame can request a call back or scheduled appointment.

The Hartford's Privacy Policy is available at: www.TheHartford.com/online-privacy-policy

The Hartford is not responsible and assumes no liability for the goods and services described in these materials and reserves the right to discontinue any of these services at any time.

4339 NS/18

Just because an accident can change your health, doesn't mean it should change your lifestyle too.

Accidents can happen in an instant affecting you or a loved one. Aflac is designed to help families plan for the health care bumps ahead and take some of the uncertainty and financial insecurity out of getting better.

Protection for the unexpected, that's the benefit of the Aflac Group Accident Plan.

After an accident, you may have expenses you've never thought about. Can your finances handle them? It's reassuring to know that an accident insurance plan can be there for you in your time of need to help cover expenses such as:

- Ambulance rides
- Emergency room visits
- Surgery and anesthesia
- Prescriptions
- Major Diagnostic Testing
- Burns

Plan Features

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions).
- Benefits are paid regardless of any other medical insurance.

What you need, when you need it.

Group accident insurance pays cash benefits that you can use any way you see fit.



Aflac can help ease the financial stress of surviving a critical illness.

Chances are you may know someone who's been diagnosed with a critical illness. You can't help notice the difference in the person's life—both physically and emotionally. What's not so obvious is the impact a critical illness may have on someone's personal finances.

That's because while a major medical plan may pay for a good portion of the costs associated with a critical illness, there are a lot of expenses that may not be covered. And, during recovery, having to worry about out-of-pocket expenses is the last thing anyone needs.

That's the benefit of an Aflac Group Critical Illness plan.

It can help with the treatment costs of covered critical illnesses, such as a heart attack or stroke.

More importantly, the plan helps you focus on recuperation instead of the distraction of out-of-pocket costs. With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned)—giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

What you need, when you need it.

Group critical illness insurance pays cash benefits that you can use any way you see fit.



Here's why the Aflac Group Critical Illness plan may be right for you.

For more than 60 years, Aflac has been dedicated to helping provide individuals and families peace of mind and financial security when they've needed it most. The Aflac Group Critical Illness plan is just another innovative way to help make sure you're well protected.

But it doesn't stop there. Having group critical illness insurance from Aflac means that you may have added financial resources to help with medical costs or ongoing living expenses.

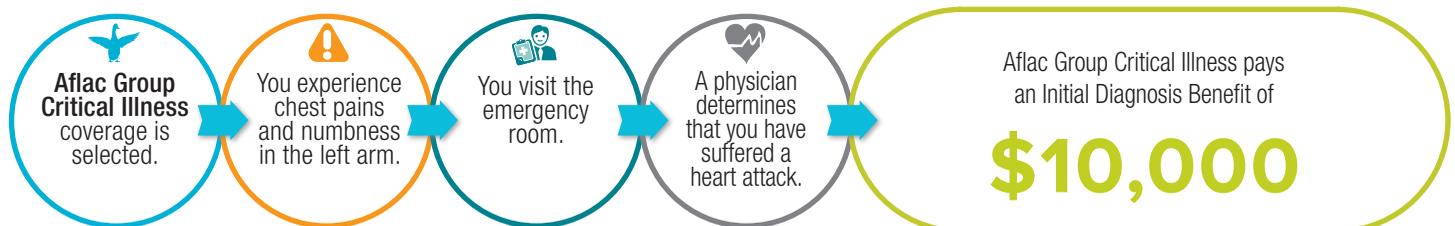
The Aflac Group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
 - Cancer
 - Heart Attack (Myocardial Infarction)
 - Stroke
 - Kidney Failure (End-Stage Renal Failure)
 - Major Organ Transplant
 - Bone Marrow Transplant (Stem Cell Transplant)
 - Sudden Cardiac Arrest
 - Coronary Artery Bypass Surgery
 - Non-Invasive Cancer
 - Skin Cancer
 - Severe Burn
 - Coma
 - Paralysis
 - Loss of Sight/Hearing/Speech
- Health Screening Benefit

Features:

- Benefits are paid directly to you, unless otherwise assigned.
- Coverage is available for you, your spouse, and dependent children.
- Coverage may be continued (with certain stipulations). That means you can take it with you if you change jobs or retire.

How it works



Amount payable based on \$10,000 Initial Diagnosis Benefit.

AFLAC GROUP HOSPITAL INDEMNITY

Policy Series C80000



The plan that can help with expenses and protect your savings.

Does your major medical insurance cover all of your bills?

Even a minor trip to the hospital can present you with unexpected expenses and medical bills. And even with major medical insurance, your plan may only pay a portion of your entire stay.

That's how the Aflac Group Hospital Indemnity plan can help.

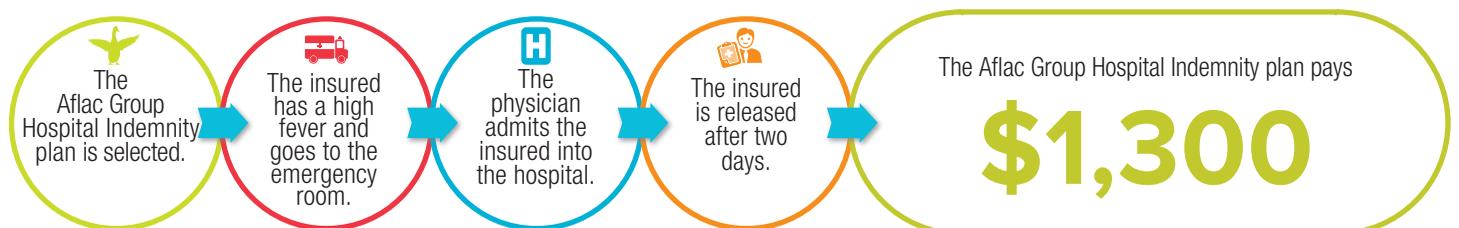
It provides financial assistance to enhance your current coverage. So you may be able to avoid dipping into savings or having to borrow to address out-of-pocket-expenses major medical insurance was never intended to cover. Like transportation and meals for family members, help with child care, or time away from work, for instance.

The Aflac Group Hospital Indemnity plan benefits include the following:

- Hospital Confinement Benefit
- Hospital Admission Benefit
- Hospital Intensive Care Benefit and more



How it works



Amount payable was generated based on benefit amounts for: Hospital Admission (\$1,000), and Hospital Confinement (\$150 per day).

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The plan has limitations and exclusions that may affect benefits payable. This brochure is for illustrative purposes only. Refer to your certificate for complete details, definitions, limitations, and exclusions.

AFLAC GROUP WHOLE LIFE INSURANCE

Policy Series C60000



While we all know that life insurance helps protect our loved ones for the long term, sometimes we don't consider that there are other benefits of a whole life insurance plan as well.

Priced to fit most budgets, Aflac Group Whole Life insurance can give your family a financial cushion when they need it. And, unlike some kinds of life insurance, a whole life insurance plan won't be canceled just because you reach a certain age.

Aflac Group Whole Life insurance doesn't only look out for your family's tomorrow--it also works hard for you today.

What you may not realize is that in addition to offering valuable life insurance protection, Aflac Group Whole Life is designed to build cash value—at a guaranteed rate of return. It's a feature that could come in handy down the road for short-term or unplanned expenses.

There are other advantages, as well:

- You may apply for benefit amounts by answering only a few medical questions.
- Once your Whole Life insurance application has been approved and payroll deductions have started, the coverage is yours to keep as long as you continue to pay premiums.
- Aflac Group Whole Life builds cash value that you can access for life's challenges and life's opportunities.

Aflac Group Whole Life insurance is flexible, too. You can apply for coverage that fits your budget and lifestyle.

Whole Life Benefit Coverage Options:

- Employee
- Spouse
- Children ages 15 days through 25 years may be covered in either of these two ways:
 - A Child Term Rider for dependent children (the rider will cover all of your dependent children), or
 - A separate Whole Life plan for each of your dependent children

Additional Benefits:

- Accelerated Benefit Rider (employee and spouse only)
- Accidental Death Benefit Rider (employee and spouse only)
- Waiver of Premium Benefit Rider (employee only)

Features:

- Premiums will not increase.
- Benefits may be paid directly to your named beneficiary.
- Coverage is portable, which means you can take it with you if you change jobs or retire.
- Premiums are paid through convenient payroll deduction.

Health care doesn't have to be hard

Meet Health Advocacy, available through Aflac.

Dealing with health care and health coverage can be complicated — and often stressful. But now you have help from Health Advocacy.

Health Advocacy provides a team of experts who can help solve your health care and insurance-related questions. They can help you with a variety of needs like finding specialists, clarifying coverage, addressing claim issues and getting second opinions.



Get care for your health care.



HEALTH ADVOCACY CAN HELP:

-  FIND DOCTORS AND TREATMENT CENTERS
-  COORDINATE CARE AND SECOND OPINIONS
-  UNTANGLE MEDICAL BILL AND CLAIM ISSUES
-  AVAILABLE 24/7, ANYTIME, ANYWHERE

Get confidential, personalized help with Health Advocate:



Find doctors, specialists, hospitals and other providers



Schedule appointments for treatments and tests



Coordinate second opinions and care



Resolve issues, from claims problems and medical bills, to coordinating benefits



Get help with eldercare issues, including Medicare and related healthcare issues for your parents and parents-in-law



Get answers about your test results, treatments, prescriptions and more



Work with your insurance companies to get approvals and clarify coverage



Transfer medical records, lab results and X-rays



Here for you 24/7 by convenient app or phone

HealthAdvocateSM

Health care just got easier with Health Advocacy.

When your coverage begins, call **855.423.8585** or visit healthadvocate.com/aflac

Available through Aflac, powered by Health Advocate.

CAIC's affiliation with the Value-Added Service providers is limited only to a marketing alliance, and CAIC and the Value-Added Service providers are not under any sort of mutual ownership, joint venture, or are otherwise related. CAIC makes no representations or warranties regarding the Value-Added Service Providers, and does not own or administer any of the products or services provided by the Value Added Service providers. Each Value-Added Service Provider offers its products and services subject to its own terms, limitations and exclusions. Value Added Services are not available in Idaho or Minnesota. State availability may vary. Continental American Insurance Company, a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated.

Medical Bill Saver has restrictions for negotiations on in-network deductibles and co-insurance in Arizona, Colorado, District of Columbia, Illinois, Indiana, New Jersey, New York, North Carolina, Ohio, South Dakota, Texas, Utah and Vermont.

aflacgroupinsurance.com | 1.800.433.3036

Continental American Insurance Company | Columbia, South Carolina

Make sure your business stays your business

Stay secure with Fraud Protection, available through Aflac.

It happens everywhere, every day. One in every 16 people in the U.S. were victims of identity theft in 2016. It's no wonder that fraud is among the top concerns for working adults.* No one wants to go through the hassle, expense and time of dealing with fraud.

But you can protect yourself. Your employer and Aflac have teamed up to provide an easy way to reduce your risk of becoming the next victim — at no cost to you.

Fraud Protection is now available to you as part of your employer's benefits package.



FRAUD IS A REAL CONCERN. BUT NOW THERE'S A REAL SOLUTION.



SAFE, SECURE DIGITAL STORAGE OF PERSONAL INFO



EMAIL ALERTS



RECOVERY PROCESS FOR LOST/STOLEN WALLET, FRAUD OR ID THEFT



LIVE SUPPORT 24/7

Fraud Protection gives you stronger peace of mind.

These services are automatically available to you when your coverage begins.



RESTORE

Certified Resolution Specialist

- Fully managed restoration services
- One-on-one dedicated care

End2End Defense SM 32-step recovery process

- For lost/stolen wallet, breached data, fraud or ID theft
- Designed to discover, isolate and prevent future fraud



24/7 LIVE SUPPORT

Expert assistance, whenever and wherever you need it

- 24/7 access to expert professionals who can help you if fraud or identity theft occurs

These services require registration and additional information before they're available for use:



SECURE

Online Identity Vault

- Secured digital storage for personal and account information, vital documents, images and other data
- Mobile app for on-the-go access to manage your identity
- Password Manager

Expert Protection Tips and Timely News

- Monthly activity reports via email detailing your account status and protection tips
- Breach alert emails to make you aware of recent breaches and scams



MONITOR

Internet Monitoring

- Fraud exposure report of your personal information on black market websites
- Daily monitoring for your personal information (stored in your Online Identity Vault)



Aflac's Fraud Protection is here for you.

When your coverage begins,
call: **866-826-8851** | visit: **aflac.ezshield.com**.

Available through Aflac, powered by EZShield.

*Identity Theft Hit an All-Time High in 2016, USAToday.com, February 6, 2017
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Continental American Insurance Company | Columbia, South Carolina

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HAVE YOU EVER?

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Needed your Will prepared or updated <input type="checkbox"/> Been overcharged for a repair or paid an unfair bill <input type="checkbox"/> Had trouble with a warranty or defective product <input type="checkbox"/> Signed a contract <input type="checkbox"/> Received a moving traffic violation <input type="checkbox"/> Had concerns regarding child support | <ul style="list-style-type: none"> <input type="checkbox"/> Worried about being a victim of Identity theft <input type="checkbox"/> Been concerned about your child's identity <input type="checkbox"/> Lost your wallet <input type="checkbox"/> Worried about entering personal information on-line <input type="checkbox"/> Feared the security of your medical information <input type="checkbox"/> Been pursued by a collection agency |
|--|---|

WHAT IS LEGALSHIELD?

LegalShield was founded in 1972, with the mission to make equal justice under law a reality for all North Americans. The 3.5 million individuals enrolled as LegalShield members throughout the United States and Canada can talk to a lawyer on any personal legal matter, no matter how trivial or traumatic, all without worrying about high hourly costs. LegalShield has provided identity theft protection since 2003 with Kroll Advisory Solutions, the world's leading company in ID Theft consulting and restoration. We have safeguarded over 1 million members, provided more than 200,000 identity consultations, and helped restore nearly 10,000 individual identities.

THE LEGALSHIELD® MEMBERSHIP INCLUDES:

-  ✓ Personal Legal advice on unlimited issues
-  ✓ Letters/ calls made on your behalf
-  ✓ Contracts & documents reviewed (up to 15 pages)
-  ✓ Residential Loan Document Assistance
-  ✓ Lawyers prepare your Will, your Living Will and your Health Care Power of Attorney
-  ✓ Moving Traffic Violations (available 15 days after enrollment)
-  ✓ IRS Audit Assistance
-  ✓ Trial Defense (if named defendant/ respondent in a covered civil action suit)
-  ✓ Uncontested Divorce, Separation, Adoption and/or Name Change Representation (available 90 days after enrollment)
-  ✓ 25% Preferred Member Discount (Bankruptcy, Criminal Charges, DUI, Other Matters, etc.)
-  ✓ 24/7 Emergency Access for covered situations

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under age 18 for whom the member is legal guardian; never married, dependent children up to age 26 if a full-time college student; and physically or mentally disabled dependent children. An individual rate is available for those enrollees who are not married, do not have a domestic partner and do not have minor children or dependents. No family benefits are available to individual plan members. Ask your Independent Associate for details.

THE IDSHIELD™ MEMBERSHIP INCLUDES:

-  **Privacy Monitoring**
Monitoring your name, SSN, date of birth, email address (up to 10), phone numbers (up to 10), driver license & passport numbers, and medical ID numbers (up to 10) provides you with comprehensive identity protection service that leaves nothing to chance.
-  **Security Monitoring**
SSN, credit cards (up to 10), and bank account (up to 10) monitoring, sex offender search, financial activity alerts and quarterly credit score tracking keep you secure from every angle. With the family plan, Minor Identity Protection is included and provides monitoring for up to 8 children under the age of 18.
-  **Consultation**
Your identity protection plan includes 24/7/365 live support for covered emergencies, unlimited counseling, identity alerts, data breach notifications and lost wallet protection.
-  **Full Service Restoration**
Complete identity recovery services by Kroll Licensed Private Investigators and our \$5 million service guarantee ensure that if your identity is stolen, it will be restored to its pre-theft status.

IDShield plans are available at individual or family rates. A family rate covers the member, member's spouse and up to 8 dependents up to the age of 18

Payroll Deduction Weekly	Individual	Family
LegalShield	3.91	4.37
IDShield	2.07	4.37
Combined	5.98	7.82

For more information, please call your independent associate:
Ali C. Sanders
 248-991-5065
 Email: alisanders@legalshieldassociate.com
 Website: alisanders.legalshieldassociate.com

This is a general overview and is for illustrative purposes only. Plans and services vary from state to state. See a plan contract for your state of residence for complete terms, coverage, amounts, conditions and exclusions.

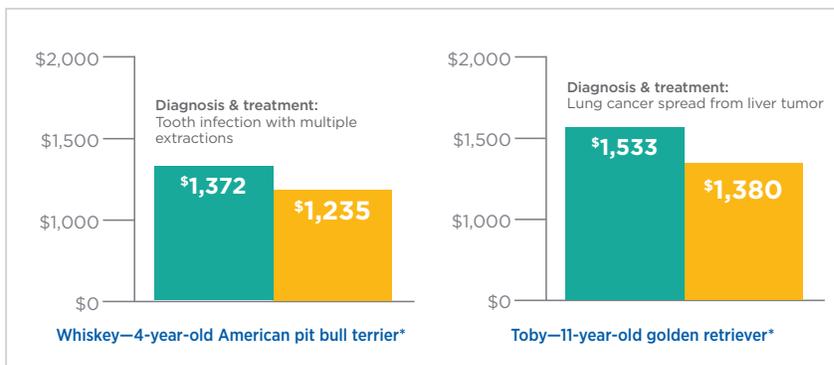
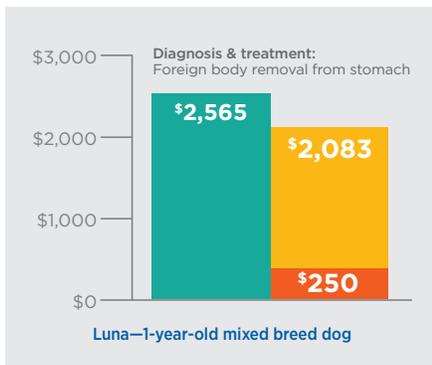
Discover the greatest **pet insurance benefit** ever offered.



My Pet Protection® is offered exclusively to employees and gives your pet superior protection at an unbeatable price.

- ✓ 90% back on vet bills¹
- ✓ Visit any vet, anywhere
- ✓ Exclusive to employees, not available to the general public
- ✓ Same price for pets of all ages
- ✓ Best deal: average savings of 30% over similar plans from other pet insurers²

My Pet Protection helped these pets' parents keep their bank accounts in the black



*Annual deductible met on previous claim

Claim amount Reimbursement by Nationwide Annual deductible

Sample reimbursements are based on actual claims but have been edited for clarity.

Sign up multiple pets with individual plans and receive a discount³ for even more savings.

Get a free, no-obligation quote today at petinsurance.com/stclaircounty



Save some bones on vet bills with **My Pet Protection**[®] from Nationwide[®].



- **Accidents**, including poisonings and allergic reactions
- **Injuries**, including cuts, sprains and broken bones
- **Common illnesses**, including ear infections, vomiting and diarrhea
- **Serious/chronic illnesses**, including cancer and diabetes
- **Hereditary** and congenital conditions
- **Surgeries** and hospitalization
- **X-rays**, MRIs and CT scans
- **Prescription medications** and therapeutic diets

Just like all other pet insurers, we don't cover **pre-existing conditions**^{*}. However, we go above and beyond with extra features such as **emergency boarding, lost pet advertising and more**. This plan has a low \$250 annual deductible and a generous \$7,500 maximum annual benefit.

***Any illness or injury that your pet had prior to the start of your policy will be considered a pre-existing condition.**

Preventive care coverage is available for checkups, shots and more through My Pet Protection with Wellness[®].

Easy enrollment

1 Select the species (dog or cat)^{*}

2 Provide your zip code

3 Pick your plan

^{*}To enroll your bird, rabbit, reptile or other exotic pet, please call 888-899-4874.



Available to all pet insurance members. Unlimited, 24/7 access to a veterinary professional (\$150 value). Only from Nationwide[®].



Get your pet insurance reimbursements deposited directly to your bank.

Submit claims right from your smartphone with the free VitusVet app.



Download from the App Store



Download from Google Play

Email, fax and snail mail claim submissions also available.

My Pet Protection[®] is available exclusively through your employer. Enroll online today—it's quick and convenient. [<URL>](#)

¹Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. ²Average based on similar plans from top competitors' websites for a 4-year old Labrador retriever in Calif., 90631. Data provided using information available as of December 2017. ³Pet owners receive a 5% multiple pet discount by insuring two to three pets or a 10% discount on each policy for four or more pets.

Insurance terms, definitions and explanations are intended for informational purposes only and do not in any way replace or modify the definitions and information contained in individual insurance contracts, policies or declaration pages, which are controlling. Such terms and availability may vary by state and exclusions may apply. Underwritten by Veterinary Pet Insurance Company (CA), Columbus, OH, an A.M. Best A+ rated company (2017); National Casualty Company (all other states), Columbus, OH, an A.M. Best A+ rated company (2017). Agency of Record: DVM Insurance Agency, Nationwide, the Nationwide N and Eagle, and Nationwide is on your side are service marks of Nationwide Mutual Insurance Company. ©2018 Nationwide. 18GRP5362b (50) 18GRPOEMP1



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is on your side

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HAVE MORE
FUN!**



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or email: customerservice@ticketsatwork.com

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- 4 Or, you can place your order by phone. Call customer service at 800-331-6483. Orders are taken from 8:30am-12am/7 days a week (holidays included). Eastern Standard Time.